

Overview of the Ouagadougou Gauge

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Thanks to the Ouagadougou team for their input in this report.

***The Burkina Faso Gauge Team
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The general equity problem being addressed is:

Inequality in and insufficient access to/utilization of basic social services by the poor in Ouagadougou, including services for health, education, and housing.

Primary health objectives

- Measurement/monitoring focus Measure inequalities in health, education, and housing and document the processes that influence them in Ouaga to document the level of disadvantage and health outcomes. Comparisons will be made among geographically small populations, between households of different SES, religion, ethnic groups, and between different types of household members (fostered/non-fostered children, boys/girls, etc.).
- Advocacy Message Highlight to government planners, bilateral donors, and the public that levels of health among the disadvantaged group in Ouaga are comparable to, if not worse than, the situation in many rural settings currently targeted for aid. Provide evidence-based urban health policy recommendations and strategies to the government and international aid decisionmakers.
- Intervention strategy to support Community Empowerment The project's focal health issues closely match the priorities of the people identified through surveys and participative community assessments, especially for general health issues, malaria, and AIDS among adolescents. Nutrition and maternal/child health have been largely neglected among the urban poor, but those populations have also expressed great concern for those issues. The intervention strategies that will be tested will be

tailored to the needs of the urban poor population, taking into account their survival strategies, financial resources, and context of decisionmaking at the household/family level. Specific interventions are described below. The defined **goal of the malaria/child survival trial** is to decrease infant and child mortality by 20% over the next 5 years in the intervention zones.

In relation to the incorporation of education into the Gauge work, preliminary results of the coordinated contextual mapping activities in health and education show that both sectors in Ouagadougou encounter the same problems in terms of equity in access and in the utilization of services. Moreover, health and education are intimately related at the individual and family levels (ill health in the household is an obstacle to child education and low educational attainment is related to inefficient health seeking behaviors). On the aggregate level, the 'disadvantaged groups' usually suffer inequities in both sectors. Finally, equity research in both fields use the same type of conceptual framework, data and indicators. UERD organized a workshop in September 2001 where, together with Nouna and Niakhar teams we developed the instruments to integrate population-based studies on education the three observatories, thus allowing for cross-cultural and urban-rural comparisons.

Challenges

In Burkina Faso, **funding for urban-based research and interventions is scarce**, as there is a lack of awareness among bilateral and multilateral donors of the existence and importance of inequalities at smaller geographic levels. Policies are developed only around urban/rural inequality comparisons, and ignore differences between smaller groups, which makes a big difference in this context.

There is little effort made beyond getting policies on paper, and **no accountability for implementation** to actually achieve equitable outcomes. There is not a sufficient level of governance to reasonably expect accountability. Accountability is generally passive and unreactive to research findings, although specific advocacy campaigns can increase responsiveness.

There is a **danger of mistranslating the concept of health equity** in a way that



itches the urban poor against the rural poor, or the urban poor against the urban middle-class, in competition for resources. In this context, we need to go beyond concepts of (relative) resource allocation within the health sector to advocating for more effective management of, and increases in public resources in general to support the population. This is a context where absolute thresholds for standards of equity would be useful.

A relatively well-off neighborhood in Ouagadougou.

Civil society is very weak and undeveloped in Burkina Faso. Consequently, there is little pressure on the government to enforce laws and regulations. Because there is also

a low level of education in society, it is often difficult to mobilize people around issues. Still, it would likely be more successful to focus on enforcing existing laws than on trying to create new ones.

TV, radio, and newspapers are all money-driven—you pay for them to come and film/record (about US\$ 100). Media in the country is really a form of advertisement; not objective nor independent. Professional development of journalists was not helped several years ago by the high profile, and very publicly disturbing assassination of a journalist who raised questions of corruption in the government.

The context: causes, barriers to opportunity, the role of other actors. The specific context and causes of the situation include the following.

Overall poverty and low level of development of Burkina Faso. The country ranks 173/175 on the United Nations' Human Development Index. Eighty percent of the government's budget is externally provided. Consequently, there is little potential for economic growth and social and/or economic development in the country.

Rapid population growth due to both fertility and urban migration. Although much of the migration is due to natural, but rapid population growth (the fertility rate is 5 children/woman), drought and unemployment have caused people to migrate from the north of the country to Ouaga. Many who have gone to Cote d'Ivoire (3-4 million Burkinabe are there) are now returning to Ouaga as refugees. Ouagadougou is one of the fastest growing cities, growing at 5% annually (1960's 60,000; 1986 400,000; 1996 700,000; 2002 almost 1 million; 2015 2 million).

Lack of interest of donors and governments in understanding and prioritizing the urban context and improving the urban setting. The bulk of available resources go to the rural areas, where 80% of the population lives, and little goes to the cities. Although people in Ouaga are, on average, better off than those in rural areas, the inequalities are huge in the city. The worst-off in Ouaga generally have no water or access to health centers, although many who live in provincial villages do. UERD survey data shows that malnutrition is worse in the peripheral districts of Ougadougou than in rural areas.

Local stakeholders in health, that is, institutions who have a mandate to improve health (and equity in health), include: the Ministry of Health, The Ouagadougou Regional Health Directorate, The Ouagadougou Municipality, WHO, Unicef, UNDP, le Comité national de lutte contre le sida (CNLS), Health and advocacy/civil society NGOs, bilateral donors and embassies, etc. UERD and SCPB have discussed the urban health and equity initiative with The Regional Health Directorate, WHO, UNDP, CNLS, INSD, the Italian Cooperation, the Dutch Embassy, The Swedish cooperation (SIDA), the Swiss Cooperation, IRD and the Centre Muraz. While all these stakeholders have shown their support for the initiative, most are constrained by their lack of resources to devote to the capital city (rural areas are their priority) and/or their own thematic agendas (HIV/AIDS, child welfare, democracy, etc.).

The absence of health intervention strategies specific to the urban setting. Strategies for the urban setting (compared to the rural setting) need to take into account different social, economic, and political networks; a wider range of services (unregulated private clinics, street drug vendors, clandestine practitioners, quacks); a mix of modern

and traditional health knowledge; coping strategies; behaviors/attitudes; resources; and daily activities, patterns, and shape and use of physical spaces.

Lack of a community based health care system. Health centers do little community outreach, and may not be located near the populations they are intended to serve. Clinics are often unsupervised and understaffed, having only a nurse, a midwife/trained TBA, and/or informally trained volunteer community health workers. The health system is funded by the state through bilateral aid, and planning is conducted cooperatively between the state and donors using a sector wide (rather than project based) approach due to the high level of aid needed. Ouaga constitutes its own health region.

Unsupportive social, economic, and political (planning) environment for education: One-third of children 5-15 do not live with their biological parents, but are fostered to other family members. Girls are often fostered for domestic work, and have lower access to education than boys. Of every 1000 children that enter first grade, 400 finish 6th grade, and 200 enter 7th. But that 1000 that entered first grade represents only 35% of the population. Schools often do not exist in, or are not accessible to those from, poor urban neighborhoods.

Lack of media access. Currently, accessing the media is a matter of market economics, as television, radio, and newspaper coverage is determined by ability to pay, usually around US\$ 100-300 per story.

The functional exclusion of the urban poor from housing infrastructure development due to 1) poor policy planning 2) poor implementation of policy to develop areas of the city inhabited by the poor 3) general lack of accountability of the government and 4) unbridled speculation.



Neighborhoods in Ouaga consist of wealthier and poorer groups clumped together. The wealthier population lives in the central area, which comprises formal zones, and have sewers, electricity, water, phones, schools, and health centers. The poor live in squatter settlements in the informal zones, located in the periphery, with no conveniences.

An informal zone in Ouagadougou

As Ougadougou expands, and the city/donors attempt to convert informal zones into formal zones. This plan was intended to help the poor in the city, who, theoretically, have opportunities to buy, at cheap prices, the land on which their house was built and which was converted from an informal to a formal zone. Keep in mind, the squatter culture is recognized as legitimate here: to build a house in an informal zone, one needs to find an open piece of land, and ask the local chief for permission to build.

When an informal zone is designated for formal development, the government does a census to establish who the residents are, and razes sub-standard housing. Then, if residents have the money, they can purchase the land and rebuild according to the new

housing standards; if not, they move out. Residents are offered deep discounts to purchase land on which they were previously squatters.

Passive exclusion: However, the CFA 100,000 (US\$ 150) it costs to buy a plot in a low level formal zone is well beyond the resources of most of the poor, and consequently they are unable to live in their own neighborhoods after they have been formally zoned. The average per capita income is US\$ 300 per year, and that figure includes vast wealth some families have. A plot in a luxury formal zone area is CFA 2 million (US\$ 30,000).

Active exclusion: Additionally, land speculation often occurs in low level zoning areas, such that people get permission to build there before it is converted into a formal zone, then receive the discounted purchase price of land. The effect of this is to create entire “shell neighborhoods” where houses exist but no one lives, because the neighborhood is expected to be formally zoned soon.

The effect: The poor are continually pushed towards the periphery, where new informal zones are created. So not only are the poor not being integrated into the development (but are rather being excluded), they are being constantly shifted and moved further from the city center.

More broadly, the choice for the poor is to stay in rural areas, and have some services, but no opportunity OR to go to the city, and have some opportunities to work, but very low quality of life and access to health, education, and housing services. So the rural area isn't sustainable financially and the city isn't supportive or stable, and so also is not sustainable.

Primary partners

The Gauge is coordinated by the Health team at UERD.

1. UERD

For the Health Component:

Banza BAYA: PhD, demographer; expertise in economics.

Christine OUEDRAOGO: PhD, sociologist; expertise in gender and childcare.

Gabriel PICTET: PhD, demographer; expertise in community-based health interventions, Rapid Appraisal Procedures, and integrated information systems.

Bob POND, MD; volunteer public health physician, currently assists the partnership in various public health issues and oversees the health and malnutrition surveys and intervention, from identification of children under 5, through referral to feeding programs.

Capacity: 14 full-time researchers, about half of whom have PhD's in their field, including computer programming/systems design, geography, demography, statistics, public health, economics, and sociology.

Role: to coordinate the Equity Gauge activities; to carry out the monitoring/measuring pillar as well as aspects of the advocacy and community empowerment through interventions pillars.

For Housing:

Hubert DABIRE: PhD

Younoussi ZOURKKALEINI, a 2-year Mellon Foundation Fellow, will be analyzing the Urban Migration and Assimilation database.

For Education:

Mark PILON: PhD, economist and demographer; specialist in family and schooling issues in West Africa.

Other team members:

Mamadou NIANG: computer programmer

Abdramane SOURA: statistician

2. Mwangaza Action

Contact: Clotide KY

Role: social mobilization; community survey development and analysis; identification of key players; perceptions and expectations of individuals and communities; partnering with Women's and Church organizations.

3. Save the Children (Netherlands)

Contact: Zina Yacouba, Representative in Burkina Faso

Capacity: 12 people

Role: generally working on health and AIDS, advocacy on the rights of children, focused on rural and urban areas, primarily interventions (but some action-based research)

4. Ministry of Health

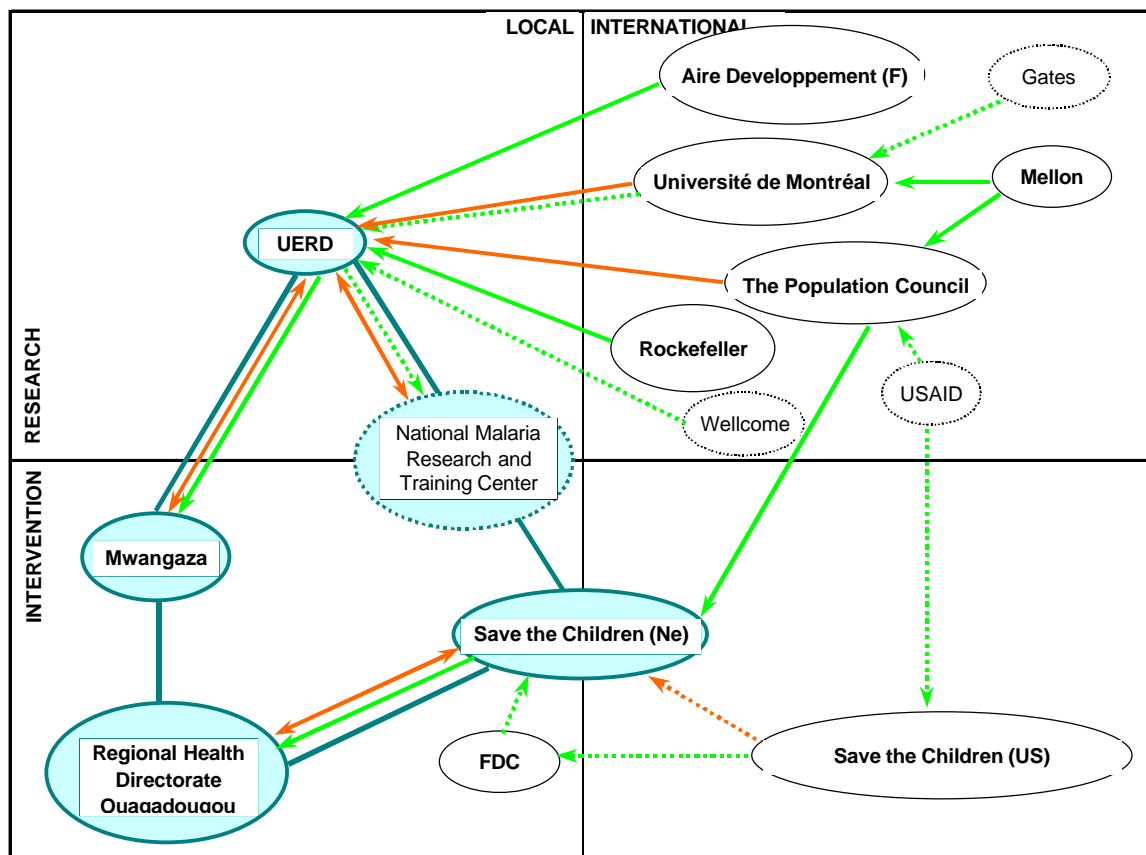
Contact: The Ministry of Health Regional Health Officer and his team

Role: implement, in coordination with SCPB and UERD, an inventory of the private and public health facilities in the Secteur 30 district. This inventory includes center and district level output statistics. Also, along with the Health District teams and the Malaria Research and Training Center, conduct the malaria research.

5. Ministry of Education

Role: The Ministry of Education and its partners have targeted 20 priority districts all of which are rural.

As Ouagadougou has the highest enrolment rates of the country, it is not expected that the government and bilateral donors will invest in Ouagadougou in the next five years. UERD, IRD, Diakonia and the French Cooperation are advocating for more research on the specific problems that it has identified in Ouagadougou during its exploratory research: inequity in access to the formal sector (both private and public), increased costs, large classes, 'double flow' management, low parental demand for quality.



Strategies for Measurement/Monitoring

The “measurement/monitoring” pillar consists mainly of primary data collection, and of the design and implementation of an integrated, real time data collection and analysis system that allows longitudinal demographic information to be combined with panel surveys, focus groups, and in-depth interviews. The surveys are integrated, and include demographic information on individuals collected every three months as well as supplementary panel surveys on education, housing, health, migration, etc. This component of the Gauge feeds directly into the interventions. For example, for a population of 5000, the nutrition program recently identified all households with children under five, scheduled 600 appointments, weighed and measured all the children (and got a 95% response rate), verified the data, and enrolled the children in supplementary feeding programs, all in less than 4 weeks.

To date, the computer program for information management has been completed and tested in the field, and analysis of the information has been successfully used for a pilot intervention on malnutrition. Currently, the team has two pilot sites, one of which is an informal zone and the other of which is a formal zone. Each has about 500 households.



Malnutrition intervention in an informal zone.

In the next phase, pocket PCs will be programmed for data collection and tested in the field (August), and interviewers will be trained (September and October). Beginning in November, all data will be collected directly into the pocket PCs, to allow for immediate analysis, public release of information, and use for planning interventions. By Jan 2003, the plans to have a multimedia website.

Advantages of this system include:

- immediate validation of information (past and present) during interview
- provides longitudinal data on residents
- provides cross-sectional data on individuals
- generates information and supports targeting strategies for more specific projects (e.g. identify households with children under 5 for nutrition screening)
- instant downloading and analysis of data
- real time public dissemination of the information on the web (base-line data is usually not available for 6 months, and then only on a limited basis; the 1996 census information is still not available publicly nor to researchers); this will provide 1 week turnaround for public dissemination of statistics, with visual presentation of information; interactive components
 - supports quick response for data requests, to be useful to a wide range of people;
 - provides researchers instant access to data;
 - supports advocacy and the development of civil society

Capacity requirements for the pillar

The team has the human resources and technical expertise to collect the data (primary or secondary). The base-line demographic information collection requires 15 days per zone, per researcher, every three months. The Gauge has 15 data collectors, 2 supervisors, 1 statistician (who also works in the field), and 1 programmer to undertake this work. For the nutrition panel study, the Gauge had 6 interviewers and 2 controllers to cover 650 households. Once an instrument is available for a panel study, the team has a 3-day turnaround to begin training for data collection, then a 10 day training on the instrument. Because of the proximity of the University, at any time they have 80-100 unemployed sociologists from which to draw, who are trained and have long-term but irregular relationships with these projects.

The team also has the capacity to analyze the data, but could use training on quickly teasing equity issues out of common databases. For example, are there ways to quickly highlight equity issues using DHS information?

Activities for Advocacy and Public Participation

1. **Data collection.** Interestingly, initial reaction suggests that the monitoring, using the



pocket PCs, serves as a form of generating public participation and interest in the project and project issues because of its novelty.

Demonstration of field data collection using the pocket PC.

2. **Fact sheets.** More formal advocacy activities have included dissemination of over a dozen fact sheets on equity in relation to the three sector areas (health, education, and housing) to a hundred workshop participants and partners (research institutes, ministries, local Government, NGOs, the press, radio and national television. To date, 15 Fact sheets have been produced for education; 4-5 for health; 1 for privatization of health system in Ouga; and 1 on ethics in health care services.

3. **Workshop.** Discussions with local stakeholders have shown that the term “equity in health” is sometimes used but that the concept’s definition and programmatic implications need to be clarified before the stakeholders can fully contribute to the initiative (i.e. in its intervention and advocacy components). Stakeholders in Health and the local Government are therefore the first targets of our health advocacy efforts. Additionally, there is a need to demonstrate the importance of the concept in relation to rural/urban differences, and why local comparisons are useful. A workshop, July 2-3 in Ouaga, will be used to tease out and generate consensus on a local concept to be used to create a vision for the Burkina Faso Gauge, to discuss preliminary findings, and to plan for moving forward. It will include local partners, donors, Ministries, municipalities, as well as key support people including Julia Dayton from the Population Council, Pierre Ngom, and Pat Naidoo.

4. **Public release of information** on the web, and publicity of that release. The website will include interactive capabilities and visually compelling displays.

5. Possible coordination and exchange with other programs from the **United Nations Observatorie project**, to strengthen the impact of advocacy.

Interventions that support Community Empowerment

Goals for community empowerment first include **understanding the context of urban communities and networks** in Ouagadougou, and then learning how to work with them and mobilize them around activities. This is being pursued through work with Mwangaza Action and through design of the integrated information system. Also, there is a need to strengthen concepts of community and population health within the public.

The specific intervention strategies being developed by the Gauge are intended to directly support community empowerment.

Health

Planned interventions, based on early findings, are aimed to create an integrated, community based child survival package, including:

1. **Prevention and Home management of malaria.** Social marketing and education on the use of insecticide-impregnated bed nets and chloroquine management supports action at the household level, an important strategy since health centers often seem either geographically, financially, or culturally out-of-reach of the urban poor.

2. Pilot activities, working at the Health District Level, to integrate outreach activities for **maternal and child health** from local clinics. The activities are currently being evaluated for process and output, and will be evaluated for intervention success once they are instituted on a larger scale.

3. Integrated approaches to **childhood survival and nutrition**, including a focus on diarrhea.

A Gauge-sponsored community outreach clinic for malnutrition.



4. **AIDS awareness** among adolescents/young adults. The intervention will be based on research results regarding risk behaviors and attitudes, produced by Mwangaza.

5. Later, activities to **increase standards of expectations for health access and quality** (also employing concepts of human rights), to support **increased use by the poor of formal providers**, and to **improve quality of health care services** (patient/provider interface; cost of drugs). Currently, there is little expectation, at least among the poor, for health providers/services to do their job with a high level of quality.

6. The public dissemination of **real time information** is also viewed as an empowering activity.

Education

The education component includes a population based approach to education, longitudinal (to identify needs), and is school based. The Gauge will probably be advocating and working with the Ministry of Education later to build partnerships. Also doing qualitative studies on barriers to education. Survey to visit all the local schools,



public and private. UERD just received funding to create a GIS on education in Ouaga that will be used to analyze the spatial disparities in education and in health. It is currently implementing a study on the links between health and education among the urban poor at the household level (impact of disease on children's schooling, and strategies used to maintain educational objectives). It is also studying disparities between fostered and non-fostered children in the households.

Housing

Housing is the least developed component of the Gauge. For the moment, it is used as an indicator of socioeconomic status. Houses will be followed longitudinally, so changes in habitat and ownership will be followed.

Appendix: Information sources currently being used by the Gauge

Database	Type of information collected	Researchers/ data collectors	Primary or Secondary information	How often is information collected	Geographically matched to DSS?	Individual matching to DSS?
Demographic Surveillance System	Baseline data: births, deaths, living location, living conditions, marriages, school attendance	UERD	1	3 months		
Migration and Urban Assimilation Survey	migration	UERD	1	As needed		
Reproductive Health Survey		UERD	1	As needed		
Household Health Survey		UERD	1	As needed	Yes	Yes
Nutrition Survey		UERD	1	As needed	Yes	Yes
Community Diagnosis		Mwangaza Action	1	As needed		
Ministry of Education Database		MoE		As needed	Yes	Yes
Survey of Health Systems	public and private availability, access, quality; center and district level output statistics	MoH, regional office	1	As needed	Yes	Yes