EXECUTIVE SUMMARY

The CCM in Burkina Faso was hurriedly set up in January 2002, on the basis of the existing national body, named CNLS-IST, created two years earlier with the purpose of fighting AIDS. The CNLS-IST was composed of public institutions, private sector, civil society, bilateral and multilateral partners; some of them, plus the main institutions for the fight against TB and Malaria, today form the CCM. Due to time constraints, it has not been possible to proceed in a more democratic and participatory way.

The Permanent Secretariat of the CNLS-IST also plays the role of CCM Secretariat. Nevertheless, this structure has not been reinforced neither in human and financial resources, nor in technical and logistical facilities. This weakness is the main - and probably the sole - hindrance to a more effective and well informed participation of the CCM members in the proposals analysis as well as in the decision-making phases.

Within the CCM, all the sectors are equitably represented.

All the CCM members appear to be strongly motivated and willing to manage the challenge. During the projects formulation phase, specific and qualified technical working groups were set up, open to anyone who wanted to give his/her contribution.

No major conflict has been observed among the CCM members, even if the civil society representatives feel that they could have been more involved in the decision-making process.

The setting up of PAMAC - *Programme d'Appui au Monde Associatif et Communautaire* (Support Programme for Associations and Communities) and its involvement in the GF Programme implementation, is partially bridging the democracy and participation gap.

Probably because of the lack of democracy in the setting up process, the information flow from/to the constituencies is very weak and scarce, especially with respect to those CCM members representing the civil society, the bilateral and multilateral partnership.

Recommendations for the coming future: measures should be taken as soon as possible, in order to:
- increase the governance, monitoring and evaluation capacity of the CCM, also involving the Burkinabè scientific bodies,
- review the CCM composition, particularly considering the frequent absence of some of the Ministers and the newly created important networks and coordination bodies,
- reinforce the communication capacities of the CCM as such,
- encourage the civil society representatives, who are CCM members, to increase their commitment with respect to the information and communication flow with their constituencies, which has been too weak so far.
- undertake as soon as possible - with the involvement of PAMAC - capacity building initiatives in favour of NGOs and CBOs who wish to submit project proposals to CCM (and consequently to the GF),

- consider the opportunity of widening the competence of PAMAC also to associations, NGOs and CBOs committed in the fight against TB and Malaria,
- provide the SP with specific office facilities, electronic devices, re-unified archives, procedures guidelines, adequate and sufficient human resources,
- define and approve a programme, a methodology and a time table in order to facilitate the SP management and - subsequently - the handing over of the PR role within the next two years.
- define a specific budget for the CCM and SP, and identify the necessary funding body/ies accordingly,
- provide the SP personnel with a short, intense, capacity building programme to enable them to fairly manage the CCM activities and play the role of PR within the next two years.

1. INTRODUCTION

1.1. BACKGROUND AND PURPOSE OF THE STUDY

The Global Fund has conducted several informal reviews and analyses to provide information on the composition and functioning of the CCM and to the extent they have fulfilled Global Fund principles on public-private partnership. These reviews, and discussions during regional meetings with CCM members and the Fund Portfolio Managers, show that CCMs are working well in some countries but not so well in other countries. A major issue is the composition of the CCM, especially the inclusion and participation of civil society.

Subsequently, the Global Fund is undertaking CCM case studies in selected countries, in order to examine:
- the setting-up and composition of the CCMs, as a public-private partnership,
- the level and scope of participation in decision-making of all members,
- the CCM governance procedures and processes,
- the involvement of members in project formulation, implementation, monitoring and evaluation,
- the co-ordination and harmonisation with national fora, policies, programmes, and funding channels,
- an assessment of the technical needs of the CCM and its members.

The studies are being funded by various bilateral partners. The one related to Burkina Faso has been funded by the Italian Cooperation.

In such a framework, this mission has studied the CCM setting up process in Burkina Faso, the reasons and the ways of inclusion / exclusion of the different actors, the participation and the information processes, the modus operandi, the perspectives and the technical needs to be addressed in order to improve not only the mechanism, but the very philosophy that paves the mechanism itself.

1.2. METHODOLOGY

The mission, conducted from 14th to 24th January 2004, carried out various activities:
- 39 individual interviews with CCM members as well as with non members that, in principle, should represent the respective constituencies;
- 2 plenary sessions with the main bodies: the CCM and the *Comité Technique de Rédaction* (Drawing Technical Committee);
- 5 visits to significant health structures, managed by different entities and associations;
- collection and consultation of the formal documentation:
  - CNLS-IST and CCM institutive decrees;
  - « Rapport Global de l'évolution de la requête générale du Burkina Faso au Fonds Mondial de Lutte contre le SIDA, la Tuberculose et le Paludisme », issued by the SP in August 2003 ;

- Implementation Plan of the AIDS and Malaria components;
- Programme Grant Agreement between the GF and the PR;
- various leaflets.

Totally, 106 persons have been met and interviewed, some of them even more than once.

People interviewed have been provided, when possible in advance, with an “open” questionnaire translated in French, so that they had the time to consider and to prepare the answers / recommendations they wished to express to the Consultant.

In order to facilitate the frankly-speaking, the Consultant reassured every person interviewed that the final report would not have reported “*who said what*”.

The meetings held are summarised in the next page.

The complete list of meetings held and people met, in chronological order, is in appendix no. 1.

LIST OF THE ENTITIES MET /INTERVIEWED
(listed in alphabetical order)

	CCM Members	Non CCM Members
Institutions	1. CCM - plenary session 2. CCM - Comité Technique de Rédaction des propositions 3. Ministère pour la Promotion de la Femme 4. Ministre de la Santé 5. PNLP - Programme National de Lutte contre le Paludisme 6. PNLT - Programme National de Lutte contre la Tuberculoses 7. SP / CNLS - Secrétariat Permanent du Conseil National de Lutte contre le SIDA	1. CMLS - Comité Ministériel de Lutte contre le SIDA du Ministère de la Santé. 2. PAMAC - Programme d'Appui au Monde Associatif et Communautaire 3. PA-PMLS - Projet d'Appui au Programme Multisectoriel de Lutte contre le SIDA et les IST
Civil society representatives	1. « Personnes vivant avec le VHI » Representative 2. Catholic Church Representative 3. CICDoc - Centre d' Information Communication et Documentation 4. Islamic Communities Representative 5. MSF - Medecins Sans Frontières Luxembourg 6. National NGOs Representative 7. Protestant Churches Representative, and related « Centre Vigilance » 8. SPI - Population Services International 9. Traditional leaders Representative	1. ALAVI - Laafi La Vi im 2. CASO - Centre d'Accueil et de Solidarité 3. CMH SC - Centre Médical Hospitalier St Camille 4. CTA - Centre pour le Traitement Ambulatoire 5. ITALIAN NGOS : CISV, GVC, ISCOS, LVIA, Medicus Mundi, Terre des Hommes Italia 6. LVIA 7. PSF - Pharmaciens Sans Frontières 8. RAME - Réseau pour l'Accès aux Médicaments Essentiels 9. UNION SACREE pour la Gratuité des Médicaments ARV
Private sector	1. Ordre des Pharmaciens	
International Organisations	1. UNAIDS 2. UNDP 3. WHO	1. European Union Delegation
Bilateral Partners	1. Dutch Cooperation 2. French Cooperation 3. Italian Cooperation	1. Belgian Cooperation 2. German Cooperation GTZ 3. US Embassy, Health Sector

Visits paid to Health structures providing services to people living with HIV/AIDS

ALAVI	Centre pour le dépistage, le traitement et le suivi (association s.b.l.)
CASO	Centre d'Accueil et de Solidarité des Pères Camilliens
CMH SC	Centre Médical Hospitalier St Camille
CTA	Centre pour le Traitement Ambulatoire (para-étatique)
CV	Centre Vigilance de la Communauté Protestante

1.3. HEALTH IN BURKINA FASO AT A GLANCE

The Burkinabè Gross National Product - at a constant rate - increased from 752 billions FCFA in 1990 to 1,068 billions FCFA in 1999, with a growth rate of 4% (source: UNDP annual reports). Having considered an estimated debt - in 1996 - reaching 237% of the goods and services total export, Burina Faso has been included among the HIPC (Heavily Indebted Poor Countries) Initiative (PPTE - Pays Pauvres Très Endettés)

The public budget share granted to health has been, in these last years:
- 1999: 9.11%
- 2000: 8.03%
- 2001: 6.32%
- 2002: 9.23%

The public expense for health has been, in 2001, approximately 4.27 US$ per capita.

From the administrative point of view, the country is divided in 13 Regions and 45 Provinces.

The health infrastructure, headed by the Ministry of Health, is being decentralised: the country has been organised in 13 Régions Sanitaires (Health Regions) (but still they have scarce power) and 55 Health Districts. Each District is provided with a CMA - *Centre Médical avec Antenne chirurgicale* (Health Centre with surgical post) or a CM – *Centre Medical*. At the very base level, 800 CSPS - *Centres de Santé et de Protection Sociale* (Health and Social Protection Centres) are also in place.

Medical doctors availability: 400, but only 350 active in the field (the remaining 50 being involved in bureaucratic tasks); i.e. 1 every 30,000 citizens.

Here below are some basic data concerning the three diseases.

<u>Malaria</u>

In Burkina Faso Malaria is a permanent endemic disease with seasonal recrudescences, from May to October.
Health statistics in 1999, issued by the Ministry of Health, show:
- ⇨ 43 % of consultations in health centres were related to malaria;
- ⇨ 53.4% of hospitalised children under 5 were affected by malaria;
- ⇨ a CNRFP study carried out in 2001, revealed that 70% of women visited in the Pre-natal Assistance Centres and 55% of women in labour had Plasmodium Falciparum in their peripheral blood;
- ⇨ 23.3% of deaths supervened in the health structures were due to malaria;
- ⇨ 70.4% of deaths due to malaria hit children under 5.

These data do not reflect entirely the reality, because of the low rate of utilisation of the health structures by the population (21.16%); furthermore, data from the private structures are not available.

HIV/AIDS

Burkina Faso officially recognised the existence of the HIV infection on its territory in 1986. Since then and until 2001, despite the extremely low diagnosis requests, 18,144 AIDS cases have been detected by the health structures (*data provided by SP/CNLS 2001*).

In 1997 the sero-prevalence rate among the sexually active population (or, following other sources, the population between 15 and 50 years) has been calculated at 7.17%. This figure increases up to 59% among the prostitutes in Ouagadougou and up to 13.1% among the truck drivers in the same city.

Data referred to 2002 indicate the sero prevalence rate at 6.1%. But these data are not comparable with the previous ones, due to the different methodologies of collection and treatment.

Tubercolosis

Also for TB the estimated data are approximate. It is estimated that there are 75 new smear-positive TB cases every 100,000 persons; thus 9,000 new cases are expected in 2004. But the real testing, and the respective treatment, remain much below such estimated figures. Actually, in 2001 only 2,530 TB forms (pulmonary and non pulmonary) were detected, with a detection rate of 17.5%.

Although the average area covered by the health structures is very good (9.69 Km) if compared with other African countries, their utilisation rate is very low (21.16%), and this explains, at least partially, the situation.

As far as the treatment is concerned, in 2000 the results were the following:

- 52.89% of cured,
- 13.22% of treatments completed,
- 5.79% of therapeutical failure,
- 9.92% of deaths,
- 18.18% of defaulters and transferred persons.

The HIV prevalence rate among the TB patients is estimated at 35% (PNLT data issued in 1995 at Bobo Dioulasso).

2. THE CCM SETTING UP PROCESS

2.1. THE LONG TERM COMMITMENT OF THE "FASO"

The whole "Faso" (i.e. "the Country") is widely committed in fighting HIV/AIDS: since the beginning of 2000, the national institutions, as well as the civil society organisations (traditional, religious, cultural, philanthropic, etc.) are undertaking initiatives aimed at preventing and monitoring the epidemic spreading. This is testified by:

- number of prevention campaigns [such as the poster showing the President of the Republic together with a girl affected by AIDS, which has been distributed and exhibited in all the public buildings, offices, schools, health structures, etc.],
- the concrete participation in some international programmes (e.g. the "3 by 5" WHO initiative, the ESTHER" programme, the World Bank "TAP"),
- the creation of a number of associations devoted to the fight against AIDS,
- the involvement of other associations in the same fight, and - last but not least,
- the setting up of strategic tools such as the CNLS-IST - *Conseil National de Lutte contre le SIDA et les Infections Sexuellement Transmissibles* (National Council for the Fight against AIDS and STI) and the CMLS - *Comités Ministériels de Lutte au SIDA* (Ministerial Committees for the Fight against AIDS); these Councils will be illustrated in the following paragraphs.

2.1.1. The commitment at the institutional level

A - The CNLS-IST

Since the year 2000 the Burkina Faso State set up the **CNLS-IST** ([1]) - *Conseil National de Lutte contre le Sida et le infections sexuellement transmissibles* (National Council for the Fight against AIDS and Sexually Transmissible Infections), whose Chairman is the President of the Republic, while the Minister of Health and the Minister of Social Action are the first and the second vice presidents, respectively. Hereinafter we will refer to CNLS-IST simply with the abbreviated acronym "CNLS".

The CNLS is composed of 72 persons, representing the State institutions, the civil society, the bilateral and multilateral partners. The CNLS is provided with a **SP** - *Secrétariat Permanent* (Permanent Secretariat) headed by the *Secrétaire Permanent* (Permanent Secretary).

Here below the membership of the CNLS:
a) the Bureau:
- President: the President of Burkina Faso
- 1st vice president: the Minister of Health
- 2nd vice president: the Minister of Social Action

[1] Presidential Decree no. 2001 - 510 / PRES / PM / MS

- Rapporteur: The Permanent Secretary of the CNLS
- Minister of Economic Development
- Minister of Information
- Minister of the Women Promotion
- One representative of people living with HIV/AIDS
- Two representatives of national NGOs and associations
- Two representatives of the UNAIDS Thematic Group, namely WHO and UNDP [presently, UNDP has been replaced by UNICEF]

b) the remaining members:

- One representative of the Prime Minister's Office
- Three representatives of the Ministry of Health
- One representative of the Ministry of Social Action
- Two representatives of the Ministry of Economy and Finances
- One representative of the Ministry of Information
- Two representatives of the Ministry of Women Promotion
- The president of the AIDS Sectorial Committee and one focal point of the following ministries:
    - ✓ Defence
    - ✓ Territorial Administration and Decentralisation
    - ✓ Secondary and High School and Scientific Research
    - ✓ Basic school and alphabetisation
    - ✓ Agriculture
    - ✓ Environment and Water
    - ✓ Animal Resources
    - ✓ Transport and Tourism
    - ✓ Youth and Sports
    - ✓ Employment, Work and Social Security
    - ✓ Mines and Energy
    - ✓ Justice and Promotion of Human Rights
    - ✓ Security
    - ✓ Art and Culture
    - ✓ Five representatives of the private sector, of which: two belonging to the health field and three belonging to the entrepreneur field
    - ✓ Three representatives of the Faith Communities
    - ✓ Three representatives of the Traditional Communities
    - ✓ Two representatives of the Municipalities Associations
    - ✓ One representative of the Economic and Social Council
    - ✓ One representative of the "Chambre des Représentants"
- Five representatives of the Civil Society, NGOs and National Associations (three of them are in the Bureau):
    - ✓ Ligue des Consommateurs,
    - ✓ IPC for the National NGOs,
    - ✓ AAS for the National NGOs,
    - ✓ CIC-DOC for the National Associations,
    - ✓ Mme Christine Kafando for people living with HIV/AIDS ([2])

[2] Christine Kafando, AAS and CIC-Doc are also in the CCM

- Two representatives of International NGOs (Save the Children Pays Bas; Plan International)
- Two representatives of Multilateral and Bilateral Organisations (World Bank and the Embassy of Netherlands)
- Three representatives of the UNAIDS Thematic Group, i.e. WHO, UNDP, European Union (two of them are in the Bureau).

With the exception of the President of the Faso, the Vice Presidents and the Rapporteur, the members are designated by their own original entity, with a mandate of three years, renewable only once.

The CNLS is the Coordination Body for the National Programme of Fight against AIDS and STI; it has the mandate to:
- define the policies and the main orientations of the fight against HIV/AIDS and STI;
- define the intervention fields, resources and kind of support needed for the implementation of the National Multi-sectorial Plan;
- assure the advocacy in favour of mobilisation and in support to the fight;
- approve the progress of work of the on-going National Multi-sectoral Plan and examine the Plan for the following year.

Given the composition and the mandate of the CNLS, and also considering that such an organism was provided with a Permanent Secretariat and a Permanent Secretary, it has been natural that the CNLS be identified as the basis on which to build up the CCM. This aspect will be deepened in the following paragraphs.

The CNLS identified 4 pillars for the fight against the pandemic:
1) prevention
2) epidemiological monitoring
3) global treatment of the infected people
4) institutional strengthening, coordination and international cooperation.

The pillar no. 3) - global treatment of the infected people - has been, so far, the weakest one, due to the high cost of the tests and drugs as well as to the scarcity of the health structures on the Burkinabè territory. Such a weakness justifies the strategic choice made in preparing the proposal submitted to the GF.

B - The CMLS

In 2000 also the **CMLS** - *Comités Ministériels pour la Lutte contre le Sida* (Ministerial Committees for the Fight Against AIDS) was set up within the Ministry of Health as well as in other 20 Ministries, in order to mobilise all the existing State infrastructures and resources.

C - The PAMAC

The PAMAC - *Programme d'Appui au Monde Associatif et Communautaire* (Support Programme for Associations and Communities) has been created in 2003 thanks to a UNDP grant; it is the "technical arm" of the CNLS with the task ofto coordinating all the civil society initiatives related to the fight against AIDS; soon we will see that it has a strategic role in the implementation of the initiatives funded by the GF.

2.1.2. The commitment at the civil society level

With regard to HIV/AIDS, the country counts 510 associations, each of them being composed of approx 50 persons, concretely involved in combating the plague, even if the majority of them have a wider range of mission ([3]). Out of them, approximately 60 are providing significant assistance to the patients; out of the 60, 18 have been defined, by the interviewed persons, as "highly qualified" and able to provide care and cure to the infected and affected people.

A special attention must be paid to the 30 associations created, in the recent years, by people living with HIV/AIDS and their relatives and friends. This phenomenon, that may be found in large parts of Africa, seems to be particularly interesting in Burkina Faso, when one compares the enthusiasm of these people with the poor (sometimes extremely poor) living conditions characterising the country. Practically every officer representing the public sector (State Actors, Bilateral Partners, Multilateral Partners) said that these associations are able not only to provide testing, treatment and psycho social support, but also to assist the orphans and to undertake successful fund raising initiatives; on the contrary, they are considered not particularly ready and not strong enough for playing an effective advocacy role.

Bilateral Partners affirmed that without the involvement of the associations it would be extremely difficult to implement any health programme, because of the weakness and inefficiency of the 800 CSPS - *Centres de Santé et de Protection Sociale* (Health and Social Protection Centres); their human resources being not sufficient and not enough qualified, nor motivated - a partner said - it would be unimaginable that such CSPS could also manage the programmes funded by the GF!

The associations proved also an important capacity to set up networks that allow to exchange experiences, methodologies, and to increase their negotiation power. Let us mention four of these networks:

- ⇨ *CIC-Doc - Centre d'Information, Communication et Documentation* (Information, Communication and Documentation Centre), composed of 7 associations plus other 70 organised in network; the associations included in this network carry out approximately 90% of the identification of infected people in the country;

[3] It is interesting to highlight that the total number of associations in the Country is around 600; this data confirms that the great majority of the civil society is committed in the fight against Aids.

- ⇨ *RAME - Réseau pour l'Accès aux Médicaments Essentiels* (Network for the Access to Essential Drugs) ; all the associations working in the AIDS sector are in this network;
- ⇨ *Union Sacrée pour la Gratuité des Médicaments ARV* (Sacred Union for the Gratuitousness of ARV Drugs), which has been created on the 13th of January 2004 by 400 associations.
- ⇨ *SPONG - Secrétariat Permanent des ONG* (Permanent NGOs Secretariat), which has been defined as the « Coalition of the National and International NGOs operating in Burkina Faso ». The SPONG has not been created specifically for the AIDS, but it is showing an important involvement in the issue.

On the contrary, the civil society does not appear particularly committed in the fight against Malaria and TB, in spite of a large number of associations/cooperatives deeply rooted in rural area.

2.2. CCM SETTING UP AND COMPOSITION

2.2.1. The process

The GFATM was established in January 2002. At that time, the Resident Representatives of UNAIDS and WHO met three times with the SP (15 January, 2 February and 13 February) in order to present and explain the nature and the perspectives of the new body, as well as in order to encourage and facilitate the setting up of the CCM.

A workshop was then held (27 February - 2 March 2002), with the specialists of the three pandemics, aimed at identifying the proposals to be submitted to GF. During a three-day meeting (3, 4 and 5 March), a *Comité Technique de Redaction* (Technical Working Group) finalised the proposals to be submitted to the CCM for approval.

The CCM itself was formally constituted on March 6th 2002; the first proposal was approved on the same day and forwarded to Geneva on March 7th [4]!. The CCM is chaired by the Minister of Health; the Permanent Secretary of the CNLS is the first Rapporteur and the Director General of the Ministry of Health is the second one.

In setting up the CCM the highest authorities of the Faso decided that:

1. the CCM would be composed of :
    - ⇨ the 12 members of the CNLS Bureau,
    - ⇨ the representatives of the structures devoted to the fight against Malaria and TB,
    - ⇨ some of the most important representatives of the local civil society already members of the CNLS,
    - ⇨ some representatives of the private sectors also members of the CNLS,

[4] In the 1st Round, the deadline for the submission of proposals was March 10th 2002.

- ⇨ one bilateral partner member of CNLS plus other two, and
- ⇨ four international organisations members of CNLS plus a new one;

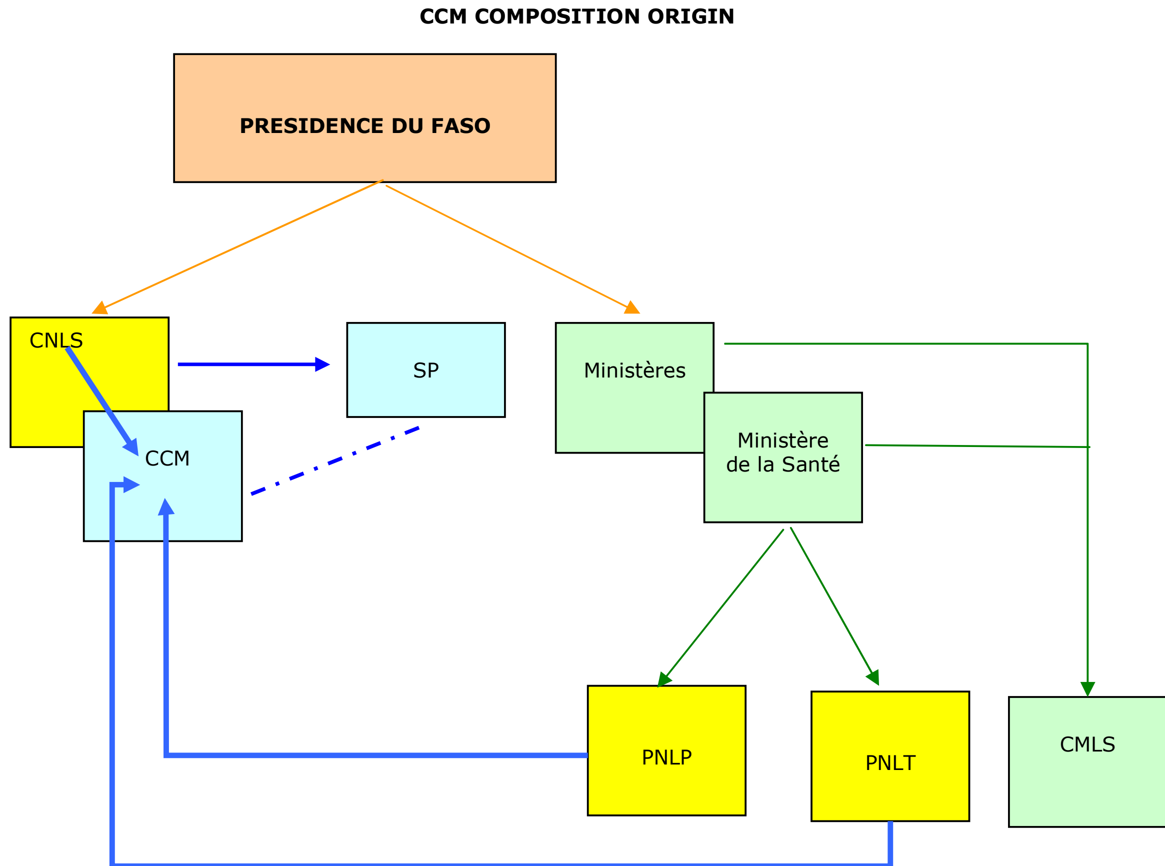
2. the Burkinabè name of the CCM is CG/STP - *Comité de Gestion du Fonds Global de lutte contre le Sida, la Tuberculose et le Paludisme*

3. the SP of the CNLS would also play the role of the CCM Secretariat.

According to such criteria, the CCM is now composed of 30 persons:

	SECTOR PARTNER	MEMBERS
1	REPRESENTATIVES OF THE PUBLIC SECTOR	MINISTER OF HEALTH
2		MINISTER OF SOCIAL ACTION
3		MINISTER OF ECONOMY AND DEVELOPMENT
4		MINISTER OF INFORMATION
5		MINISTER OF THE WOMEN PROMOTION
6		PERMANENT SECRETARY OF THE CNLS-IST
7		PNLT COORDINATOR
8		PNLP COORDINATOR
9		MINISTRY OF HEALTH, DIRECTOR OF STUDIES AND PLANNING DPT
10		MINISTRY OF HEALTH, DIRECTOR GENERAL
11	REPRESENTATIVES OF THE PRIVATE SECTOR AND CIVIL SOCIETY (NGOS, CBOS)	PEOPLE LIVING WITH HIV/AIDS
12		NATIONAL NGOS
13		NATIONAL ASSOCIATIONS
14		POPULATION SERVICES INTERNATIONAL
15		MEDECINS SANS FRONTIERES
16		CHEMISTS ORDER
17		MEDICAL DOCTORS AND DENTISTS ORDER
18		UNIVERSITE' DE OUAGADOUGOU
19		CATHOLIC COMMUNITY
20		MUSLIM COMMUNITY
21		PROTESTANT CHURCHES
22		TRADITIONAL COMMUNITIES
23	PARTNERS	UNDP
		UNAIDS
25		WB
26		WHO
27		UNICEF
28		NETHERLANDS EMBASSY
29		FRANCE EMBASSY
30		ITALIAN COOPERATION

The following design could be the graphic representation of the CCM composition origin:



2.2.2. Analysis of the CCM composition and designation

The strategic choice made by the authorities - i.e. to build up the CCM on the basis of the existing structure - must be considered in the light of the timetable constraints; nevertheless, this implied a certain disregarding of the democratic principles and practices, particularly with respect to the civil society. Actually, an analysis of the CCM composition reveals the following elements.

As far as the representatives of the local civil society are concerned, it has to be noted that neither public announcement, nor public selection or election from the constituencies were made. The SP called the single persons who were already in the CNLS and/or people designated by their respective hierarchies (this is the case of the Faith Based Organisations' Representatives).

This branch of the CCM includes the representatives of the following realities:
- ⇨ Representative of People living with HIV/AIDS
- ⇨ National NGOs
- ⇨ National Associations
- ⇨ Population Service International
- ⇨ Medécins Sans Frontières
- ⇨ Ordre des Pharmaciens
- ⇨ Université de Ouagadougou
- ⇨ Catholic Community
- ⇨ Islamic Community
- ⇨ Protestant Churches
- ⇨ Traditional Leaders

When examining the group of the civil society representatives, some shortcomings appear: there is no representation of the associations operating, or that could be mobilised, against Malaria and TB such as rural associations (cooperatives, etc.). Such shortcomings are among the most evident and serious consequences of the choice mentioned above (i.e.: basing the CCM on the CNLS).

The “profit” Private Sector is represented only by the Chemists Professional Council and the Medical Doctors and Deontologists Professional Council, both being already included in the CNLS. Other private actors whose sense of solidarity would be particularly precious, such as the journalists and mass media operators, pharmaceutical factories, health operators other than doctors, etc., are not represented at all.

As far as the International Organisations are concerned, practically all those directly involved in the fight against the three diseases have been included in the CCM.
- ⇨ UNAIDS
- ⇨ UNDP
- ⇨ UNICEF
- ⇨ WHO
- ⇨ WB

The European Union is conspicuous for its absence, despite its commitment in the fighting against Aids!

The Bilateral Partners have been co-opted on a mutual agreement basis, but they were not designated by the community of the bilateral partners present in the country.
- ⇨ Dutch Embassy
- ⇨ French Embassy
- ⇨ Italian Cooperation

The State structures members of the CCM seem to be sound, with the exception of the CMLS of the Ministry of Health, whose exclusion is not easily understandable. They consist in:
- ⇨ Minister of Health - Chair
- ⇨ Minister of Social Action
- ⇨ Minister of Economy and Development
- ⇨ Minister of Information

- ⇨ Minister of Women Promotion
- ⇨ Permanent Secretary of the CNLS
- ⇨ Coordinator of the PNLP
- ⇨ Coordinator of the PNLT
- ⇨ Director of the Studies and Planning Dept. of the Ministry of Health
- ⇨ Director General of the Public Health of the Ministry of Health

Practically, among 10 State members of the CCM:

- ⇨ 4 are non health related bodies
- ⇨ 6 are health related bodies, of which:
  - ✓ 3 generic, coming form the Ministry of Health
  - ✓ 3 specific, one per each disease

Nevertheless, if more time was available, very probably the State actors could have been chosen more carefully, thus avoiding some serious absences. For example, somebody representing the focal points on HIV/AIDS in the different ministries could be more effective and could reinforce also the presence of the five ministries included. Also the PAMAC representative (see below) would have been an important resource person if included in the CCM but, as said, the PAMAC has been created one year after the CCM constitution.

It is particularly interesting to note that, in the Decree instituting the CCM the civil society representatives are defined as "*personnes resource*" (resource persons).

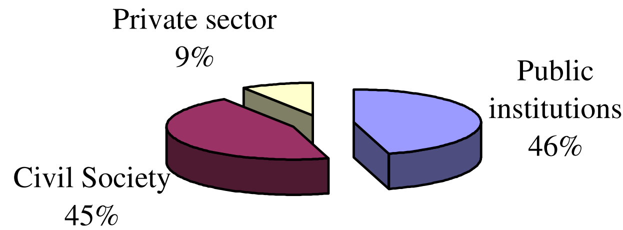
Analysis of the composition of the CCM from the point of view of the balance among the various types of actors:

Here below are the figures of the CCM members:

Public Institutions	10
Civil Society	10
Private sector	2
Bilateral org.	3
Multilateral org.	5
Total	**30**

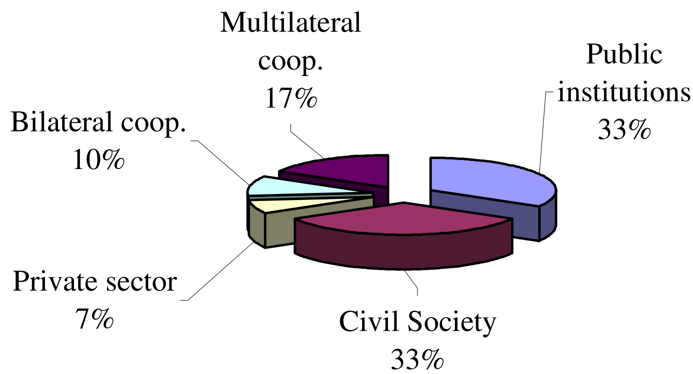
The CCM is composed of 30 members. If we consider only the Burkinabè entities (22 members), we observe that the balance between the "State" and the "non State" actors (the latter including both civil society and private sectors), is in favour of the "non State", which represents 54 % against 46% of the public institutions presence.

Only Burkinabè members



But if we consider the whole composition, it is evident that the "Institutional" sector (Burkinabè State bodies, bilateral co-operation and multilateral co-operation), represents 60% of the whole CCM, the remaining 40% being shared between civil society (33%) and private sector (7%).

Composition of the whole CCM



We can then conclude that, in terms of "space" formally given to the various actors, the attitude of the Burkinabè authorities has been fair.

3. GOVERNANCE AND ORGANISATION

3.1. GENERAL OVERVIEW

First of all the Consultant had the opportunity to note that both the Minister of Health and the CNLS Permanent Secretary are sincerely appreciated by all the members of the CCM. No major conflict has been noted among the members. The scarce critics expressed towards some mechanisms and dynamics have been attributed to the objectively difficult working conditions.

On the contrary, despite various difficulties due to the time and language constraints, the CCM has been able to work in great spirit of solidarity and participation, so that the various requests coming from the Global Fund Secretariat (clarifications, integrations, new forms to be filled etc.) have been always answered quickly and effectively.

Status of GF grants towards Burkina Faso

	Round	Total amount approved US $	Approved amount for 2 years US $	Grant agreement signed on	Funds disbursed US $		Future proposals
					date	amount	
HIV/AIDS	2	19,632,122	7,130,400	Nov. 04, 2003	Dec. 2nd, 2003	667,300	
Malaria	2	7,499,988	7,499,988	Nov. 04, 2003	Dec. 2nd, 2003	627,513	
TB	4						to be submitted within April 4th, 2004

3.2. MODUS OPERANDI AND SUPPORT STRUCTURE

The Permanent Secretary has convened the CCM plenary sessions each time a decision had to be taken ([5]).

From the minutes of the 11 sessions, we learnt that almost all the members regularly participated in the meetings, even if no financial benefit is granted. The main problem is represented by the Ministers, who normally prefer to be represented by some of their officers.

Practically, every proposal submitted to Geneva, included amendments, clarifications, integrations, has been previously approved by the CCM, with no exception.

The setting up of the *Comité Technique de Rédaction* has given the possibility to the CCM to have, in a very short time, complete proposals to be submitted and also to have the capacity to reply quickly to the requests of clarification / integration coming from the GF Secretariat. Another important positive aspect of the *Comité Technique de*

[5] Dates of the CCM plenary sessions: 6 March 2002, 14 April 2002, 5 May 2002, 25 May 2002, 28 June 2002, 23 September 2002, 14 March 2003, 8 July 2003, 14 March 2003, 10 June 2003, 18 July 2003.

Rédaction is that it has been open to everybody that wanted (and was able) to give his/her contribution for the definition of the proposal. This means that even people not included in the CCM has participated to the definition of the proposals.

In order to design the proposals and to answer to the GF Secretariat requests, the *Comité Technique de Rédaction* held 6 sessions ([6]).

In the Country there are 3 important institutions for medical research: the *Centre Muraz* based in Bobo Doulasso, the *Centre de Nouna in Nouna* based in Ouagadougou, and the *CNRFP - Centre National de Recherche et Formation sur le Paludisme* based in Ouagadougou. Due to time and budgetary constraints, only the CNRFP took part in the process of proposal making and reviewing.

As previously mentioned, the support structure of the CCM is the SP - *Secrétariat Permanent* (Permanent Secretariat) of the CNLS. The SP is organised in 7 Departments:

- Health
- Administration and Finances
- Monitoring and Evaluation
- Communication
- Relationship with CBO and FBO
- Solidarity Fund for the AIDS orphans
- Relationship with other Ministries and various companies.

Surprisingly, such structure has not been reinforced in view of the new task. Even physically, the Secretariat is divided in two different offices, the one far from the other:

- The Permanent Secretary, with two members of his personal secretariat, has the archives of the formal convocations, and relations with Geneva,
- The Director of the Health Dept. of the SP takes care of the minutes and archives of the CCM and Comité Technique de redaction.

Apart from this, the division of tasks between the two offices is not completely clear.

Both the Permanent Secretary and the Director of the Health Dept. have computers, e-mails, telefax and photocopy facilities, but the electronic devices seem to have more than a problem, particularly linked to the “fasonet.bf” provider.

So far, the CCM and its SP did not have a specific *budget de fonctionnement* (management budget); expenses have been covered by the CNLS budget.

3.3. INFORMATION - SHARING, PARTICIPATION AND DECISION MAKING MECHANISMS

The CCM members expressed an almost unanimous complaint concerning the timing of convocations and provision of documentation. It has been repeatedly said that the call for meetings and the supply of heavy documentation related to the decisions to be taken,

[6] Dates of the sessions: 3 - 5 March 2002, 24 - 24 April 2002, 15 - 18 May 2002, 29 June - 2 July 2002, 27 - 28 February 2003, 10 - 17 June 2003

normally arrived just a few days before the meeting date; because of lack of time, members were often unable to read, examine in depth the papers and to formulate questions and suggestions aimed at fostering ideas and improve the texts. More than one person said that they accepted to approve the proposal destined to the GF Secretariat only because they were confident in the professional and political capacity of the leadership.

Some CCM members also added that the responsibility of this problem is due to the very short notice given by the GF Secretariat in asking issues.

Some members also noted and complained that, after the approval of the proposals, the SP did not convene additional meetings that could have been useful for information about the state of the art of the proposals, reflection and examination of the work done.

A serious concern has been expressed by the CCM members representing the civil society: both the national and the international NGO/CBO/FBO/private sector representatives affirmed that they did not have the opportunity to participate in the political - strategic decisions.

One member also said that "*la vision médicalisée*" of the AIDS problem has damaged the participation of the civil society associations that, on the contrary, had to be invested with much more responsibility, especially taking into consideration that the health structures are weak and the Country does not have the means to reinforce them in the adequate ways and in the proper time.

Nevertheless, beyond the difficulties and the constraints, the voting mechanism for the approval of the proposals has always been fair.

3.4. COMMUNICATION WITH CONSTITUENCIES

Most probably due to the designation modalities, practically nobody, among the non-State members of the CCM, feels the necessity to inform its group of reference about the CCM works, decisions, perspectives. They never convened their respective constituencies, neither before nor after the proposals approvals. A minority gives information about the CCM to their constituencies during meetings held for other reasons, most likely in a very quick way.

This lack of communication towards the constituencies has been reported by the civil society <u>and</u> by bilateral partners.

On the other hand, the reference groups do not feel to be represented and do not share their necessities and resources with the CCM members.

Someone underlined that meetings have a cost that is not easily sustainable.

Particularly surprising is the case of a health structure that is planned to be one of the centres that will be supplied with the ARV drugs financed by the GF: the head of this

structure has never been consulted in order to define the number of patients the structure would have been able to enrol for ARV treatment and follow up. Furthermore, the head of such a structure does not have any knowledge of the CCM and even that of the GF is quite poor.

As far as the "public sector" is concerned, the SP considered that it was more prudent not to give big publicity to the programme, in order to avoid false hopes and the subsequent "avalanche" of proposals and actors.

Nevertheless, the Regional Health Directions are aware about the GF, while the information has not been forwarded at the Health District level.

3.5. LINKAGE WITH OTHER PROGRAMMES AND BODIES

The involvement of, and cooperation with, UNAIDS and WHO has been positive and constant, starting from the very beginning of the CCM setting up process and during all the proposals formulation.

So far no particular measures have been taken, in order to coordinate the GF programme with the WHO "3 by 5" initiative that is around to start in Burkina Faso.

The ESTHER Initiative - *Ensemble pour une Solidarité Thérapeutique Hospitalière en Réseau* (Together for a Hospital Therapeutic Solidarity Network) is supported by the Bilateral Cooperations of France, Italy, Spain and Luxembourg and is aimed at assuring technical assistance and training on ARV use in 4 main hospitals; although the SP is member of the ESTHER Liaison Committee, the coordination seems to be poor.

A special problem could be created by the WB TAP - Treatment Accelerated Programme, that will finance directly micro projects proposed by CBOs, thus bypassing the State. The Ministry of Health fears that not enough control will be exercised on patients under ARV therapy, and problems could arise concerning the treatments correctness; furthermore, the lack of control would imply that, at the end of the Programme (which means end of financing, or even the breakdown of a CBO), patients will remain with no therapy and no assistance, thus claiming the State intervention.

4. THE PROGRAMME IMPLEMENTATION: THE PRINCIPAL RECIPIENT AND SUB RECIPIENTS

4.1. THE PR SELECTION

An important setback occurred during the setting up of the whole programme: initially the CCM proposed the SP as the Principal Recipient. An evaluation was made of the SP by the "Prince Waterhouse" consulting company, whose conclusions were not in favour of such a choice.

Subsequently, the CCM decided to ask UNDP to play the role of PR. IN this respect, the Consultant registered some perplexities, especially among the non-Burkinabè people interviewed.

Some fears were expressed, based on previous experiences, such as that of the heavy bureaucratic UNDP machine that could jeopardise the necessary agility of the programme. Some others complained that no public tender was called aimed at selecting the PR in a transparent way. Finally, some CCM members said that no alternative was given: either to vote the UNDP, or not to vote!

As far as the first perplexity is concerned, the Consultant can testify that the UNDP Representative, in charge of the GF Programme implementation, affirmed that a special office and a special team has been set up, named *Comité Interne de Gestion* (Management Internal Committee). Composed of key persons - such as the UNAIDS representative and a SP representative - it will meet weekly in order to assure the good management, the coordination and the information flow related to the Programme running.

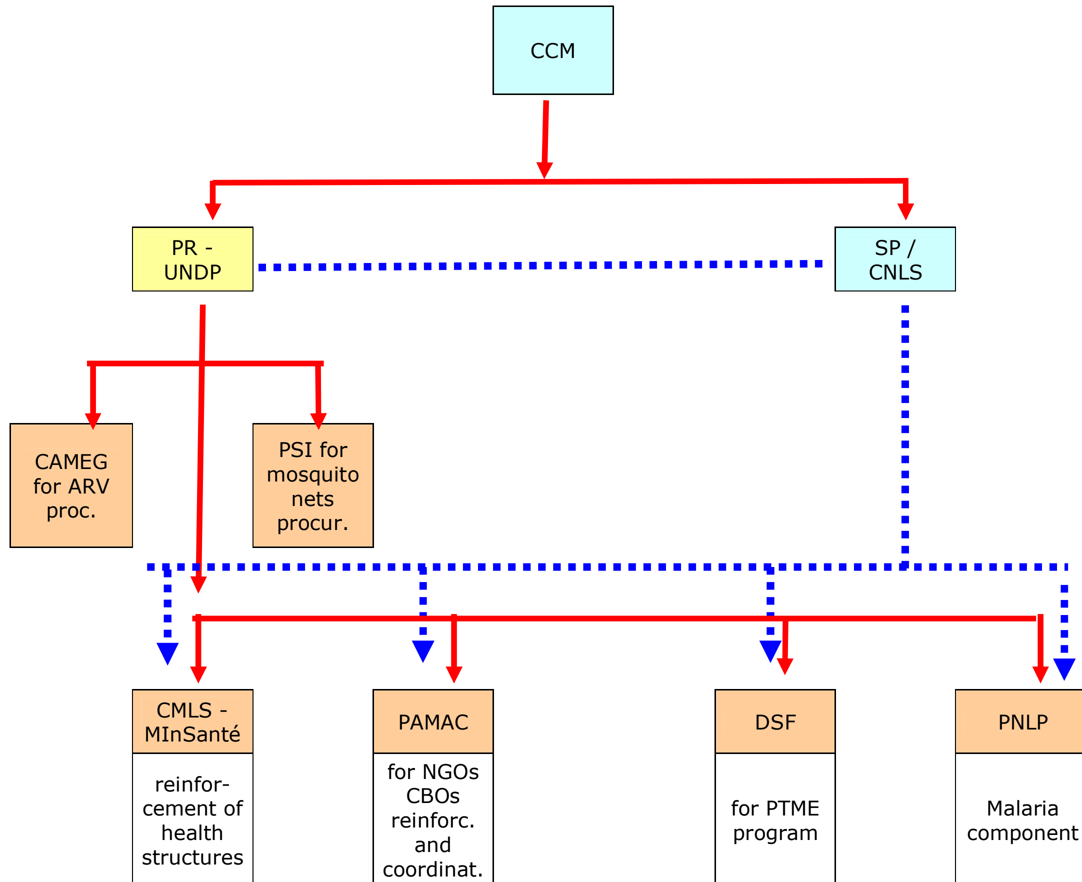
It has to be stressed that an agreement was reached within the CCM, on which basis the UNDP will play the role of PR only for the first two years of the Programme, while for the remaining two years the SP will step in. In order to facilitate a fair and effective handing over, it has been decided that UNDP will strictly associate the SP in all its activities and procedures during the last 6 months if its mandate.

4.2. THE SUB RECIPIENTS

A special attention must be paid to the process of selection of the sub- recipient. A short scheme here below summarises the actors and their involvement in the programme:

ARV procurement	**CAMEG** Centre d'Approvisionnement Médicaments Essentiels et Génériques
Mosquito nets procurement	**PSI**
Capacity building of health structures	**CMLS**
Capacity building of NGOs CBOs	**PAMAC**
PTME extension	**DSF**
Malaria component	**PNLP**

The implementation structure of the Programme can be represented by the scheme below:



No tenders have been launched for the identification and selection of the Sub Recipients; nevertheless, we can affirm that each of them is, in the Burkinabè context, the "natural" sub contractor, for experience, capacity, "mission" and, most likely, because of lack of alternatives.

It is not clear what has been the criteria that led to the choice of the:

- 13 health structures where the infected / affected people can have access to the treatment;
- 14 health structures where the PTME will be implemented.

In any case among those structures there are:

- public structures: 10 (3 national hospitals, 2 OPD and 5 regional hospitals)
- semi public structure: 1 (medical centre of the Army)
- no profit private structure: 1 (Centre Médical St Camille)
- profit private structure: 1 (private hospital)
- profit structures for distribution of ARV: 13 (pharmacies)

The SP is aware of this unbalance, justified by the fact that, so far, the State structures did not have the opportunity to really treat people living with HIV/AIDS; the SP is planning other requests to be submitted to the GF, where the no profit sector will have much more space.

As far as the selection of the NGOs CBOs is concerned, this task is performed by PAMAC: in a democratic and transparent way PAMAC, with its *Comité de Pilotage* (Piloting Committee), is now identifying the 120 NGOs / CBOs that will be reinforced in their capacity to assist people in the testing, treatment, medical follow-up and psychosocial support process. Having learned that the NGOs / CBOs greatly appreciate the PAMAC, the Consultant is very optimistic from this point of view.

5. RECOMMENDATIONS

5.1. PRELIMINARY CONSIDERATIONS

Two preliminary considerations:

a) the Programme is now starting-up. Its implementation depends on the PR (UNDP for the first phase, and SP for the second one) and its sub-recipients;
b) new projects, one concerning the TB and others concerning - most probably - the civil society initiatives, will be formulated and submitted to the GF.

This means that the CCM activity will be diversified:

a) on one side, it will supervise and monitor the implementation of the projects that are about to start, and will prepare the handing over of the PR task;
b) on the other side, it will continue to play the present role, by promoting, formulating, approving and submitting to Geneva new proposals.

Subsequently, the CCM should quickly strengthen its governance capacity. Such a strengthening could be realised through a few actions that should be carried out by all the CCM members.

5.2. TECHNICAL AND SCIENTIFIC ASPECTS:

- ✓ To assure a direct participation of the Ministry of Health (Direction Générale Santé and Direction des Etudes et de la Planification) in the new proposals formulation process, in the monitoring activities related to the ongoing projects, and in the capacity building of the local personnel; such an involvement is essential, in order to avoid that the health system collapse under the burden of the various programmes.
- ✓ To involve, more than in the past, the scientific institutions existing in the country in the proposals formulation process, as well as in the monitoring and evaluation activities of the projects under implementation.
- ✓ To involve in the programme UN agencies such as WFP and UNICEF, that could contribute in alleviating the AIDS patients (both adults and children) malnutrition; actually, people infected/affected who can not even eat enough - i.e. the most vulnerable and desperate cases - risk to be considered “ineligible” for treatment!

5.3. PARTICIPATION / COMMUNICATION:

- ✓ To reinforce the task of every member of the CCM, valorising the capacities, the knowledge and the abilities of everyone.
- ✓ To review the CCM composition, if possible by:
    - o including some key-actors, such as PAMAC,
    - o considering the opportunity that UNDP, being now the PR, can continue to be CCM member, with no “conflict of interest”,

  - o replacing the Ministers with the focal points in charge for the diseases in the same Ministries,
- ✓ To prepare and implement a communication plan that helps the CCM: a) *ad intra*: to regularly inform the members about the state of the art of the proposals and ongoing projects; b) *ad extra*: to mobilise the mass media in order to spread information about the opportunities given by the GF.
- ✓ To encourage the civil society representatives, who are CCM members, to increase their commitment regarding information and communication with their constituencies which, so far, has been too weak.

5.4. MANAGERIAL AND FINANCIAL ASPECT:

- ✓ To provide the SP with specific office facilities, electronic devices, unified archives, procedures guidelines, adequate and sufficient human resources with clear tasks.
- ✓ To define and approve a programme, a methodology and a time table in order to facilitate the SP management and - subsequently - the handing over of the PR role within the next two years.
- ✓ To define a specific budget for the CCM and SP, and find out the necessary funding body/ies.
- ✓ To provide the SP personnel with a short, intense, capacity building programme that can enable them to fairly manage the CCM activities.

5.5. NEW PROJECTS

- ✓ To encourage the NGOs, CBO, Associations, to formulate and submit project proposals that integrate and widen the interventions already approved; being the State the main actor in the implementation of the projects funded so far, it is now the time to give more space to the civil society involvement.
- ✓ To provide the local NGOs, CBO, Associations, with capacity building support programmes, that can help them in fostering their ability in designing and implementing projects, following well tested methodologies, such as the PCM and/or the RBAPM. The involvement of PAMAC in such programmes could help in the organisational, coordination and managerial aspects.
- ✓ To consider the opportunity to widen the competence of PAMAC to those associations, NGOs and CBOs, that are committed to the fight against TB and Malaria.

5.6. RELATIONS WITH GF SECRETARIAT

The most crucial GF organisational and methodological aspects being now clarified and consolidated, it would be highly desirable that the GF Secretariat could:

- ✓ establish more “human” scheduling and time elapse between a call and the deadline for submission of proposals;
- ✓ on the other hand, speed up the process of proposals analysis, final decision, contract signature and funds disbursement;

- ✓ take into consideration the serious problem represented by the English language as the only or the privileged language, for the non-English speaking countries.