

Chapter 5

**HIV/AIDS, Lagging Policy Response and Impact on Children:  
the Case of Côte d'Ivoire \***

Jacques H. Pétagatiénan and Didier A. Blibolo  
(e- mail [Phirime@africaonline.co.ci](mailto:Phirime@africaonline.co.ci))

**Summary:** From 1985 up to 2000, Côte d'Ivoire experienced a terrific progression of HIV/AIDS. The number of the reported cases increased from 2 in 1985 to 56,000 in 1999. AIDS has become the leading cause of mortality among adults and one of the first in children, and the mortality associated with the disease has reduced life expectancy at birth from 65 years to 55 years in 2000. In response to the epidemic the government and communities have implemented some prevention measures since 1987: it is no easy task to evaluate these actions. The few cases of success must not obliterate the huge inadequacies of prevention actions.

As for the child welfare situation, the improvement of the 1980s has been succeeded since 1994 by an increase in mortality. The socio-economic survey on households reveals that the HIV-infection causes the children's well-being to deteriorate: more than others, HIV-affected children have no access to care when they are sick and drop out of school because they are orphans. The consequences of HIV/AIDS thus exclude them from society. A considerable number of households with an AIDS-related death react with unsustainable strategies, selling their assets, reducing food expenditures, withdrawing children from school and living on external helps.

No specific policy responses have been taken to address the social, economic, and legal consequences of HIV/AIDS. In view of enhancing its capacity to cope with the impact of the epidemic, the government recently created a ministry especially in charge of AIDS control.

*JEL:* D13, I12, I31, I38, J13

**\* This study presents the views of its authors and not the official UNICEF position in this field.**

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Florence, June 2002

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This is chapter 5 of the overall study "AIDS, Public Policy and Child Well-Being" edited by Giovanni Andrea Cornia.

CHAPTER 5: HIV/AIDS LAGGING POLICY RESPONSE AND IMPACT ON CHILDREN:  
THE CASE OF CÔTE D'IVOIRE

**AIDS, PUBLIC POLICY AND CHILD WELL-BEING \***

edited by Giovanni Andrea Cornia

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\* This project was started in 2000 at the UNICEF's Innocenti Research Centre under the leadership of the Director of the Centre and of the Regional Director of the Eastern and Southern Africa Region Office (ESARO) of UNICEF. Giovanni Andrea Cornia of the University of Florence took care of the framing, implementation and finalisation of the study, with the assistance of Leonardo Menchini. The project could not have been implemented without the support of many colleagues in many UNICEF offices around the world. The financial support of the Italian Government and UNICEF ESARO is gratefully acknowledged. **The papers included in this study present the views of their authors and not those of UNICEF.**

## **1. Introduction**

### **A. The issue**

Sub-Saharan Africa was already hard hit by unfavorable exogenous impacts such as unstable rainfall, fluctuations of commodity prices, international interest rates and rate of the US dollar as well as the other structural problems which the continent must solve as a matter of urgency as regards debt and poverty. The HIV/AIDS pandemic is a new addition to this long list. However, quite contrary to the other impacts, it is especially known for decimating the working population when they reach their most productive age, thus depriving the continent of its most precious capital, its labor force.

Africa is the continent mostly affected by the pandemic. In fact, at December ending 2000, it had 25.3 million of adults and children living HIV/AIDS (out of 36.1 million), being 70% and had 3.8 million of newly infected patients (out of a population of 5.3 million) being 71.7%. The rate of HIV infection was 8.8%, being eight times the world rate of infection; HIV infected women accounted for 55% of HIV infected adults and children, representing 17% more than the world's proportional average (UNAIDS 2000).

Côte d'Ivoire is the most affected country in West Africa with an infection rate of 10% in 2000. Meanwhile, this is also the country where in spite of the visible effects of the pandemic concrete actions on a large scale are yet to be implemented though comparable countries, and even less privileged countries are in the process of checking the growth of the pandemic in a significant manner (see for instance chapters 2 and 4 of this compilation).

HIV/AIDS appears for the moment as basically an urban problem with a few regional disparities. Basically, the virus is transmitted through heterosexual intercourse while sex workers are the most infected group and they are also the most infected with STDs. TB is the first opportunistic disease with high rates of HIV infected people. Teachers are the most infected group with the rate of deaths due to AIDS rising by 60%. The victims of this disease are concentrated in the most productive age groups, thus leading to loss of revenue for families and the country's entire productive system.

In fact, families become poorer following their most active family member's incapacitation or death (see chapter 11 of this compilation of studies). Consequently, orphans are left in the lurch and they are devoid of adequate family support in such a way that an increasing number of children are obliged to quit school and work. They end up on the streets and become easy preys to all dangers in the city. Moreover, the negative impact of the pandemic on infrastructures and social amenities especially health care and educational systems aggravate the deteriorating living conditions of children (see chapters 12, 13 and 15 of the whole study).

## **B. Conceptual framework**

The broad objective of this study is to determine the impact of HIV/AIDS on the child's well-being with a view to identifying the appropriate methods for mitigating these effects and finding objective arguments for making a case for urgent action.

These objectives will be met by collecting secondary data through a review of existing documents on the subject on one part and by collecting primary data by a series of field interviews on the other hand. A socio-economic survey among urban households in Abidjan and the three regional capitals (Bouaké, Korhogo, Daloa) was conducted in order to determine the channels by which HIV/AIDS affect the society's population structure of households, their revenue and spending patterns, family and community-based strategies aimed at adapting to changes taking place in the society and in the child's health and education. A sociological survey was also conducted for socially-oriented Ministries (Health, Education and Social Affairs), representatives of NGOs, Community-based organizations and people living with HIV(PLW) in order to collect information on their perceptions, judgments and assessments on the measures and programs implemented for HIV/AIDS control in Côte d'Ivoire.

## **2. Past trends and future incidence of HIV/AIDS and AIDS induced mortality**

### **2.1. Introduction**

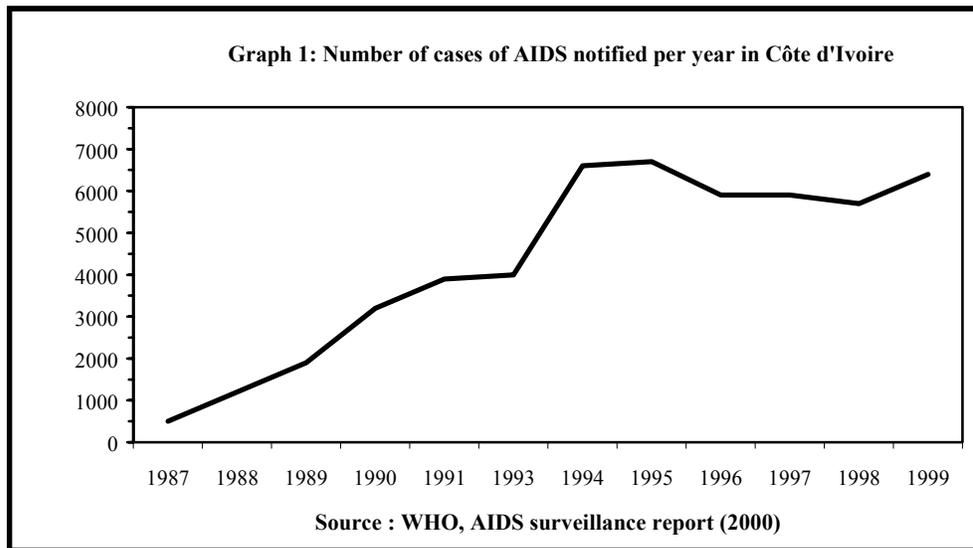
The objective of this section is to appraise the dimension, the gravity of the disease and the rate of deaths it inflicts on the population according to its various channels of transmission. To this end, a statistical observation measure put in place plays both a strategic and delicate role considering the difficulty people have of speaking openly about HIV/AIDS. The quality and efficiency of this measure is a prerequisite for identifying and evaluating adequately the determinants of the pandemic's spread such as biomedical factors, sexual behaviors and social risks.

### **2.2. The trend of HIV infections**

This section describes the general trends of HIV infections on one hand and the trends per age-groups, regions and especially according to the urban/rural criteria on the other hand.

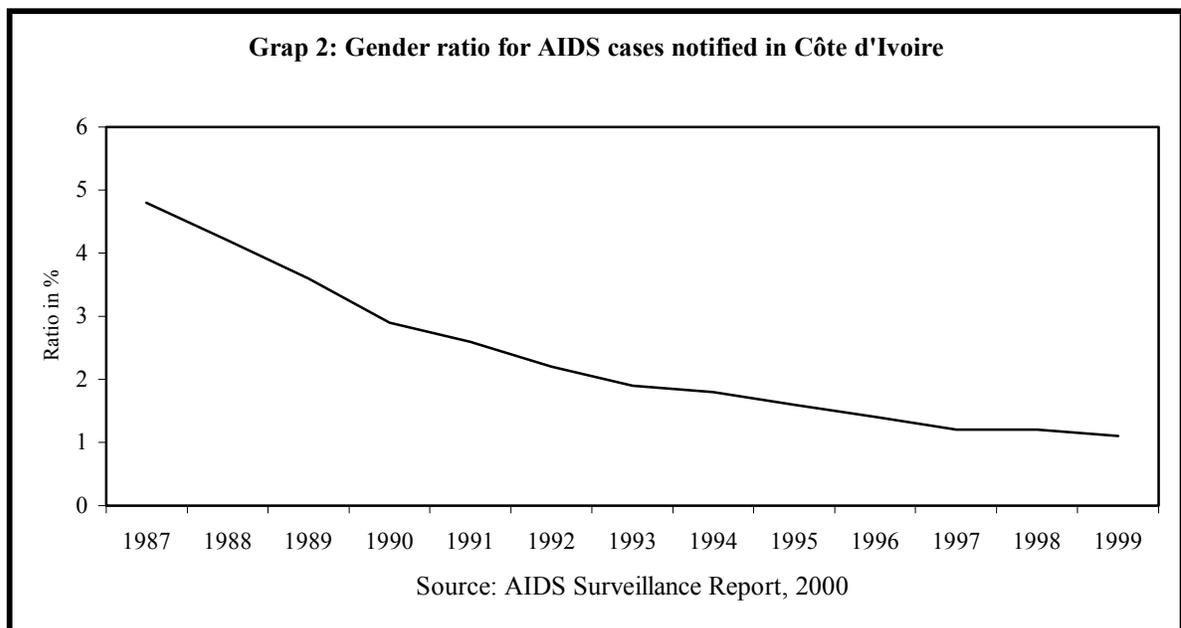
AIDS was discovered late in Côte d'Ivoire in 1985 in comparison with other East and Central African countries (EU, 1997). The number of people living with HIV(PLWH) in the country is estimated at one million people in 2000 as against 800 000 in 1998. The number of reported AIDS cases by Côte d'Ivoire increased rapidly(Graph 1). At the end of 1999, 52.000 cumulated cases were officially reported. However, the authorities believed that cases are both under-reported and the scope under-evaluated and that only a case of AIDS infection out of 17 was really reported (Kadio-Morokro, Coulibaly, 1999).

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Two types of HIV exist side by side in Côte d'Ivoire, HIV1 and HIV2. The first is the most common while the second contributes less and less to the spread of the epidemic (EU,1997) and its action is restricted to certain geographical areas (Kadio-Morokro et Coulibaly, 1999).

Today, Women are equally infected as the men. In fact, the Man/Woman ratio fell drastically (Graph 2); of all the reported cases in 1997, 55% were male compared to 45% infected female (Kadio-Morokro and Coulibaly, 1999). In 1999, the equilibrium process continued with the proportions getting closer, that is, 53.6% for male patients and 46.4% for female patients (Surveillance Report, 2000). One could deduce that the situation of women deteriorated during the last few years.



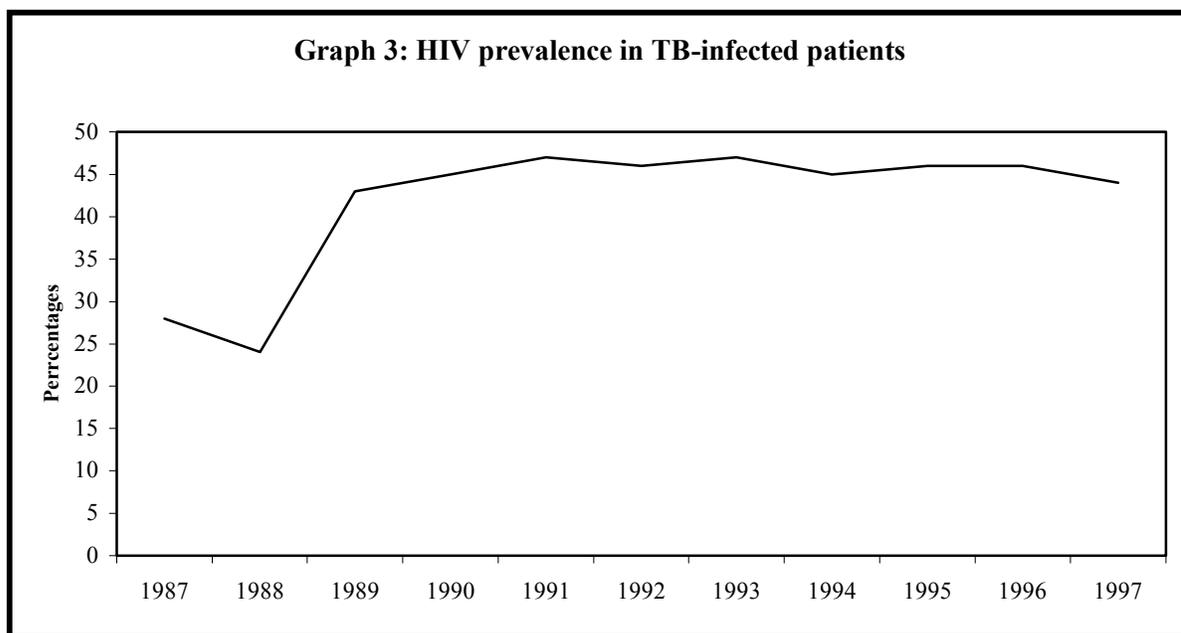
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Côte d'Ivoire does not have a national HIV infection measurement system based on a representative sample of the adult population. In the absence of such a system, the prevalence rate within the country's population was extrapolated from the population of infected women considered to be a reliable prediction tool of the total ratio( EU,1997).

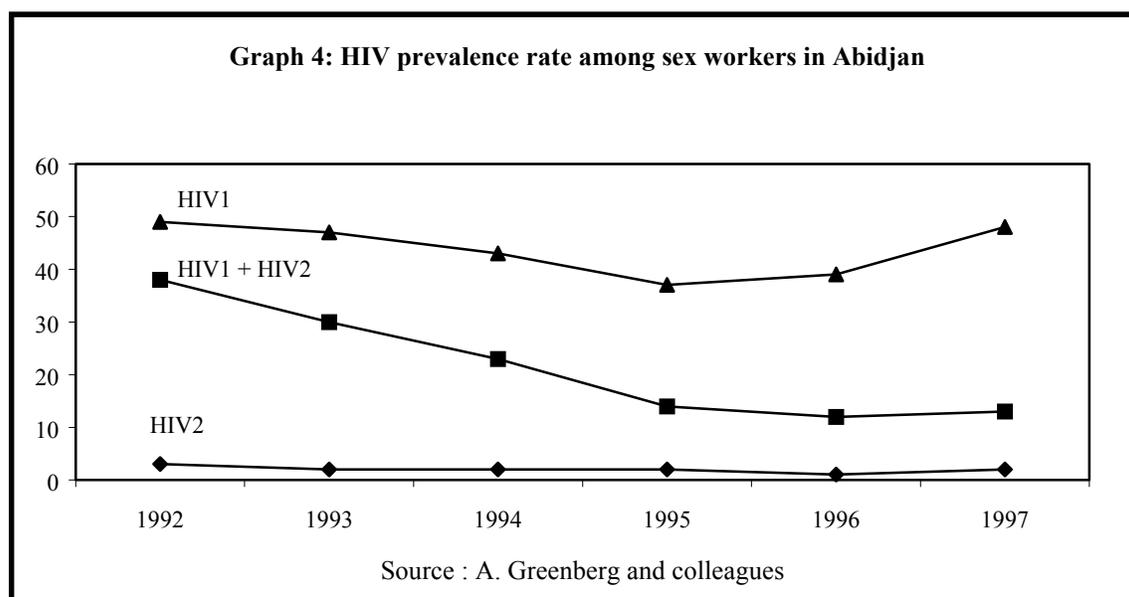
According to the study by Greenberg et al. (1997) relating to 33.940 pregnant women examined during the 1987-1997 period, the prevalence rate was already high in 1987(10%) as it rose rapidly to hit 14% in 1998 (Ministry of Public Health, 1999).

The majority of other studies revealed prevalence rate oscillating between 12 and 16.7% (Ramon R. et al., 1997; Welfens-Ekra et al., 1997; Stefan et al., 1997; Msellati et al.,1997; Noba et al.,1997; Sylla-Koko et al., 1997; Ali-Napo et al.,1997). The lowest rate of prevalence was 8.9% based on a sample of 2047 women drawn from the ten biggest cities of Côte d'Ivoire (Kassim et al, 1997). Among the pregnant women infected with STDs, HIV rate of prevalence was estimated at 16.7% (Ali Napo et al., 1997)

TB is the primary cause of morbidity and mortality of people infected with HIV (Kadio-Morokro,1997). It is first on the list of infectious diseases between 29 and 46% of cases (Domoua et al., 1997; Coulaud JP,1997; Kadio-Morokro et Coulibaly, 1999) the second on the list is pneumonia bacteria between 21 and 35% of cases (Domoua et al., 1997). HIV rate of prevalence was particularly high for patients infected with TB though it is difficult to ascertain which of the two diseases induces the other. Greenberg et al. (1997) examined 32.878 cases of TB and found out that the prevalence rate was increasing rapidly (Graph 3).



HIV rate of prevalence was high for diseases which were subjected to consultations in the various units of hospitals in Abidjan : 51% in 1987 and 71% in 1992 for patients in the infectious diseases unit, 23% and 68% respectively for patients in the pneumonia unit. Concerning the intern-medicine unit, the rate was 23% in 1998 and 29% in 1991. It was 43% in 1998 and 46% in 1992 in the dermatology unit (Béchu, Delcroix and Guillaume, 1997). Aka P.A (1997) observed that between 20 and 30% of HIV infected patients had skin infections. According to a survey conducted by the University Teaching Hospital (UTH) of Treichville 90% of patients consulted for shingles were infected with HIV (Kadio-Morokro and Coulibaly, 1999).



Sex workers belong to the group mostly infected with HIV/AIDS. For the sex workers working in Abidjan, the rate of prevalence was high and the expansion of HIV1 resumed its growth as from 1995. However, there is a downward trend when the two types were cumulated (Graph 4) (Greenberg et al., 1997; Ghys et al., 1997; Diallo et al., 1997). Among street girls, 95% of them were carriers of HIV anti-bodies (Sangaré et al., 1997).

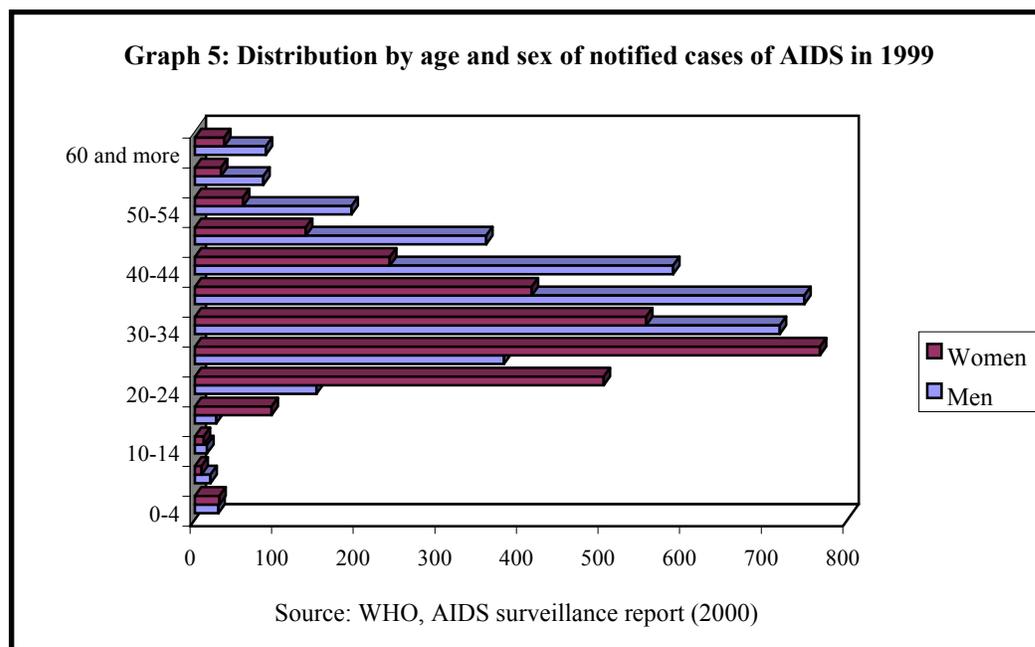
In 1991, HIV prevalence rate stood at 11.5% among youths within the ages of 15 and 29 years (PNLS,1999) and it was estimated at approximately 12% for the 1997-2000 period(Surveillance Report, 2000). No national survey is available to evaluate the general serological situation of children. The estimated rate of prevalence based on diverse considerations was high and fluctuated between 22.2% and 43% (Kouassi et al.,1997; Beau JP et al, 1997; Adonis Koffi et al.,1997). The estimates showed a prevalence rate of 7.2% among pregnant girls between the ages of 10 and 14 (Kassim et al.,1997).

HIV prevalence rate was high among malnourished children. In fact, on one hand, out of a sample of malnourished children, Beau et al. (1997a) found a HIV1 prevalence rate of 36.5% and on the other hand, 45% of a sample made up of slow-growth children were infected(Beau et al. 1997b).

Studies relating to prevalence in private companies were almost non-existent. Available estimates referred to workers of agro-industrial enterprises and they revealed a prevalence rate of 22.9% (Sangaré et al., 1997), higher than that of the general population.

### 2.2.1 Trends according to age -groups, region and rural/urban area

The age structure of victims of the disease showed (Graph 5) that young adults were the major targets of the disease. In fact, the most affected people are within the ages of 20 and 49 (Béchu, Delcroix and Guillaume 1997) and patients within the ages of 30 and 34 represented 20% of reported AIDS cases in 1999 while youths between the ages of 15 and 24 represented between 18% and 24% of reported cases respectively(Ministry of Public Health, 1999; Surveillance Report, 2000). Women within the ages of 20 and 29 are more infected than their male counterparts (Table 1).



According to the 1989 National survey, five regions of the country were diversely infected by the disease : North (2.2%), West (4.2%), Central (6%), East (7.3%), South (8.3%) (Béchu, Delcroix, Guillaume, 1997). Between 1989 and 1998, the rate of HIV infection outside Abidjan was estimated at 2/3 of the Abidjan figure representing 8-10% in 1995 (EU, 1997). Since 1998, as a result of the regionalization of the National AIDS control campaign (PNLS) and research projects, prevalence rate among pregnant women is available for the country's 10 regions. Table 1 showed diverse situations according to the region but these disparities were not highly pronounced.

**Table 1:** HIV/AIDS prevalence rate per region (in %)

	<b>1998</b>	<b>2000</b>
Abidjan	13,75	10,8
Abengourou	12	12
Bondoukou	12,75	11
Bouaké	9,8	7,7
Daloa	8,41	8,4
Korhogo	8,36	8
Odienné	9,09	8,9
Man	10,23	10,6
San Pedro	8,05	9,1
Yamoussoukro	-	8,6

**Source:** Surveillance Report, 2000

Given the importance of agricultural production in the Ivorian economy, it is important to identify the HIV infection differential between the urban and the rural areas as well as ascertain its expansion over time. In 1989, HIV infection among the general population was estimated at 7.4% for city-dwellers and 49% for rural dwellers (Kadio-Morokro and Coulibaly, 1999). In 1997 this rate rose to a level between 12.5% and 14.2% for the urban areas and between 6.3% and 7.6% for the rural areas (Surveillance Report, 2000). The rate of prevalence in the city exceeds 51% in 1989 and the rate in the rural area differed by 93% in 1997. Moreover, over time the gap widened between the two rates which were on the increase but in about ten years, the former rose two times faster (+80%) than the latter (+41%). One can then opine that for now, HIV contamination is basically an urban phenomenon. Meanwhile, in view of intense relationships between the city and the rural areas, for how long will it be confined to urban areas?

### **2.2.2. HIV infection projections**

The trend projections of the disease indicated that the prevalence rate will hit a maximum of 15.5% in Abidjan in 2000, 12.25% outside Abidjan in 2003 and 13% for all of Côte d'Ivoire by the beginning of the year 2000 (Lévy Bruhl et al., 1997 ; EU, 1997). A survey conducted by the National Institute of Statistics of Côte d'Ivoire estimated a plateau of 10.4% in 2001 (low assumption), 12% in 1999 (medium assumption) and 15.3% in 2000 (high assumption) (INS, 1994). In 1997, PNLs predicted a national prevalence rate of between 9.5 and 11.5% for the year 2000 and between 9.5 and 12.7% by 2005 (PNLS, 1997). The low assumption estimates of the National Institute of Statistics (INS) and PNLs estimates seemed to be validated by observed situations.

In addition, the number of infected persons also varied according to the survey : 1.3 million representing 42% since 1996 (Lévy Bruhl, 1997; EU, 1997) while INS estimates (1994) are given in table 2. Outstanding disparities exist in terms of new AIDS cases : 60 000 in 2001 according to Lévy Bruhl et al. (1997) and EU (1997). These figures differ from the ones released by INS (1994) and PNLs according to which the number would vary between 90 000 and 106 000 in 2000 and between 108.000 and 135.000 by 2005 (PNLS, 1997).

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**Table 2:** Projections on the number of infected people, new AIDS cases and AIDS related deaths (in thousands)

	Number of infected people			Number of new AIDS cases			Number of annual AIDS related deaths		
	1	2	3	1	2	3	1	2	3
1988	304	304	304	20	20	20	20	20	20
1993	662	756	835	51	59	62	42	47	50
1998	903	1018	1271	94	106	124	81	92	105
2003	1030	1161	1485	106	121	154	103	116	145
2008	1163	1359	1720	114	130	169	112	127	164

**Notes:** 1= Low assumption : prevalence rate (10,5%)

2= Medium assumption : prevalence rate (12%)

3= High assumption : prevalence rate(15%)

**Source:** INS (1994)

Heterosexual sexual intercourse is the principal medium of HIV/AIDS transmission among adults and children. The rate of Mother to Child Transmission(MTCT) was estimated at 25% , 19% and 1% for HIV1, HIV 1+2 and HIV2 respectively (Kadio-Marokro and Coulibaly, 1999). Blood transfusion is becoming less and less a vector for HIV/AIDS infection due to good selection of blood donors. In fact, the prevalence rate in collected blood samples was low and in rapid decline falling from 36.66% in 1993 to 0.78% in 1996 (Abisse et al., 1997). However, three-thirds of transfused blood is meant for children (Kadio-Marokro and Coulibaly, 1999) and 11.5% of child AIDS infections were due to blood transfusions (Abisse A, 1997). Transmission by way of homosexual intercourse was observed in the prison population with a contamination rate estimated at 27.5% for prisoners and 6% for prison wardens (Sangaré, 1997).

### 2.3. Trends of AIDS related deaths

Today, AIDS is the primary cause of mortality among adults, right ahead of malaria and road accidents. It is the second cause of career loss for teachers apart from retirement. In 1999, 72.000 people died of AIDS (UNAIDS, 2000).

Few advanced studies are available on AIDS induced mortality. Available estimates revealed that the rate of deaths increases as the disease deteriorates (7% after six months, 17% after twelve months and 28% after eighteen months) and patients age (6% for the under 30s, 16% for people between the ages of 30 to 39 and 39% for over 40s) (Djomandé et al., 1997). The probability and rate of deaths remain quite high, 33.5% and 21% respectively even after undergoing AZT treatment (Coulaud et al., 1997), Mortality rate before the end of the treatment among AIDS infected TB patients was estimated at 6% for HIV- and 20% for HIV+ (Coulibaly et al., 1997).

Death rate among infected children varies according to surveys conducted but it is quite high: 19.6% for children between the ages of 1 and 14(Adonis Kjoffi et al., 1997) or 71.4% for children less than five year old. For children of all ages, Beugré et al. (1997) observed a rate of 49%.

AIDS affects total mortality rate and life expectancy at birth, as shown in table 3. In 2000, life expectancy was estimated at 55 years though it ought to be in the neighborhood of 65 years, being ten years less by reason of the pandemic(BNETD, ...).

The levels of infection prevalence and mortality observed as well as projections on epidemiological and demographical variables helped in evaluating the gravity of the pandemic. Meanwhile, an adequate and comprehensive appraisal will largely depend on the system of observation which produces basic information. The number of women who underwent antenatal consultation rose from 44.4% in 1996 to 87.5% in 2000. (PNLS,1999;UNICEF/MICSS 2000). In addition, when they were enjoined to do the test, women accepted to do the test and took test results. The rate of test acceptance varies from 69 and 94%(Gourvellec et al. 1997; Welfens-Ekra et al., 1997; Stefan et al., 1997; Boka Yao et al., 1997; Noba V.L, 1997). The rate of return to collect test results was equally high and varies between 14.6% and 90% (Stefan et al., 1997 ; Msellati et al., Welfens-Ekra et al.1997; Gourvellec et al., 1997; Noba V.L, 1997). However, the rate of notification of HIV+ status to their partner was very low 2.2% (Ouattara, R, 1997). It is not systematic and it varies according to gender. (Ouattara Y. et al., 1997). The reasons adduced for refusing to notify HIV positive status to a partner are diverse : fear of misunderstanding, lack of financial resources, fear of losing the spouse (Ouattara Y. et al., 1997; Ouattara A.R , 1997).

**Table 3:** Projections of gross mortality rate and life expectancy, with or without AIDS

	1985-90	1990-95	1995-2000	2000-05
1. Mortality rate (per thousand)				
With AIDS	14.7	14.7	14.5	13.5
Without AIDS	14.5	13.2	11.8	10.5
2. Life expectancy (in years)				
With AIDS	51.9	51.5	50.8	51.6
Without AIDS	52.4	54.4	56.4	58.6

**Source:** United Nations (1994)

Thus, the high proportion of women who went for antenatal consultation and the high level of HIV/AIDS test acceptance indicated that the inability to understand the dimension and gravity of the pandemic is not a matter of willingness to be tested but rather a matter of availability of HIV testing and testing facilities. In fact, the existing screening systems are located in regional capitals and they are far away from the rural population who make up the bulk of the national population. In addition, testing facilities are mainly operated by private projects and financed by foreign assistance. The data base for the population's HIV infection status is scanty and limited to major urban centers while rural areas are not taken into consideration. Consequently, the accurate and comprehensive knowledge of the pandemic is also limited.

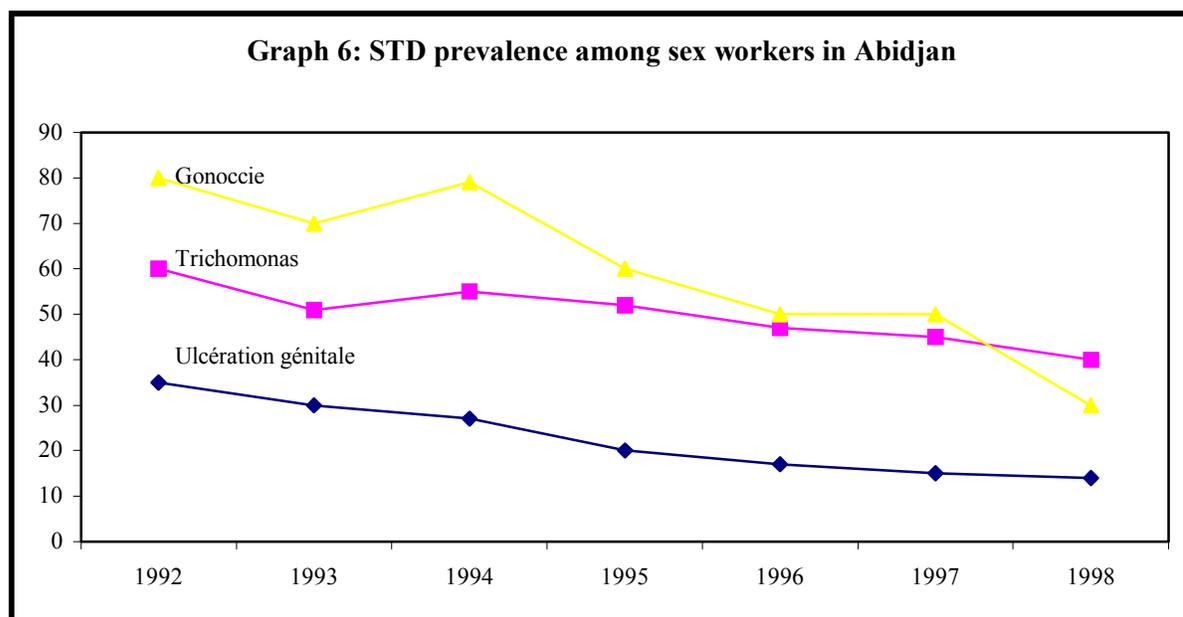
#### **2.4. Determinants of HIV infection**

This section discusses the factors enhancing contamination. They are: biomedical factors, sexual behaviors and social risks. The biomedical variables touch on the role played by STDs and nutritional status in the contamination process. The sexual behavior variables

emphasize on risky behaviors of sex workers and youths. The social risk variables describe the role played by mobility, poverty, status of women, family disintegration in the spread of HIV.

#### 2.4.1. Biomedical factors

Cumulated sexually transmitted diseases (STDs) (discharges, ulcerations and genital vegetations) affected 15.6% of the adult population while they represented 6.9% of medical consultations nationally.



The prevalence rate of STDs was high among sex workers (Essombo et al., 1997; Sani S et al., 1997) but on the decline for all types of infections (Graph 6). This downward trend was confirmed by a recent survey of ENSEA (1999a) in which an estimated 12.3% of sex workers declared having had discharges and 7% claimed to have had acne and/or wounds on sexual organs. There is a greater number of young sex workers who declared that they had STDs during the last twelve months.

STD prevalence was high among the youths. In 1989 it was 24.7% for boys and 28.9% for girls within the ages of 20-24 (Situation analysis, 1999). Also, ENSEA survey (1999b) revealed that in 1999 the rate of STD prevalence fell among the youths. The survey conducted by Bouabi et al. (1997) showed that rate of prevalence fell from 14% (being 7% for boys and 20% for girls) in 1995 to 1.75% in 1997 among students of Vavoua High school in Côte d'Ivoire.

Other target groups are: migrant farmers, truck drivers, soldiers and sportsmen. STD rate of prevalence was low among migrant farmers as in 1998 4% of them said they had genital discharge and 2.5% had genital acnes/wounds, the youngest, the most educated

and unreligious were the most infected (ENSEA, 1999c). The rate of prevalence among truck drivers is estimated at 7.4% for genital discharge and 6.3% for genital acnes/wounds(ENSEA, 1999d). Concerning soldiers, 62% of them said they had an STD at least once (Kouamé, 1997). STD prevalence rate in this group fell from 17% in 1993 to 7% in 1996 (Lorougnon et al., 1997). This rate is estimated at 17% among sportsmen and women (Coulibaly, M, 1997).

#### **2.4.2. Sexual behavior factors**

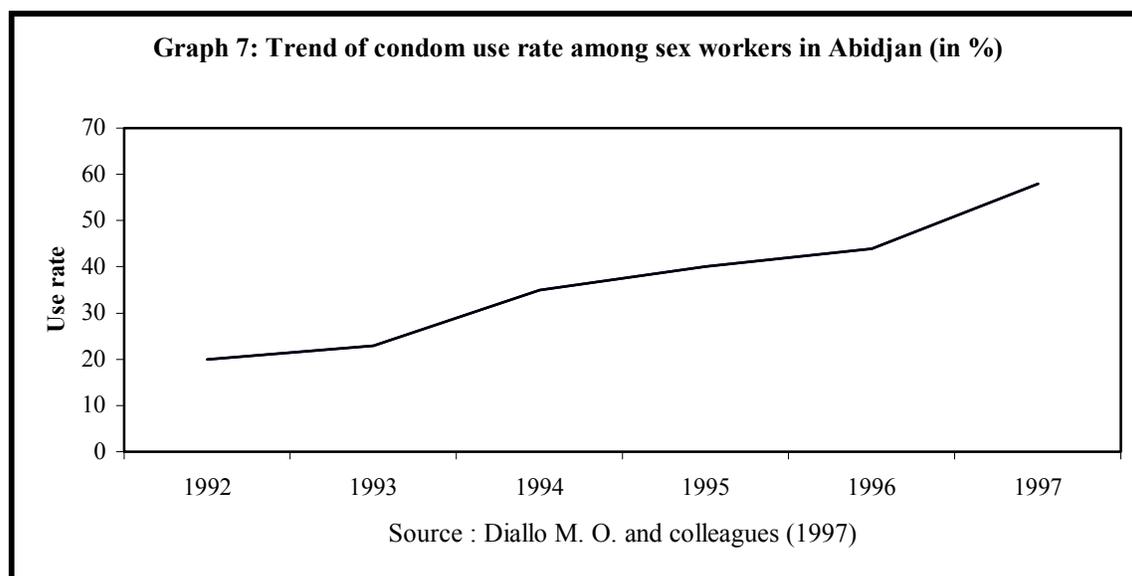
Four groups were targeted for the strategic plan for AIDS control. They are : youths, pregnant women, sex workers and migrants. The challenge is to reduce risky sexual behaviors, notably unprotected sex, alcohol and drugs.

##### **A. Sex workers**

The typical prostitute of Abidjan has the following profile : her age varies between 26 and 30 years (Diallo et al., 1997). The activity is increasingly dominated by Ivorian ladies and they are increasingly more educated (Diallo et al; ,1997: ENSEA, 1999c)

Basically, girls are attracted to prostitution for economic reasons and in fact 60% of minors engage in prostitution because of lack of income (Gbadi et al., 1997) while street girls are into prostitution because of being maltreated leading them to a live on the streets as homeless people (Sangaré et al., 1997). In 1999, lack of support and parents' poverty remained the major causes of prostitution for 81.2% and 59.8% of girls respectively (ENSEA, 1999c). The other significant causes are: the need for autonomy (26% of sex workers) and unhappy love affair (for 24.1% of them).

The high prevalence of STDs require protected sexual practices in order to reduce the risks of contacting HIV/AIDS. The proportion of sex workers who practice 100% condom use was low in 1992(20%) but it increased rapidly (Graph 7) (Diallo et al., 1997). 60% of minors do not use condom (Gbadi et al., 1997) and its use was not systematic among sex workers in Bouaké (Essombo et al., 1997). The situation seems to have improved in 1999 because at the national level 83.6% of sex workers said they used condoms with an occasional client, 81.6% sex workers with regular clients and 16.4% for a non-client partner.



On the whole, sex workers are the most HIV/AIDS infected group though the prevalence rate was on decline among these ladies.

## **B. Youths**

Premature sexual intercourse was highlighted in 1989 (PNLS, 1999; Tapé Gozé et Dédy Séri, 1989): at 14 almost a quarter of adolescents (26% of boys and 19% of girls ) already had their first sexual intercourse. This percentage rose to 60% for 16 year-old adolescents. In 1994-95, 10.4% of them were sexually active (PNLS, 1999). In 1999, the proportion of adolescents who had had their first sexual intercourse at age 15 was 29% for boys and 27.5% for girls (ENSA, 1999d). Thus, premature sex among adolescents was on the increase.

In addition, there is the issue of premature pregnancy. In fact, in 1995 35% of adolescents delivered at least one baby or were pregnant for the first time (PNLS, 1999). This premature pregnancy was more predominant among less educated adolescents (40%) and adolescents living in the rural area (45%).

In 1993-1994 (PNLS, 1999) sexual intercourse with regular or occasional partners were identified among 60% and 17% of Abidjan youths respectively. Close to a quarter of adolescents abstain from sex. The number of various partners was estimated at 3 for boys and 4 for girls and this number increases as they grow older, irrespective of the gender. In 1999, it is observed that 32.2% of boys and 56% of girls had a sexual partner in the last twelve months while 35.5% of boys and 21.2% of girls had sex twice. Thus, sexual wandering is more peculiar to boys (ENSEA, 1999d).

Being that the prevalence of STDs is very high among youths, it is worrisome to observe the low rate of protected sex. In fact, 7% of youths use condoms systematically. This percentage falls to 4% and 2% among boys and girls within the ages of 20 and 24 respectively. 34% of all youths combined use condoms occasionally. The majority of youths, both male and female was 60% while 41% of street children never used a condom (PNLS, 1999). But condom use has improved because in 1999 35% of boys and 31.7% of girls said they used male condoms during their last sexual intercourse.

While premature sexual intercourse was on the increase, the majority of youths practice unprotected sex. Sexual wandering is basically a male phenomenon but having multiple partners is as frequent among boys as among girls. Generally, youths are carefree and underrate the risk of contamination through sexual intercourse.

### **2.4.3. Social risk factors**

#### **A. Migrant rural workers**

Migrant workers are considered as people who run a high risk of being contaminated with HIV/AIDS because they live far from their families in remote areas far away from the town, especially migrant farmers. HIV infection is high in this group in East Africa (Kigongo et al., 1992, cited by ENSEA, 1999b). There is a correlation between international mobility and AIDS in the case of Senegal (Sow et al cited by ENSEA, 1999b) and Niger (Ousseini et al., 1989 cited ENSEA, 1999b). According to ENSEA (1999b) sex workers come on a monthly visit to migrant rural workers who stay with them for a few days on agro-industrial plantations of Béttie, SOGB and Zuénoula in Côte d'Ivoire . In fact, for the purpose of using seasonal migrant laborers, Côte d'Ivoire maintains significant national and international movements of migrant workers.

Prior to the last twelve months before the survey (ENSEA, 1999b) 15.6% of migrant rural workers had one occasional partner and 9% had at least three occasional partners. This account depicted the behavior of 24% of under twenty year old young migrant workers for those of them who had one partner and 18.4% for those of them who had at least three partners. The average number of prostitute partners is 0.13% but percentage rose to 0.24 and 0.28 for the under-20s and those within the ages of 20 and 24 respectively.

Condom use increases with the degree of exposure to contamination and the level of educational attainment. In fact, 21% of migrant workers having regular partners used condoms and the rate rose to 67.3% for occasional partners and 82% for sex workers. Those who always use condoms the most are the under-24 year olds and educated people. Condoms are always used by 50.3% of migrant workers having an occasional partner and 68% for those who visit sex workers. On the whole, it is mostly youths who had been to school, excluding seasonal farm laborers, who displayed risky sexual behaviors.

## **B. Truck drivers**

The practice of having multiple partners is widespread among truck drivers. In fact, 17% of truck drivers had an occasional partner in the last twelve months prior to the survey while 12% had at least three partners (ENSEA, 1999d). It is young truck drivers and educated youths who have the highest number of partners. The average number of partners is 1 but under-20 adolescents have twice that number (2.1) while the most educated have between 1.3 and 1.4.

Truck drivers visit sex workers and 3.6% of them had one prostitute partner during the last twelve months, 4.5% of them had two while 8.3% of them had at least three. It is the most educated ones who resort to visiting sex workers. The average number of prostitute partners is 0.9% but it is greater for under-20 year old truck drivers (1.7).

Condoms are frequently used, it is always used by 61% of truck drivers during occasional partners while 77.4% do the same with sex workers. Young truck drivers who act in this way are more in number: 73% of them use condoms with their occasional partners and 92% of them when having sex with sex workers. During their last sexual intercourse, 30% of truck drivers used condoms with their regular partner, 72% did the same with their occasional partners and 88% used condoms with prostitute partners. The under-20 year olds use condoms less (43.3%, 73% and 92% respectively for regular, occasional and prostitute partners). In summary, it is young truck drivers and the educated ones who mostly adopt risk-prone sexual behaviors.

## **C. Mobility of sex workers**

The movement of sex workers is a risk factor contributing to the spread of HIV/AIDS. During the last twelve months, 33.4% of sex workers said they were away from their place of residence. The sex workers who moved to Bouaké (42.6%) are more than those who moved to San Pedro (26%) and it is only the older sex workers who have the tendency to move (after 25). 70% of sex workers said they are in the habit of working in other cities (ENSEA, 1999c).

## **D. Refugees**

Studies showed that 60% of West African refugee population living in Côte d'Ivoire do not feel threatened by the HIV/AIDS menace (Bliobolo, 1995, cited by PNLS, 1999). This undoubtedly explains why 66.6% of Ivorians and 71.55% of refugees had occasional sexual partners. The prevalence rate of STDs among refugees is estimated at 26.3% (Lorougnon, 1996 cited by PNLS, 1999).

### **2.4.4. Poverty**

The lack or absence of income is one of the major causes of prostitution, the principal vector of STDs and HIV infection. In fact, lack of financial resources is the source of premature sex among youths accounting for 98.9% among boys and 97.4% among girls

as well as school drop-out rate since 19% of students dropped out of school. (PNLS, Situation Analysis ; ENSEA, 1999d). Sexual promiscuity of the urban population who fled rural areas is another poverty indicator (Becker, 1996). Often, there is a high dependence in the families to whom youths turned for assistance. In fact, 38.5% of these families accommodated 5-8 people while 47.5% accommodated more than 9 people. (Situation Analysis, 1999).

#### **2.4.5. Status of Women**

Society confers an inferior status on women which is clearly shows through in many factors: low level of education, submission to men, marginalization due to STDs purported to have come from her alone and the precarious nature of her economic and financial situation (Situation analysis, 1999). The low level of women's education or the ignorance of Ivorian women make susceptible to infection and subsequently to the disease. This situation is enhanced, on one hand, by parents' preference for educating boys to the detriment of girls and on the other hand, by premature pregnancies which accounts for 32% of the reasons why girls drop out of school. (Situation Analysis,1999).

The submission of women, who traditionally do not choose their husbands, make them run the risk of being contaminated by the disease as a result of the man's sexual wandering and his inability to protect himself through condom use. The fact that popular culture automatically attributes any sexually transmitted disease to the woman including AIDS, marginalizes her in society. Finally, her precarious economic and financial situation in spite of her decisive contribution to agricultural production, especially foodstuff production constantly makes her vulnerable to premature sex, professional sex or otherwise. The status of women accounts for attitude vis-à-vis the HIV+ test and her reluctance to notify her husband of her HIV positive status.

#### **2.4.6. Family disintegration**

It is a well-known fact that the extended family and the community are sources of social solidarity (Béchu, Delcroix and Guillaume 1997) while AIDS incapacitates a family member thus rendering the person increasingly incapable of meeting his/her basic needs. At this juncture, family instability or disintegration increases the physical and moral suffering of the infected person.

Nowadays, family trends show a propensity towards preference for nuclear families which limits solidarity progressively to the father, mother and children. On the one hand, this trend is facilitated by the 1964 marriage and heritage law as modified by the 1983 law and the current urbanization on the other hand. It creates a renewed family cohesion whereby the individual increasingly takes precedence over group solidarity (Ouattara Y, 1997) hitherto induced by the extended family.

Family disintegration tears apart the natural fabric of society and leaves infected family members in the lurch. However, the need for confidentiality or secret, non stigmatization and lack of understanding spur them to seek for other types of solidarity outside the

extended family, for example among the Associations of people living with HIV(Hassoun et al., 1997; Béchu, Delcroix and Guillaume 1997).

#### **2.4.7. Highly mobile professionals**

##### **A. Teachers**

A comprehensive national survey was conducted in the 1996-1998 period on *HIV/AIDS impact on Côte d'Ivoire's educational system* funded by UNICEF, UNAIDS, World Bank, UNESCO and other partners. According to the survey, 641 teachers were living with HIV. They include 81% were elementary school teachers, 15.9% secondary school teachers and 3.1% educators (Project impact Bulletin, 1998). During the 1996-1997 school year, out 218 known cases of elementary school teachers' deaths, 140 being 64.22% were due to HIV/AIDS. Thus, 5 primary school teachers died of AIDS during each calendar week. For the 1996-1997 school year, 59 deaths out of 85 known cases were recorded representing 69.4% HIV/AIDS-related deaths. Concerning secondary school teachers during the 1996-1997 school year, 19 deaths out of 44 known causes representing 43.18% were due to HIV/AIDS. During the survey, no teacher was undergoing Antiretroviral treatment(ARVT) ( Project Impact Bulletin, 1998).

The average age of deceased primary school teachers was 36 and their years of service in the profession was 13 years. The leave of absence for sick leaves of primary school teachers living with HIV was 6.2 months on the average compared to 10 days for their colleagues on sick leave for a disease other than HIV. In 1996-1997, deaths and sick leaves of these teachers prevented 119.000 pupils aged between 6-11 to be trained. The number of pupils who suffered from the absence of primary school teachers because of the HIV infection(1.600 pupils) was higher than that of other pupils whose education was hampered by any other reason (1.2000 pupils). Moreover, in 1997-1998, the survey showed 796 AIDS orphans including 447 under 15, representing 56.15%(Project Impact Bulletin, 1998).

The Ivorian educational system is characterized by a chronic shortage of teachers for which the government had to adopt a political stop gap measure including, among other things, the recruitment of assistant primary school teachers generally less qualified than regular primary school teachers. During the 1996-1997 school year, the teaching staff supply was 1.4% lower than teacher supply excluding AIDS and for the rate of supervision of 40 pupils/teacher, the shortage of AIDS-infected teachers exceeded by 8.8% the shortage excluding AIDS. The excess rate rose to 47 while the rate of supervision was between 40 and 45, respectively(Project Impact Bulletin, 1998; Fassa et al., 1997). This number is estimated at 71.655 pupils including 30.023 girls for the 1998-2000 school year thus representing 2.47% of the pupil population.

##### **B. Others**

The HIV/AIDS contamination rate among security and defense personnel (military, police, gendarme and customs) is higher than the national average. Thus, the equivalent

of a unit was lost annually as a result of AIDS (BNETD...). However, it is observed that there is a shift in the prevalence trend of STDs, being one of vectors of HIV as it showed a decreasing rate from 17% in 1993 to 7% in 1996 (Lorougnon et al., 1997).

Health personnel were prone to HIV contamination risks because of exposure to blood accidents (EBA) associated with their profession. According to a survey conducted by Yoboué (1997), 45.3% of the Yopougon University Teaching Hospital (UTH) staff had experienced cases of EBAs and the most exposed categories are: nurses and midwives (31%) and cleaning workers (19%) as hollow needle is the major cause in 73% of cases. The risks of contamination is high among the personnel of anti-TB centers where the prevalence rate of HIV was 45%. Though, the personnel felt that they were more prone to being contaminated by TB than AIDS while it is the opposite with urban health centers. (Blibolo et al., 1997) where the contamination risk of medical personnel is pegged between 0.3-0.4%.

Sportsmen and women are at risk because they move about a lot and suffer from body accidents leading to EBAs in 72% of cases. They suffer from bleeding injuries in 25.3% of cases during which hemostasia is carried out with bare hands and without gloves in 67.6% of cases. These sportsmen and women who in 17% of cases had previous STDs infection engage in sex with an average number of 2.3 multiple partners. Meanwhile, they seldom use condoms in a proportion of 69.7% (Coulibaly M, 1997).

The acute prevalence rate among teachers is worrisome not only because of the fact that the epidemic will spread due to their presence across the country but most especially for the child's development who cannot attend school because of the disease. The connections between high prevalence areas and low prevalence areas also contribute to the spread of the disease.

#### **2.4.8. Connections between high prevalence areas and low prevalence areas**

In the short term, isolated rural areas are witnessing a low prevalence rate as already mentioned. On the one hand, this situation is due to the poor development of health facilities and the low utilization level of available health facilities (Brown, 1996) and on the other hand, due to under-diagnosis and under-notification (PNLS) of AIDS cases. However, in the medium long term, the rate of prevalence in rural areas will increase as a result of the intensity of its relationships with high prevalence urban areas through propagating agents. These are: mobile sex workers, truck drivers and their commercial activities, seasonal farm laborers, teachers and periodic migrations of youth associations.

As mentioned earlier, 33.4% of sex workers said they were sometimes away from their place of residence and 70% of them are in the habit of working outside their place of habitual residence (ENSEA, 1999c). Another survey mentioned above that two-thirds of sex workers change their residence at least thrice in two years. In 33% of cases, these movements are due to the search for new clients. (Kouamé Kalé cited by PNLS, 1999). In view of the high prevalence rate of STDs and HIV in this group their high rate of mobility was a major factor for the spread of HIV/AIDS (Lalou and Piché cited by PNLS, 1999).

The rural areas situated along the routes of truck drivers and those producing surplus farm produce generate intense flow of commercial activities and thus are exposed to HIV contamination (Brown, Webb et Haddad, 1994; Lalou et Piché, 1994 cited by PNLS,1999) because of the above-mentioned risk-prone sexual behaviors and practices of truck drivers.

Since the rural areas provide seasonal manpower to urban areas they are also at risk (Brown, Webb, Haddad, 1994; Lalou et Piché, 1994 cited by PNLS,1999) because of more or less frequent return journeys of seasonal workers to their native villages for various reasons: funerals, marriages (Painter et al,1992; Anarfi, 1993 cited by PNLS,1999), youth and professional associations including for example, the PAKINOOU phenomenon relating to the periodic return of Baoulé young workers to their native villages each year during the long Easter weekend.

Teachers are civil servants who travel the length and breadth of the country according to their transfers and the elementary school teacher is an important personality in the village where he works. The above-mentioned high HIV prevalence in the teaching profession implies that the elementary school teacher is an efficient propagator of the disease in the rural area, notably through female pupils as evidenced by the high rate of girls who drop out of school due to pregnancy.

The existence of a large refugee population and the high prevalence rate of STDs in this community are factors fostering the propagation of HIV/AIDS in the rural areas of Côte d'Ivoire.

Thus, one can surmise that in a few years, the prevalence rate of STDs and HIV/AIDS will escalate as a result of the rapid expansion of prevalence in the rural areas due to sustained interactions between the city and rural areas.

## **2.5 Conclusion**

In view of the foregoing analysis, one can make the following observations: (i) the prevalence rate of HIV increased rapidly since 1985 to hit 10% by the end of 2000 ; (ii) AIDS is the primary cause of adult mortality and the second cause of career exit for teachers among whom 60% die of AIDS; (iii) projections relating to the negative impact of HIV/AIDS on mortality rate and life expectancy are rather alarming; (iv) sex workers are the most infected group with STDs and HIV/AIDS. However, in this group, the rate of prevalence of STDs and HIV is declining thanks to prevention programs; (v) the rate of infection is generally not well known among youths while premature sex is increasing and that, in most cases, it is unprotected sex; (vi) it is educated youths who in comparison to seasonal farm laborers and truck drivers, practice more risk-prone sexual behaviors while their rate of HIV prevalence is not known; (vii) the high prevalence rate among teachers is worrisome not only because it disorganizes the educational system but also for lack of concrete action on the part of government and the teaching profession itself ; (viii) no attention was given to the real and highly dangerous increase of HIV prevalence rate in the rural area though the country's economy is dependent on agriculture; (ix) the

existing information system does not allow for a comprehensive understanding of the scope and trend of the pandemic.

The conclusion one may draw is that in spite of progress already made, the dimension of the pandemic was not adequately measured with regards to certain important groups because of limitations of the existing system. Consequently, available knowledge is limited or non-existent in terms of HIV prevalence rate among youths (especially rural youths ), migrant farm workers, truck drivers, teachers and security personnel. In addition, we do not have information on the pandemic's impact in the rural area, in general and how it affects agricultural production in particular.

### **3. Government and community-based actions for HIV/AIDS prevention**

#### **3.1. Introduction**

Prior to taking the decision to announce the existence of AIDS in Côte d'Ivoire, the authorities had to wait until 1987 after having discussed the issue on many occasions during Cabinet meetings. (A. Eba, 1995). In fact, it was two years after discovering the first cases of AIDS that the Minister of Public health officially acknowledged the existence of AIDS in the country while at the same time reassuring the somewhat frightened population during a televised statement: "AIDS is not more worrisome than malaria fever...All one needs is to be faithful to his/her partner to avoid this terrible disease." (Blibolo A.D. 1998).

The year 1987 is a vital reference-point in the process of AIDS control campaign, in Côte d'Ivoire: The National Program for AIDS Control and the first short and medium term plans were introduced that year. Since that period (1987), real efforts were made by Government and Non -Governmental Organization (NGOs)for the prevention of various forms of HIV:

#### **3.2. Preventive actions against heterosexual transmission of HIV**

In Côte d'Ivoire, the HIV virus is mainly transmitted through heterosexual transmission. IEC (Information, Education, Communication), condom use and care provision for STDs were the major tools used to prevent it.

- ***Information-Education-Communication actions***

From 1987 until 1990, most IEC activities were conducted by the Government (BCC). Non-governmental organizations (NGOs and AIDS control committees) started participating actively in the process of HIV/AIDS prevention. Today, AIDS control campaign is essentially based on these organizations. Generally, IEC actions for the prevention of heterosexual transmission of HIV/AIDS undertaken by the Government

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THE CASE OF CÔTE D'IVOIRE

and NGOs/CBOs (Community-based organizations) are the major publicly-oriented activities:

- information and sensitization conferences
- billboards and posters, hand bills and brochures,
- T-shirts,
- radio and television commercials and programs,
- films, plays, musical concerts,
- youth games on AIDS
- seminars and training workshops
- Specifically, marketing social of male condoms and the actions for increasing its use were developed for professional sex workers, youths and migrant/ mobile persons.

These numerous Information, Education and Communication (IEC) actions enabled a large proportion of the population to know about the existence of AIDS: in 1989, 90% of the population had heard of AIDS (Dédy. s. and Tapé G, op. cit.) while in 1994, 91% of rural dwellers from the Western part of Côte d'Ivoire said they knew about AIDS and 81% of them knew that its transmission was through heterosexual sex. (Bliobolo AD, 1995).

One of the inadequacies of the IEC programs remains that it was limited to major urban centers and that they were not sustained actions. Moreover, these actions rarely targeted young people specifically: Certainly, CESAM, a students' Anti AIDS/STD unit set up many health committees in schools but it was unable to make them function properly. Presently, these committees are almost non-existent and there are no more STI/AIDS prevention activities in spite of the sheer resolve of the Elementary school Teachers' Union to get involved in STI/AIDS control programs. The same applies to health officers and officials of the Ministry of Social Affairs: apart from various continuous training sessions some officers attend occasionally, there were no IEC programs tailored to the needs of these officers.

Finally, apart from some information on the population's knowledge of AIDS which may be attributed to IEC programs, it is difficult to evaluate the real scope in terms of changes in risk-prone behavior. This leads to believe, rightly or wrongly, that IEC programs did have an effect on the population's risk-prone behaviors. However, the use of condoms may serve as an indicator for evaluating these IEC activities.

• ***Trend of condom use and HIV/AIDS prevention***

Problems relating to the use of condoms is expressed in terms of availability, accessibility and evaluation.

Concerning condom availability, let's say that an international NGO such as PSI (Population Service International ) was responsible for conducting social marketing for condoms. Thus, this NGO strives to make PRUDENCE condom brands available at a

reduced rate everywhere in the country (FCFA 25 a piece). However, condoms are not usually available in most short-time hotels, the place where people run the risk of occasional sexual relationships. Likewise in brothels where professional sex workers are found condoms are not often available, apart from sex workers who received care within the framework of Confidence Clinic of the RETRO-CI project.

**Table 4:** Trends of the number of condoms sold by PSI (1991-2000).

Year	1991	1995	1996	1997	1998	1999	2000
Sale of condoms	1 800 000	10 605 761	12 370 581	16 362 741	20 269 178	22 424 581	20 036 121

Source: Population Service International, 2000

Table 4 shows that the number of condoms sold by PSI, an NGO responsible for the social marketing of condoms in the country rose from 1,800,000 in 1991 to 20,000,000 in 2000. Obviously, there was a considerable increase in the quantity of condoms sold from year to year.

Studies have shown that adolescents in Côte d'Ivoire started sexual activities at age 12 (Dédy S. et Tapé G. 1995) while the proportion of male singles stands at 55.5% out of 9 880 648 inhabitants aged 12 and more (RGPH. INS, 1998), representing 5 483 760 of singles. By comparison to the number of condoms sold in 2000 to the number of singles who are the potential condom users in the general population, one obtains an annual average of 4 condoms bought per person. Thus, one can infer that the sexually active male population bought 1 Prudence condom per quarter in 2000. This does not mean that these condoms were used for STI/AIDS prevention.

Concerning the use of condoms, it is noteworthy that it is very difficult to objectively measure its effectiveness. Then, researchers are in the habit of limiting themselves to the statements of interviewed persons or the number of condoms sold to measure condom use, of course this method does not depict the real situation.

In the community of professional sex workers, until 1992, HIV prevalence was above 82% but presently it stands at 30% in the settings of intervention of RETRO-CI project's Confidence Clinic. This relative fall in HIV prevalence in this population is partly due to the fact that these women increasingly make use of condoms and that they are treated whenever they have an STI. Moreover, 92% of clients of sex workers in Abidjan asserted that they systematically used condoms with these sex workers. (Béa V. et al, 2000).

A new pilot experiment implemented in the country as from 1997 enabled, among other things and for the first time, to measure most objectively the effectiveness of condom use. It is a research -action of the West African Initiative (OAI) conducted under the aegis of UNAIDS in the area of migration and AIDS. This scheme showed that it was possible to effectively use condoms under specific conditions: 22% of short-time hotel lodgers in

Ferkessedougou in Northern Côte d'Ivoire unequivocally used condoms given to them (Blibolo AD et al. 1998).

Female condoms exist in Côte d'Ivoire and were effectively distributed at RETRO-CI project's Confidence Clinic. However, in the general population, they are not used in most cases, probably as a result of the very high cost of these condoms. Consequently, only male condoms are widely used.

- ***HIV/AIDS prevention through the management of sexually transmitted infections***

The inclusion of STD program in the principal organs of PNLS took place in 1990. It is justified by the fact that in Sub-Saharan Africa, there is a correlation between AIDS and certain STDs which play a joint factor role in the transmission of the disease. STIs rank 5<sup>th</sup> in the reasons for medical consultation in the 1990s. Presently, measuring STI prevalence is done by trial and error because of the lack of reported cases.

In Côte d'Ivoire, serology surveillance watch now includes syphilis in women antenatal consultations (ANCs) in 2000. This revealed the fact that 0.4% of these women had syphilis. Moreover, we know that in 1990 in Abidjan, 46% of tested HIV positive patients having consulted three times STD management departments were diagnosed with genital ulcerations. (Mamadou O.Diallo, 1992). In 1990, 19% of all STI patients in anti-venereal disease dispensaries were carriers of HIV, 35% in 1991, 27% in 1992, respectively.

Since 1993, the project's Confidence Clinic tested and treated free of charge STIs among sex workers in Abidjan. In this community, HIV prevalence is on the decline: As far as syphilis is concerned, it fell from 40% in 1992 to 12% in 1997.

From 1994 to 1995, training sessions for all public health workers on therapeutic STI management were organized in the ten districts of Abidjan. But, the results were equally insufficient as acknowledged by Laruche G.: "the immediate impact of the training course was satisfactory. The knowledge of health workers on STI management was inadequately improved between 1994 and 1995, thus justifying the pursuit of retraining. Care algorithms of these diseases were formulated, but it was not possible to extend these training courses to all public and private health workers."

The testing and STI syndrome management strategy is under dissemination with the support of the Canadian Project. STD drug kits were packed for the use of health workers previously trained to this end. Meanwhile, for the moment, with the establishment of a Ministry of AIDS affairs, STI prevention and management which is henceforth the responsibility of the Ministry of Public Health may take another turn.

Meanwhile, for the moment, STD care in clinics was not systematically accompanied by HIV infection testing in anti-venereal disease dispensaries. Though, testing is a

prevention strategy for HIV infection. Therefore, the non-inclusion of testing in STD care is insufficient.

### **3.3. Prevention of HIV transmission by blood transfusion**

The objective was the definition of a national blood transfusion policy, capacity-building for testing the HIV infection, hepatitis, syphilis, etc. and the definition of rational indications for blood transfusion. At this level, various types of measures were taken. They are mainly biomedical (“transfusion safety”) and legal measures (law n° 93-672 of August 9th 1993 relating to therapeutic substances of human origin ”).

Protocols of the biological diagnosis of HIV infection were developed for biologists and laboratory technicians of the country’s Blood Transfusion Centers. Many other laboratory technicians were trained in urban health centers of big cities (Abidjan, Bouaké, Korhogo, etc.). According to one the specialist of the discipline, “The act of transfusion is not devoid of risks. It must then be strictly reserved for cases of immediate death threat. Otherwise, look for another alternative”.

Beside these biomedical measures, other measures were taken. Thus, the Abidjan Transfusion Center was rehabilitated. Other regional blood transfusion centers were established in Korhogo and Bouaké. Finally, a law was promulgated in 1993 with a view to regulating human blood collection and use (law N°93-672 of August 9th, 1993). The objective of “transfusion safety” was met at more than 99.44% throughout the entire country (as indicated by the PNLS report). However, efforts are underway, notably with the assistance of WHO(Afro) to further guarantee the security of blood meant for transfusion: from July 23rd to August 17th, 2001, experts coming from 12 African countries including Côte d’Ivoire were trained on Quality management of methods and techniques for blood transfusion.

### **3.4. Preventive actions for Mother-to-Child HIV transmission**

According to WHO, 90% of HIV-infected children are citizens of Sub-Saharan Africa with a Mother-to-child transmission (MTCT) rate of 15 to 48%. In Côte d’Ivoire, HIV prevalence among pregnant women was 14% in 1995 (Angoran-Bénié H et al. Abidjan, 1999). Clinical tests aimed at reducing vertical HIV transmission (short regimen AZT) were conducted in the country. These tests were only children-oriented prevention actions. It indicated that a 37-50% reduction of MTCT is possible.

Presently, there is the need to improve and extend this prevention strategy to all antenatal consultation services in the country. In this perspective, the RETRO-CI project is implementing an extended program aimed at training health personnel and diagnostic capacity building of health centers with a view to disseminating the prevention of mother-to-child transmission of HIV (PMTCT).

Currently, the trend is the use of Nevirapine as a replacement for AZT which is too costly. This wish is yet to become reality and the AZT-based regimen is still continuing.

### **3.5. Preventive actions for transmission of HIV through medical settings and equipment**

One of the significant measures taken by the country to avoid HIV transmission through health equipment and settings is to impose the systematic use of disposable syringes/needles in all (public and private) health services. Today, this measure has become an habit and its success in terms of application can be estimated at 99%. That is to say that presently, it is almost a certainty that only disposal syringes are used throughout country. However, there is the need to define and apply other methods for the prevention of the transmission of HIV through medical settings.

### **3.6. Voluntary HIV testing**

Testing is one of the mostly used methods for testing/diagnosis and for verifying the progression of HIV/AIDS infection. Meanwhile, because of the fear surrounding HIV infection due to stigmatization which often accompanies HIV+ status, it is not permitted to carry out HIV test on someone without their consent. Accepting the HIV test is a precondition in the process of HIV testing and management.

The review of documents on socio-behavioral sciences show a lack of studies relating to the acceptability of HIV testing among the general population in Côte d'Ivoire. However, there are some write-ups and fragmented data figures on the topic.

Generally, we frequently mention people's reluctance vis-à-vis HIV testing (outside institutions specifically dedicated to counseling and testing), much on the part of patients who hesitate to ask for it or to accept it as well as on the part of medical doctors who are reluctant to propose it to patients. In order to explain the lack of interest for HIV testing, diverse reasons are adduced: Those who did not take the test are afraid of discovering that they are infected (1 out of 3 people).

But, in spite of the reluctance to undergo HIV testing, there are a certain number of individuals who accept testing proposals or who voluntarily make moves to be tested. Thus, from March 1995 to August 2000, out of 43 997 pregnant women having benefited from HIV counseling in the framework of RETROCI project's activities, more than 72% accepted to test for HIV. At CIPS in 1997, 5669 voluntary HIV test were conducted, 5455 in 1998 and 4705 demands in 1999. It is important to note that in 1994 and in 1996, at a time when CIPS was its best level of operations, 279 and 489 HIV testing demands respectively were made per month(CIPS Reports).

This set of information show that even if there is a certain reluctance to do HIV testing, that should not be understood as a systematic rejection of testing by the entire population. Meanwhile, since the above-mentioned figures only refer to people who seek healthcare for specific reasons, it could not be a yardstick for measuring the general opinion of HIV

testing among the population. As such, it becomes interesting to conduct a study on the acceptability of HIV testing in the general population. Such information could lead to discussions aimed at improving the results of certain AIDS control interventions.

### **3.7 Conclusion**

Initially the Government was the first stakeholder in AIDS control. But the scope of the task revealed very early the inadequacy of government's resources. This fostered the massive arrival of NGOs and community-based organizations in the field of AIDS control.

The evaluation of all Government and community-based responses is difficult to carry out in terms of changing risk-prone behavior. Nevertheless, the majority of the Ivorian population is aware today of the existence of AIDS. But prevention methods, notably condom use, reciprocal faithfulness of sex partners and sexual abstinence are still at a low ebb. STD and HIV prevention among children has up till now been the wish of all though it was not really effective. One of the obstacles mentioned is to know how to talk about sexuality with children? For some people, one has to talk about AIDS and teach sex education in school, thus the need for designing a training module (for teachers and elementary school pupils). For others, the target group should rather be youths (and not children, thus the need for STD and AIDS control activities in schools (CESAM) and universities (CRISE).

Finally, it is only now that Ditrane (ANRS) and RETROCI (CDC Atlanta) projects and the Ivorian government are implementing a draft strategy for generalizing MTCT prevention.

The trend is growing day in day out and there is an avowed intention to sensitize children before their first sexual experiences. Research projects which could lead to a better approach are much welcomed. But the first interventions are yet to be launched. However, youths are one of the four risk-prone groups in the population for whom the 2000-2004 Strategic National Plan hopes to make priority interventions.

## **4. Government and Community-based Actions for the treatment of HIV/AIDS and Opportunistic diseases**

### **4.1 Introduction**

The management of the HIV/AIDS infection is generally synonymous with care, counseling, psychological support and assistance for HIV-infected persons. But this therapeutic management entails the clinical and biological diagnosis of the HIV infection, which also poses the problem of HIV testing. Ensuring clinical and psychosocial management of an HIV patient after a positive test, it means giving him/her medical care any time his health fails due to any infection whatsoever. It is also giving him/her counseling and specific ARV-based care capable of stalling the appearance of AIDS and

prevent his/her partners from being infected. It is finally give him affection and social support by listening, helping and sharing his fears and hopes. It is in this way that the terminology treatment or care is used in this study.

#### **4.2. Official therapeutic management policy for HIV infected people**

The first specific management and counseling for HIV+ people was initiated in Côte d'Ivoire in 1990-1991 to take care of the fast increasing number of HIV infected people. The pre-test period, announcement of HIV + status are almost systematic in all reference centers.

Improving the diagnosis of HIV/AIDS infection, associated infections and therapeutic and psychosocial management of HIV infected patients were selected as priorities in the National Program for AIDS control seven years after the discovery of the first AIDS cases, that was, in 1994. Before that year, the first short and medium term plans implemented prioritized prevention through sensitization and IEC.

The form of “comprehensive” care advocated by health officials entails putting in place a care mechanism which integrates the habitual activities of each doctor at health centers. Therefore, it excludes the creation of specialized units in health centers. According to the officials, the establishment of specialized units can lead to an abnormal ‘specialization’ of some health workers in the management for HIV infection and contribute to “the marginalization of HIV patients”.

Some observations give an impression that this ideal is yet to be realized: in University Health Centers (UHCs) of Abidjan, only some health workers were trained in the management of the HIV infection. In addition, in most health centers in the country, therapeutic and psychosocial management of HIV is not self-evident: out of 26 health centers in Abidjan, only 5 have a care unit for People living with HIV(PLVH) in 2000.

##### **4.2.1. Care for Opportunistic infections of HIV/AIDS**

At the beginning of the epidemic in the 1980s, HIV care entailed treating opportunistic infections and providing psychosocial care for infected persons. There were no specific treatments for HIV infections through the use of ARV.

Obstacles to access to care for opportunistic infections in Côte d'Ivoire were analyzed in 1997 in a study which was hinged on an observation that very few patients were provided with care in public health centers. We only find them in hospitals some years later when, their infections worsened (LEBAS. 1997:3). In 1994, there were at least 50 private laboratories and a few of them in the public sector conducting anti-HIV antibody tests in Côte d'Ivoire. State-owned health centers conducting care for HIV/AIDS infections are very few. Most of these specialized centers involved in care provision for HIV/AIDS infection in Côte d'Ivoire are privately-owned.

One of the major obstacles to therapeutic care for HIV/AIDS in Côte d'Ivoire was diagnosis/biological testing: in 2000, out of 28 health centers of Abidjan, only 5 conducted HIV detection tests. Essentially, biological tests were conducted by non-governmental research projects and laboratories (RETRO-CI, CEDRES, CIPS, *Instituts Pasteur* of Abidjan., etc). Thus, there is a very high dependence on non-governmental health institutions. (R. Aka et al. 2000). In rare public health centers where tests are available, the price paid by patients vary between CFAF 3000 and FCFAF 5000.

#### **4.2.2. UNAIDS Initiative for access to ARV treatment**

In Côte d'Ivoire, access to ARV treatment is a joint initiative of the Ivorian Government and UNAIDS. The X<sup>th</sup> ICASA was a privileged occasion for the official establishment of the UNAIDS Initiative aimed at providing access to ARV treatment for large number of patients, notably the poor (Coulibaly, 1998). But, ARV treatment was already in existence in diverse forms in the country: mono therapies in the form of preventive treatment of MTCT (Ditrame and Retroci projects) and in the form of curative treatments among adults (especially at CNTS FONSIDA). The bi and tri-therapies replaced mono-therapies and the UNAIDS Initiative of access to care was put in place in August 1998.

Patient care and monitoring were ensured by “accredited” centers. The accredited centers are reference centers where patients undergo ARV treatment in the framework of the initiative. Drugs are given to patients in the following centers:

- UTH's Infectious Diseases Unit of Treichville (SMIT)
- Ambulatory care and Counseling Unit of Treichville UTH (USAC)
- Anti-TB center of Adjamé (CAT)
- Le Service de Pédiatrie du CHU de Yopougon
- PPH unit of Cocody UTH
- Center for Integrated Biomedical Research of Abidjan (CIRBA)
- Military Hospital of Abidjan (HMA)
- National Center for Blood Transfusion (CNTS)

All these accredited centers are located in Abidjan and most of them belong to the public health sector (except CIRBA and FONSIDA which are private sector-sponsored). There are also patient monitoring centers whose role is to direct patients to accredited centers. The RETRO-CI project was approached to provide technical assistance from the launching phase of the Initiative up till the end slated for August 2000. This technical support entails managing collected data and conducting biological and virology tests under the initiative and during monitoring. Financial costs generated by these various benefits were borne by RETRO-CI project. The first therapeutic pattern based on bi-therapies having shown the limits of their efficiency, it was decided that henceforth tri-therapies should be adopted.

### **4.2.3. Role of pharmaceutical firms**

Within the framework of the initiative, the procurement of ARV drugs is handled by many institutions. They are mainly, pharmaceutical firms (Glaxo, BMS, Roche, MSD, Abbot) and Public Health Pharmacy (PHP). Price agreements were signed between UNAIDS and pharmaceutical firms. The role of these firms is very complex, but on the whole, one can say that they supply ARV drugs to the Public Health Pharmacy (PHP). PHP is responsible for supplying accredited centers with ARV drugs.

### **4.2.4. Accessibility to generics and cost of ARV treatment**

The percentage of generic drugs accounted for 57% compared with all Public Health Pharmacy drugs in 1999. But the availability of drugs is not synonymous with obvious accessibility: even when 90% of drugs were available at Treichville UTH in 1996, more than 73% of patients could not have access to it. Even if the issues of generic drugs for ARV treatment remain to be solved in Côte d'Ivoire, yet they need to be made more accessible to a greater number of people after making them available.

In fact, in Côte d'Ivoire, the use of ARV treatment takes into account bio-clinical and socio-economic criteria, notably in the framework of the UNAIDS Initiative. On the bio-clinical scene, symptomatic patients are treated in all cases. Concerning symptom-free patients, treatment takes into account viral load measurement and the percentage of CD4. It is noteworthy that there were (in July 97) three centers earmarked for carrying out viral load analysis: RETRO CI, CEDRES, CIRBA. The cost of the test was approximately CFAF 50 000. The pre-therapeutic check up was at the cost of CFAF 100 000 (including the viral load). This check up consists of a series of tests (different from viral load measurement) such as blood numbering formula, the percentage of CD4, etc.

Economically, the patients' eligibility depends on their ability to pay for their treatment with or without subsidy. If the patient is eligible, that is, if he/she meets the biological conditions and if he/she is able to pay for his/her treatment (personally or with a subsidy), he is put under antiretroviral treatment. The socio-economic criteria help to "evaluate financial access, understanding of the disease and the required treatment for compliance". (Coulibaly, 1997).

These various criteria, notably economic criteria which is justified in terms of utility is in itself an hindrance to access to ARV treatment.

The Ivorian Solidarity Fund was established in order to subsidize patients' treatments for those who are unable to pay for their treatments and meet the eligibility conditions. In other words, the fund can not subsidize the treatment of wealthy patients: this class of people pay for their treatments.

For under-privileged patients or members of Associations of People living with HIV (PLWH), the management board defines the nature of the subsidy in terms of socio-demographical criteria. Thus, for certain patients, price reduction is 50% or 75% with the

approval of the management board while for others, it varies between 95 and 100% (Solidarity fund plus ITSF).

International Therapeutic Solidarity Fund (ITSF) subvention does not only concern patients who are members of PLWH/A Associations, women and children having participated in Ditrane tests (ANRS) and KZT (RETRO-CI) as well as the underprivileged designated by the management board. Whatever the therapeutic pattern, ITSF contribution to the subsidization for ARV treatments varies between 5% and 20%.

For example, the average monthly cost of un-subsidized bi-therapy was CFAF 100 000 and tri-therapy CFAF 300 000 in 1998. Presently, the hope of greater price reductions were said to be given to the Ivorian Authorities by pharmaceutical firms so that the patient could pay either CFAF 10 000 or CFAF 5 000 for tri therapy. Finally, it is noteworthy that from 1998 to July 2000, 1 013 patients were receiving ARV treatment, deceased patients not included.

#### **4.2.5. Financing structures of ARV treatment**

The Ivorian Solidarity Fund (ISF) and the International Therapeutic Solidarity Fund (ITSF) are the two major sources of subsidizations for ARV treatment in the framework of the UNAIDS Initiative. The Ivorian Solidarity Fund was established by the presidential decree N° 98-204 of April 30th, 1998. The first grant of the Ivorian Government to this Treatment support fund stood at CFAF six hundred million. In 1999, this grant rose to the sum of CFAF 750 million to CFAF 1 billion in 2000. The ITSF is an international fund (\$1 million in 1998) for which the idea of establishing it was mooted in 1997 during the X<sup>th</sup> International Conference on AIDS and STDs of Abidjan (ICASA) by the Ivorian and French Presidents. It is a fund which should be potentially supported by the European Union, governments of industrialized countries, private foundations and the private sector.

The ITSF managed by non-governmental bodies. the process of disbursement of the Ivorian Solidarity Fund is as follows: The management board responsible for analyzing patients' subsidization requests sends these requests to the Initiative's technical coordination secretariat. After approval, the requests are sent to the technical coordination secretariat to the ISF. Disbursement is then effected in the direction of accredited centers through the Caisse Autonome d'amortissement (CAA).

### **4.3 Conclusion**

The trend of therapeutic and psychosocial management of HIV infection in Côte d'Ivoire is done in 4 phases.

- (i) The phase during which testing was nonexistent, but a few rare patients were given medical care in the country.
- (ii) The phase during which biological testing was done in Côte d'Ivoire often without the knowledge of patients.

- (iii) The phase during which doctors practicing in Côte d'Ivoire received specific training for ensuring care for opportunistic infection and where many specialized institutions started conducting therapeutic and psychosocial management of PLWH.
- (iv) The phase during which some health centers and doctors became specialized in the care using ARV treatments.

At all these stages of the changing process, children were taken into account but in a non-specific way. It is at the advent of clinical test project for the prevention of MTCT and ARV treatment that these initiatives aimed specially at the mother and child were implemented at Yopougon UTH (pediatrics). As we can see, we have started to conduct interventions targeted at children, but due to the enormity of needs, we can talk for now about marginal actions. In addition, it is important to note that therapeutic and psychosocial management of HIV infection is provided in most public health centers, except in specialized centers.

It is for this reason that efforts are made for health worker training so that therapeutic and psychosocial management of the HIV/AIDS infection extends to all public health centers in Abidjan and in the interior. Because, presently, it is true that any HIV infected person receive medical care, either he/she is an adult or a child, either he ignores or not his /her blood infection level with respect to HIV. Meanwhile, in most public sector health centers, free and informed. Thus, the need for consent, the announcement and psychosocial monitoring are not common. This justifies the need for health workers' training to be pursued and emphasized throughout the country. But most especially, we noticed that some institutions specialized in management of for PLWH are centers of excellence as compared to unspecialized health centers.

## **5. Long term socio-economic impact of HIV/AIDS on Child welfare**

### **5.1 Introduction**

The main objective of this study is to evaluate the impact of HIV/AIDS on the Child welfare. Realizing this objective require knowing the past history of major indicators of children welfare, namely mortality rate, nutritional status, gross schooling rate, on one hand and to seek for links between the pandemic and these indicators, on the other hand. However, the deficiency in the existing information systems does not permit to adequately establish these links with adequate confidence. This is why, a socio-economic study was conducted in households in order to collect needed information to throw some lights on these links. Hitherto, a review of economic documents was conducted so as to identify the various channels, direct or indirect, through which HIV/AIDS affect families, the production system, savings and investments, economic growth and children. This inventory of channels through which HIV/AIDS influences the socio-economic

conditions of patients and their families is also geared towards predicating the economic analysis of study outcome on scientifically solid grounds.

## 5.2. Past trend of Child welfare

### 5.2.1. Child health

The child's welfare is tied to his health when he/she is at a very tender age and his education after age five. The factors affecting his health are morbidity and mortality.

#### 5.2.1.1. Child mortality rate

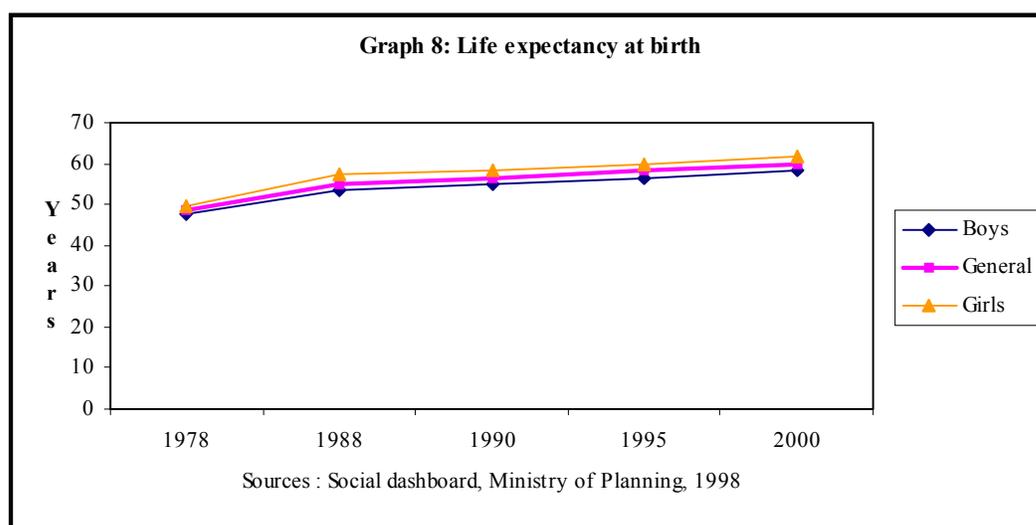
Significant progress was made in the area of infant mortality but they do not represent sustained progress (Table 5, see also chapter 13 of the compilation).

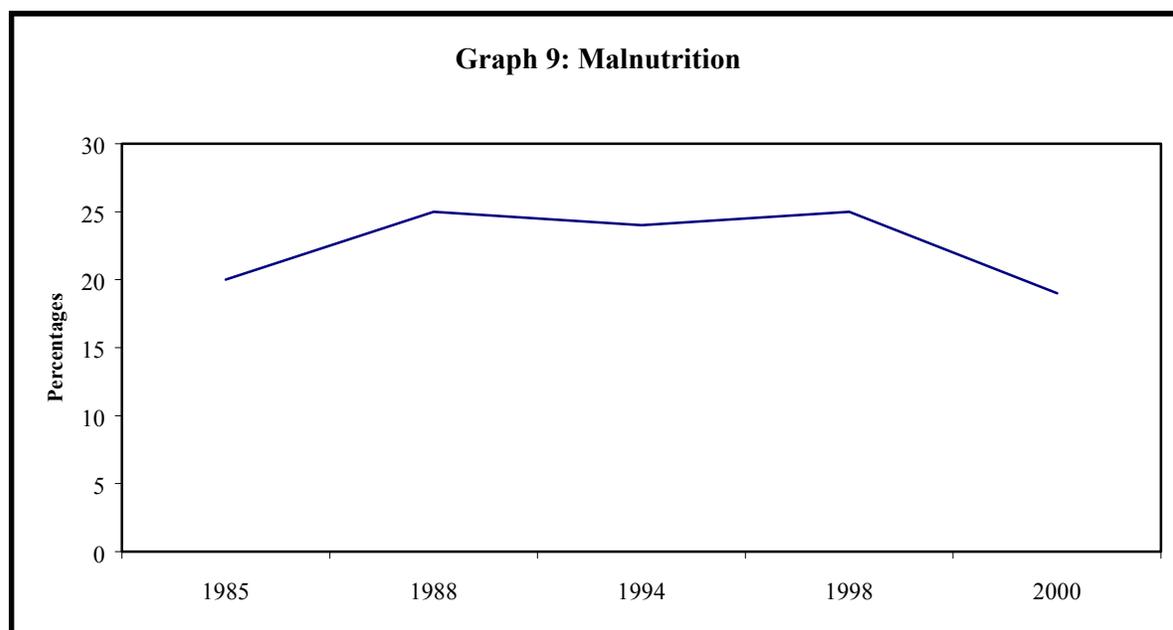
**Table 5.** Infant mortality/Infant and Child mortality (in %)

	Infant mortality rate	Child and Infant mortality rate
1978	103.3	179.9
1979	103	-
1988	97	150
1990	93	149
1994-1995	89	150
1996	88	-
1998	112.3	171

**Source:** Social Indicators, 1998; EDS-CI 1994 and 1998/1998

In fact, the improvement recorded in the 1980s, were followed since 1994 by a 31% upsurge in mortality rate for boys and 12% for girls with regional disparities to the detriment of the rural areas (24%) compared to urban areas (14%). Concerning Child-Infant mortality, we noticed that between 1990 and 1993, the figure fell to 22% (UNICEF, 2000, MICS 2000). This backward trend is probably due to the stagnation of life expectancy at birth (Graph 8).





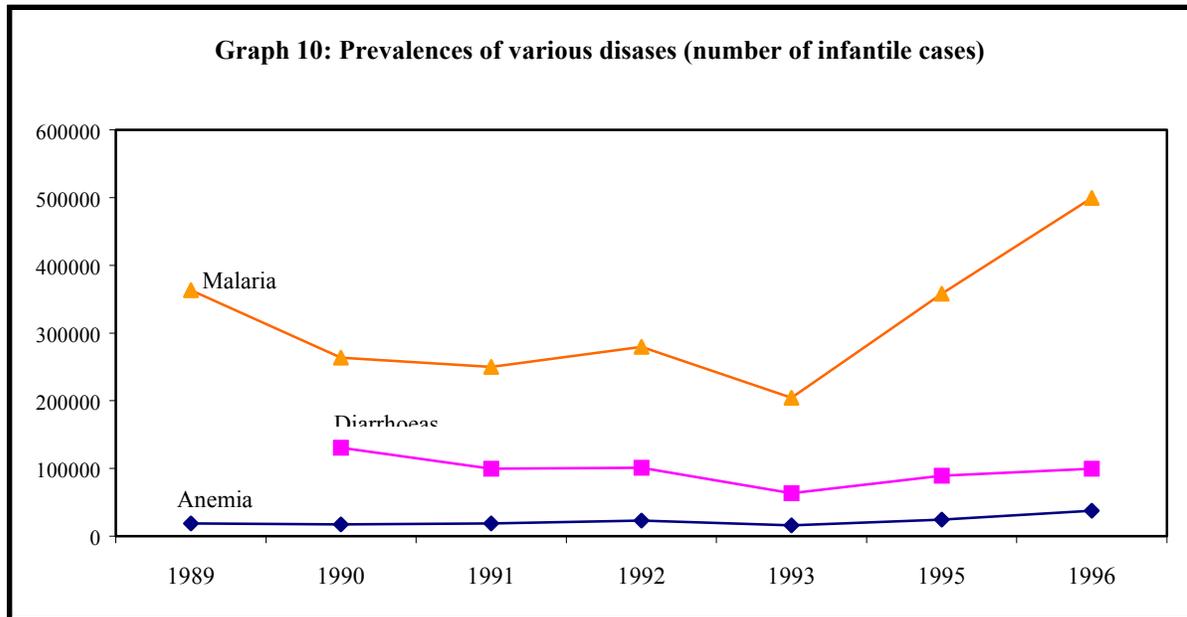
#### 5.2.1.2. Child diseases

The immediate causes of the child's survival are diseases and food/nutritional deficiencies. The rate of energy-protein malnutrition is characterized by a certain imbalance between 1985 and 2000 (Graph 9) coupled with regional disparities to the detriment of the rural areas. Serious and moderate malnutrition affect children respectively at 0.3% and 1.2% for children from 0-4 years in 1998 (UNICEF, 1996). Studies revealed that in 1994 acute malnutrition affected 10% of infants from 12-24 months and 14% of children from 24 to 36 months. In 1998-1999, the incidence of malnutrition was estimated at 20% for children in cities and 18% for children living in the rural areas (UNICEF, 2000; MICS, 2000).

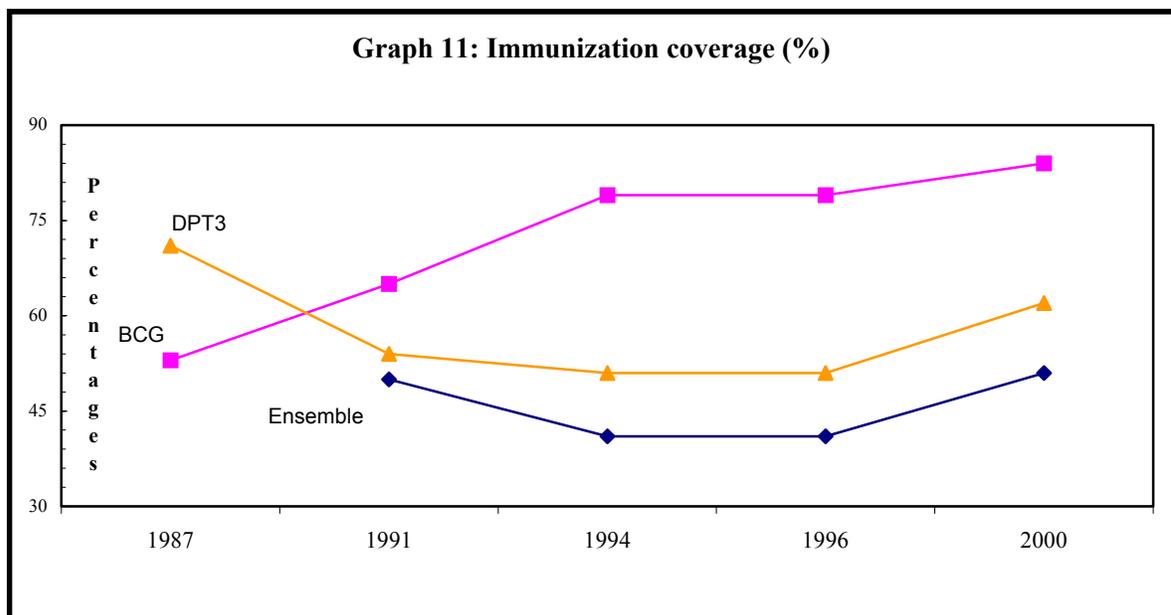
The situation deteriorated as far as anemia is concerned since this disease rose from the 7th place in 1983 to the occupy the first place in 1989. The number of anemic children increased over time (Graph 10). In 2000, the prevalence rate stood at 3.7%, representing 25% for city children and 4% for children in the rural areas (UNICEF, 2000; MICS, 2000). The vitamin deficiency situation is a source of concern in the North where the rate of prevalence accounted for 68% in 1989 for children within the ages of 12-47 months compared to the South where the prevalence rate was 37.5%; in 1994 deficiency rate was 37% in the North-East (UNICEF, 1996).

The downward trend in the number of diarrhea cases has given way to an upsurge as from 1993 (Graph 10). In 1986-1989, diarrhea patients accounted for 27.3% of consultations involving under 5 year old children, 12% for hospitalization reasons and 10% of mortality cases while the prevalence rate in some neighborhood of Abidjan was 10%. Meanwhile, in 2000, there was a sudden upsurge in the outbreak of diarrhea illnesses since 20.1% of children were affected, being 16.9% in cities and 22.5% in rural areas (UNICEF, 2000; MICS, 2000). 50% proportion of mothers aged 25-29 knew about Oral rehydration solution (ORS) and 31% of them used it. The proportions were greater for

urban mother (56.7% and 31.5% respectively ) compared to rural mothers (38.8% and 21.7% respectively) (UNICEF, 1996). In 2000, 16.1% of children had access to ORS, being 25.8% in cities and 10.6% in rural areas. (UNICEF, 2000; MICS, 2000).

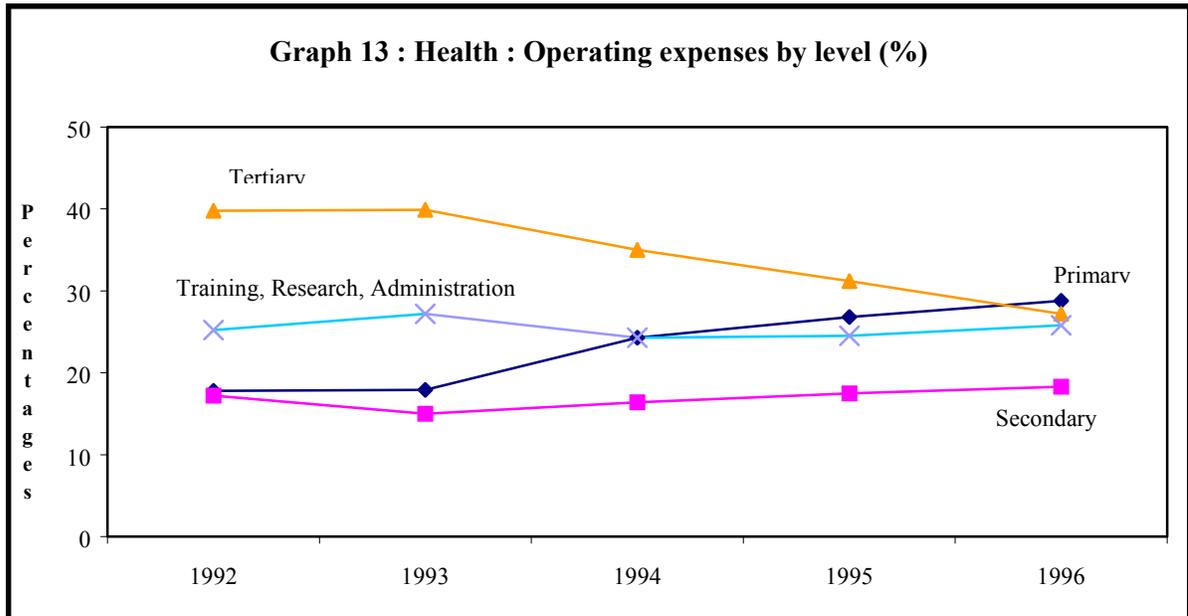
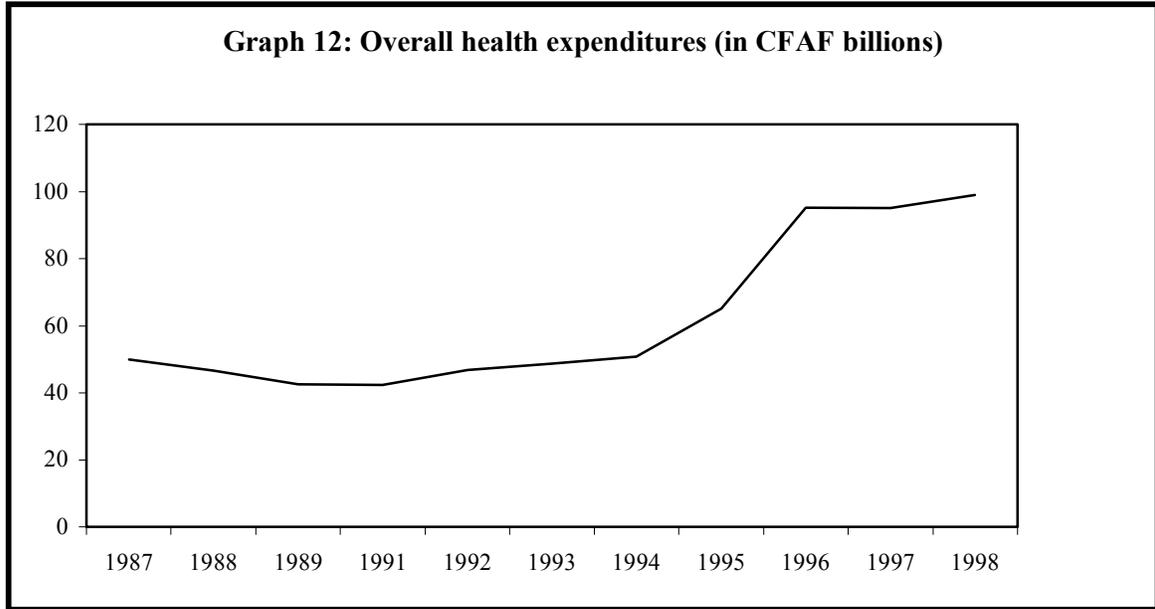


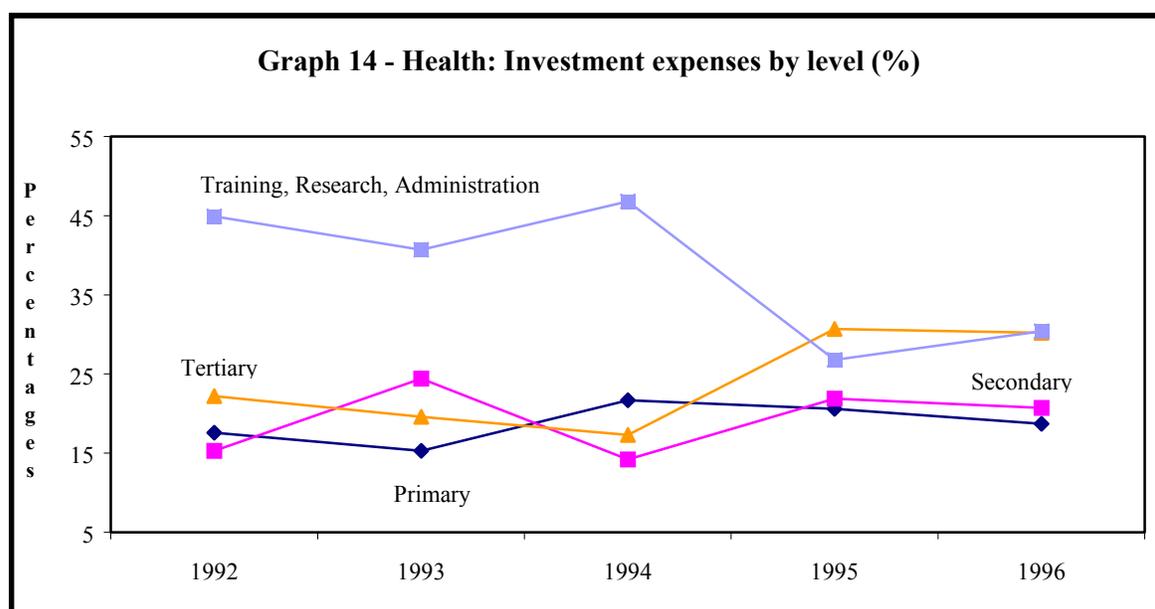
Graph 10 shows a significant upswing in the number of malaria cases since 1993. In 1998, 2,000,000 malaria cases were reported affecting especially under 5 year-old children, malaria represented 16-20% of overall morbidity states with approximately 50% for children, malaria-induced mortality was estimated at 10% among under 5 year-old children (UNICEF, 2000). In 2000, 30.7% of children had fever, being 29.1% in cities and 31.8% in rural areas (UNICEF, 2000; MICS 2000). On the whole, vaccination coverage for children witnessed an increase over this period (Graph 11).



**5.2.1.3. HIV/AIDS and the healthcare system**

The deteriorating indicators of child welfare is basically due to structural weaknesses of the healthcare system which could not contain the impact of child diseases. This gap can be partially attributed to the low level of total health budget which stood at 32% in real terms, being 4%/year, for a nominal increase of 133% during 1991-1998 period (Graph 12).





The inadequacies observed could be equally explained by the structure of public health expenditure (Graph 13 and 14) which gave priority to administration, secondary and tertiary healthcare levels to the detriment of primary healthcare delivery system up until 1992. Healthcare activities affecting mostly families to which problematic children belong did not receive sufficient funds. However, the trend has started moving anti-clockwise since 1993.

What is the pressure of HIV/AIDS on the healthcare system and on child welfare? Available statistics revealed that between 1987 and 1996, the level of healthcare system fell nationally and to the level of individual health centers at a time when HIV/AIDS was spreading. At Treichville UTH, hospitalization of AIDS infected persons represented 24% and 17% of total admissions respectively in 1995 and 1996 while 24% and 20% accounted for day hospitalizations. AIDS accounted for 7% of care activities at Regional Hospital Center (RHC) of San Pedro in 1995 compared to 2-9% at FSU of Marcory and 5-18% of Anonkoua Kouté hospitals (UE, 1997). The EU study (1997) indicated that in 1996 between 10-20% of theoretical therapeutic needs and 18% of AIDS patients' theoretical hospitalization needs were met by the public healthcare system. Therefore, there is a rampant under-utilization of health centers, with the exception of the Anti-TB Center where the volume of activities doubled during this period (Soucet et al., 1997; Kakou et al., 1997).

The low utilization rate of healthcare centers and the apparent low pressure of HIV/AIDS on the health system are linked to the inadequacies of the health system. These inadequacies induced the desertion of formal health centers by families who sought for care in traditional circles. (EU, 1997; Rossert, 1997).

However, since 1996, the rate of bed hospitalizations in public health centers by HIV/AIDS patients increased considerably. It rose from 55% in 1996 to 70% in 2000 for secondary healthcare and from 48% to 80% for tertiary healthcare respectively. Hospital

beds in pavilions reserved for infectious diseases were occupied at 80% capacity utilization by HIV/AIDS infected patients (Surveys in Ministries). At the same time, public funds allocated for AIDS control campaign was too low. In fact, AIDS control grants fluctuated between 0.15% of total health budget and 1.25% in 1996 and approximately 1% in 2000 (Ministry of Public Health). Generally, there were no job creations nor single transfer of specialized staff, HIV/AIDS linked activities were simply added to existing schedule of duties. However, the establishment of the Ambulatory Care and Counseling Unit (ACCU) led to the transfer of doctors and paramedics (EU, 1997).

Available information does not permit to conveniently establish a link between deteriorating child welfare indicators and HIV/AIDS. One can only hazard a guess that the low level of patients' visits to public health centers prior to 1996 and the saturation of urban hospitalization units after 1996, in the absence of adequate technical and financial resources allocated to AIDS control, could produce a negative impact on the family's health and that of children.

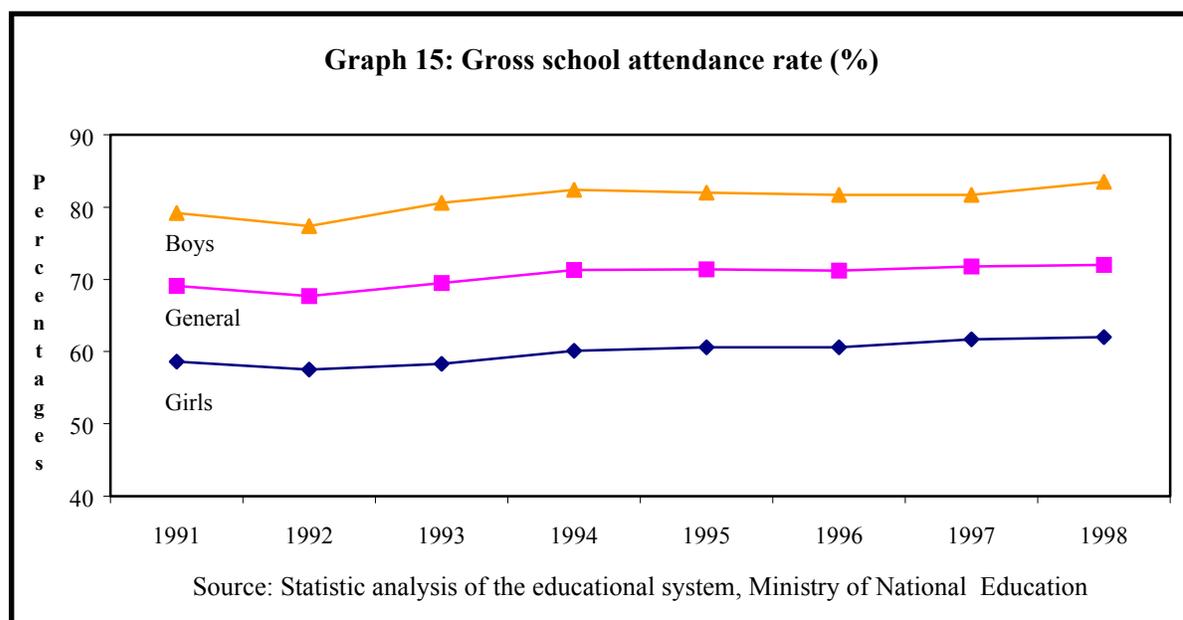
In summary, progress made in term of mortality rate levels in the 1980s were highly amortized by the backward trend recorded in the 1990s. This imbalance is the same for malnutrition rate and the number of malaria and diarrhea cases. On the contrary, vaccination coverage is improving continually. The deteriorating trend of indicators as regards the health of most children is traceable to the weaknesses of the healthcare system in general, notably the low level of budgetary allocations and the priority given to secondary and tertiary healthcare systems to the detriment of the primary health sector. Available information is insufficient to establish a link between the deteriorating condition of child health and HIV/AIDS.

### **5.2.2. Child education**

The Child's development is essentially based on the normal and harmonious growth of his/her intellectual capacities at various stages of his/her physical growth through access to basic social amenities, in particular school. These problems arose in a context in which young people accounted for 52% of total population with 18.4% of children within the ages of 0-5 years, 37.8% of children within the ages of 6-12 years and 13% of children within the ages of 13-18 years. The high number of youths represent a strong social demand, notably in terms of education and training (UNICEF, 1996).

#### **5.2.2.1. Access to school and pupil performance**

In 1998, the gross rate of schooling in the kindergarten was very low, 2.15% nationally (being 2.10% for boys and 2.2% for girls) representing 1.5% of school-going age population compared to 1.8% in 1994 (UNICEF, 2000). In 2000, 6.2% of children attended kindergarten, being 5.7% for girls and 6.8% for boys (UNICEF, 2000 ; MICS, 2000). This low rate is traceable to low infrastructure availability and the predominance of private kindergarten schools with its high cost beyond the reach of many poor households. In addition, kindergarten schools are almost nonexistent in rural areas. However, efforts were made at this level since this level of education increased from 14% annually and pupil enrolment tripled during 1991-1997 period.



The gross rate of schooling of children aged between 6 and 11 at elementary school has stagnated significantly during the past ten years (Graph 15) with a negative trend for girls. The major characteristic of this situation is that about half of children within school-going age do not go to school. In 1997-1998, the net rate of schooling was 58.2% for boys and 44.8% for girls, thus more than half the number of girls and less than half the number of boys were not in school. The net rate of schooling is unevenly distributed across the country. The rate is particularly low in the North (Korhogo: 33.5%; Odienné: 35.2%), in San Pedro (40.3%) and Bondoukou (43.6%) (UNICEF, 2000). There is a slight improvement in 2000 compared to 1998, with the net rate of schooling of 56.9%, being 61.4% for boys and 51.8% for girls (UNICEF, 2000; MICS, 2000).

**Table 6:** Internal Performance of Elementary Education (%)

	Rate of Elementary-Secondary Transition	Percentage of Class Repeats (Both)	Percentage of Class Repeats (girls)
1990	29.8	-	-
1991	32.6	-	24.1
1992	37.3	27.0	27.4
1993	36.9	26.6	26.3
1994	36.9	24.9	29.2
1995	37.5	23.1	26.5
1996	39.6	23.5	23.5
1997	38.8	25.1	25.5
1998	36.8	26.0	-

**Source:** Statistical analysis of educational system, Ministry of National Education

Performance in school is very low as evidenced by the high rate of class repeats and the low level of admission from elementary to secondary school (Table 6). The rate of school drop-out is high, 61% overall, it is higher among girls (74%) than (53%) among boys with the average number of years spent in elementary school varying from 7-10 years

instead of the normal 6 years. The rate of passes at the Elementary School Certificate (40.2%) is lower than 50% (UNICEF, 2000).

In 1997-1998, the gross rate of schooling for secondary education was low; at the Junior High school it was 23.4%, being 30% for boys and 16.6% for girls; at the Senior High school was 10.5%, being 14.4% among boys and 6.4% among girls. This means that 70% of adolescents do not go to school while girls are the most affected compared to boys. (UNICEF, 2000). In addition to the inadequacy of school infrastructures and low performance level, many other problems limit adolescents' access to school as well as their performance, notably premature pregnancy of girls. In fact, in 1997, out of 2962 cases of school drop-outs, 19% were due to pregnancy and one-third only of these girls resumed their education after child delivery (UNICEF, 2000). Thus, adolescents are facing serious obstacles because the system of education and training does not allow them to embark on suitable professional training with a view to developing all their intellectual potentialities and practical know-how.

#### **5.2.2.2. HIV/AIDS and the educational system**

The negative impact of the educational system's weaknesses on gross rate of schooling and performance at school is a well-known fact. There is also the need to consider the role of HIV/AIDS with regards to the rate of schooling stagnation of children. Earlier on, statistics showed that the teaching profession is particularly affected by the pandemic through the high proportion of teachers' deaths due to HIV/AIDS and the high number of school-going age children who cannot go to school because of lack of teachers. Therefore, it is plausible to establish a link between HIV/AIDS and stagnating gross rate of schooling but this link has not been scientifically proven due to lack of sufficient information. This situation is somewhat abnormal by reason of the scope and gravity of its effects on the educational and productive systems, notably agricultural production.

#### **5.2.3. Children rights**

According to available statistics, the children rights situation has deteriorated. In fact, the number of street children increased by 23% between 1992 and 1997 while 27% of Abidjan under 5 year old children found themselves in working situations among whom 1% of Abidjan population is made up of young housemaids. The number of children in conflict with law increased by 31% in 1999 compared to 1998 (UNICEF, 1996, 2000; MICS 2000). The number of AIDS orphans is estimated at approximately 400.0000 in 2000 and these children are running the risk of getting inadequate education thereby depriving them of occupying their rightful place in society. Apart from AIDS orphans, available information does not help in evaluating the role of HIV/AIDS in the deterioration of children rights. This gap will be partially bridged by the outcome of the field survey.

In summary, the gross rate of schooling has stagnated during the last ten years and student's performance in school is low with high rates of repeats in classes while the percentage of pupils who obtained the Elementary School Certificate is lower than 50%.

A large proportion of teachers die of AIDS every day. However, the existing information system does not encourage the establishment of a link between stagnating gross rate of schooling and the high incidence of HIV/AIDS among teachers.

In conclusion, characteristic changes in child welfare depict an unfortunate situation in terms of the child's health, nutritional status, education and rights. However, we do not have sufficient information to enable us infer that this backward trend is traceable to the advancement of HIV/AIDS.

### **5.3. The impact of HIV/AIDS on economy**

HIV/AIDS has a negative impact, in the short and long terms, on the national economy. The economic hardships facing Africa in general and Côte d'Ivoire in particular are dependent upon : the labor force(quantity, structure and quality), labor productivity, health expenditure, labor force mortality rate, savings and investments, consumption and demand, total revenue and per capita income, impact differential on urban economy and agricultural production, food security and poverty, HIV/AIDS and enterprises. Few studies are available on the economic impact of HIV/AIDS in Côte d'Ivoire.

### **5.4. Socio-economic survey and outcome**

#### **5.4.1. Methodology of socio-economic survey**

The household is the observation unit and three types of households were identified, namely : the household having recorded an HIV/AIDS related death of an adult in the last 24 months (type 1), the household where a non HIV/AIDS related death of an adult occurred in the last 24 months (type 2) and the household having recorded no death(type 3). The difficulty in identifying an observation unit is based on the fact that it was not possible to obtain information relating to the infection status of the deceased person directly from the household. We got around this difficulty by requesting the assistance of ACCU of Teichville UTH and that of PLWH NGOs(CASM in Abidjan, RSB in Bouaké, CIDV in Korhogo, and .... in Daloa. The household survey needed to be conducted in homes in order to observe visually the household characteristics and environment, the practical advantage of the NGO is the fact that they regularly visit infected and affected families at home, this can not be said of ACCU. Based on the foregoing, 600 households were selected, not by random sampling (the programming could not allow such arrangement), but rather by informed sampling. Thus, 300 were selected in all the neighborhoods of Abidjan and 300 in the interior on the basis of 100 per city.

**The questionnaire.** The survey being the Ivorian component of an international project, the questionnaire was proposed by the Project Coordinator for the purpose of comparability and the Ivorian team simply had to adapt it to local circumstances. In reality, detailed adaptations were relatively few. Conversely, the formal presentation of the questionnaire was more professional. The questionnaire comprised the following parts: (1)the information framework on households; (ii) the socio-demographical characteristics of some family members ; (iii) the household's assets ; (iv) the household

income; (v) the household's expenditure; (vi) the impact of HIV and other diseases; (vii) variations in the household's consumption pattern in relation to the last twelve months; (viii) variations in access to health and education; (ix) variations in the household's demographical composition; (x) variations in household income; (xi) variations in the household's make up in terms of demography, manpower employment, and physical capital; (xii) variations in the household members' activity time; (xiii) the supported provided by the community, the civil society and government.

**Execution of the questionnaire.** The questionnaire was administered by a team of 24 field workers. 12 field workers for Abidjan and 12 others for the interior on the basis of 4 per city, under the supervision of the project's technical team. For three days, field workers were previously trained on the fundamentals of the questionnaire and how to administer it. The actual data collection exercise started off really late, from May 10th to June 30th, 2001.

#### **5.4.2. Outcome analysis**

##### **5.4.2.1. Socio-economic characteristics of households having had an HIV/AIDS related death**

Households having had an AIDS related death (tagged HAD) accounted for 34% of 594 households interviewed in the 4 major cities of Côte d'Ivoire and accommodate 33.3% of 4 781 family members. The technical characteristics of the survey suggest that HAD did not suffer from technical bias. There are more children, less adults, more aged people and more women than in other households thus implying that it has the highest dependency rate.

The annual household income of HAD is estimated at CFAF 387.234, being 89.5% and 84.6% of the household having had a disease –related death other than AIDS (tagged HDDA) and the household having had no death (tagged HND) respectively. This relatively low income compared to other households comes from lowly and averagely qualified salaried workers, up to 28.1% compared to 16.9% for HDDA while only 8.5% come from highly qualified salaried workers compared to 4.8% and 17.6% for other households. In addition, in HAD households income was generated more through a salaried job. Finally, transfer is a higher supplementary income than in the other households.

The human capital of HAD is lower than that of other households. Indeed, the proportion of illiterates surpassed by 11-25% that of other households. The proportion of household members with elementary school education surpassed by 31% the proportion observed in HND households; its members with secondary education accounted for 91% of those in HND households. Concerning its members with higher education, HAD households is clearly handicapped compared to others because numerically they accounted for 74% and 45% of their counterparts in HDDA and HND respectively.

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**Table 7:** Major characteristics of interviewed households (the gray parts show various blocks of similar indicator types)

	Households having had AIDS related death (type 1)	Households having had deaths induced by another disease (type 2)	Households having had no deaths (type 3)
Households interviewed in the Urban area (if applicable) - <i>Applicable</i>	202	196	196
Total Households interviewed	202	196	196
Total number of households' member	1592	1662	1527
% of children members among total members	48,5	45,8	44,2
% of adult members among total number of members	43,7	46,8	49,1
% of aged people among total number of members	7,8	7,4	6,7
% of Men among the total number of members	46,0	45,8	49,5
Average per capita income	387234	432765	457697
% of under qualified salaried workers on total income	13,3	9,9	11,6
% of averagely qualified salaried workers on total income	14,8	7,0	12,8
% of highly qualified (specialized) salaried workers on total income	8,5	4,8	17,6
% of self-employed workers' income on total income	16,9	19,5	21,4
% of transfers on total income	5,7	5,8	4,8
% of adult members and aged illiterate members	27,6	24,7	22,1
% of adult members and aged members with elementary education	28,0	28,2	21,4
% of adult members and aged members with secondary education	37,4	37,7	40,9
% of adult members and aged members with higher education	7,0	9,4	15,5
% of households without land ownership *	76,7	75,0	77,6
% of households who do not own cattle *	86,1	78,1	83,2
% of households who do not own the houses they live in	47,0	38,8	54,1
% of households living in houses made of permanent structures	8,9	8,7	10,2
% of households without toilets in the house	61,9	55,1	49,0
% of households without car ownership(no personal means of transportation whatsoever)	81,7	71,4	74,0
% of households not owning tools of production	83,2	84,2	82,1
% of households who do not own any household appliances (durable consumer goods)	14,9	12,2	11,7
% of Household heads who do not belong to any social, community-based or economic association	23,2	31,5	22,3
% of Household heads who do not belong to any political or religious association	36,3	32,6	37,0

Close to half of HAD households (against 39% among HDDA households) do not own the houses they live in. However, this situation seem better than that of HND households but available information does not permit to know why. Though HAD households are on the same pedestal as the other households for the unsustainability of home building materials, the facilities in these houses are less comfortable than in other households. Indeed, the proportion of HAD households having no toilets surpasses other households by 12.5 -26% . the situation is less dramatic concerning car ownership because the gaps

are ranging from 11-15%. The situation is the same for all households concerning ownership of means of production. The gaps are wider, ranging from 23 –28% for non-possession of household appliances.

The position of HAD households with regards to their degree of non political socialization is ambiguous while their degree of political or religious socialization is almost identical to that of other households.

Whenever we look at things from the viewpoint of the household head, this person is illiterate or of low education in the proportions comparable to those of others, with the exception of the illiterate proportion of HAD households is 22% higher than that of HND households. Conversely, the proportion of household heads with higher education is only 51-72% of the proportion of other households. The proportion of households who own urban land accounted for 88.5% than that of HDDA households.

The classification of income according to low, average and high levels, reveal an ambiguous situation for HAD households because though there are more of them with low and high income), few of them have average income. Thus, there is a high differentiation in HAD households.

HAD households dedicate less time to child care and many of them dedicate more time to children (though this latter information is statistically insignificant). The proportion of HAD households who dedicate average time to child care is higher than the others , the ratio varies between 43% and a multiple of 3.5. In fact, HAD households dedicate more time to child care.

HAD households who did not receive any form of aid are less numerous and they received less Government and community-based aid more than the other groups. In general, households under survey did not receive social assistance from government (old age pension, unemployment allowances, orphan child allowances, retirement and public transfer allowances). Likewise for loans, public transfers, food and any other form of aid in kind.

In summary, the HAD households have a population structure different from others, notably dependency rate is much higher. Their income is 11-15% lower than that of others due to a higher proportion of members with little or no education. The frequent salaried work does not shield them from transfers from elsewhere. The group's human capital is significantly lower than that of other groups. Its physical capital is less and its living conditions are more deteriorated. Generally, the income and life conditions of HAD are precarious and this situation was aggravated by lack of social assistance and aid from government which in any case does not give any direct assistance to any household. However, in spite of these handicaps, HAD households also seem more sociable than other households.

### 5.4.2.2. Children welfare in households under survey

Tables 8 and 30-36 (Annex A) show differentiated indicators of children welfare of each type of household(HAD, MNDS and HND). The HAD household accommodated more children than other households, being 1.4% and 14.3% more than HDDA and HND respectively. In addition, they accommodated more boys, being 0.5% and 10.9% more respectively. However, the proportion of boys compared to the total size of the household, 48.8%, is lower than that of other households, which is equivalent to saying that HAD households have more girls than other households.

**Table 8** : Children welfare indicators according to household type

	Households having had AIDS-related deaths (type 1)	Households having had deaths other AIDS induced disease (type 2)	Household without deaths (type 3)
N° of household-based children (HC) (1)	772	761	675
N° of household-based male children (2)	377	375	340
% of father and mother orphans(proportion of orphans)	10,9	4,1	2,1
% of father orphans only	32,3	35,5	7,7
% of mother orphans only	11,5	10,1	3,1
% of HC who died (out of a total number of HC in the household ) of all causes during the observation period (3)	2,5	0,7	0,1
% of HC who were sick, whatever the disease during the observation period(prevalence rate of diseases)(4)	46,4	40,7	39,1
% of HC who had a professional activity during the observation period	4,4	5,0	4,9
% of HC who could not have access to health centers though they had a need for health services	48,7	26,8	29,5
% of HC who were withdrawn from school	27,7	18,5	16,0
% of HC who suffered from serious problems(malnutrition, insults, others) (5)	NA	NA	NA
Average Daily Time (working days) by children in professional activities(games, studies, sleeping)-Boys	21hrs 05 min.	21hrs 39min.	21hrs 14min.
Average Daily Time used (working days)by children in personal activities (games, studies, sleep)-Girls	19hrs 42 min.	20hrs 17 min.	19hrs 50 min.
Average Daily Time used (time off) by children in personal activities (games, studies, sleep)-Boys	20hrs 49 min.	21hrs 28 min.	21hrs 12 min.
Average Daily Time used (working days )by children in personal activities (games, studies, sleep)-Girls	19hrs 41 min.	19hrs 34 min.	19hrs 38 min.
% of HC having suffered discriminations whatever the reason (6)	0.1	0.1	0

HAD households have 2.65 times and 5.2 times more fatherless and motherless orphans than HDDA and HND respectively. For fatherless orphans, the situation is more ambiguous because HAD households had more orphans than HDDA households (proportion ratio is 0.91%) while they had more than 4.15 times than HND. The proportion of deceased children in HAD households is 2.5% and 3.57 times and 2.5 times than HDDA and HND households respectively. The proportion of sick children is high in this group, 46.4% and higher than 14.8% to 19% than that of other households. Less HAD-based had a professional activity more than other households. However, the differences are not significant.

More than half of HAD children did not have access to health centers, even when they needed healthcare, being 1.65 to 1.82 times more than other households respectively. More than a quarter of them were withdrawn from school, being 1.49 to 1.73 times more than other households. Whatever their gender, HAD children had less time for personal activities compared to their counterparts in other households. In HAD households, girls were more at a disadvantaged than boys. However, the gap is small, ranging from 5-8% in favor of boys. This favorable trend for boys is not surprising in the traditional Ivorian society but it is greater in other households, the gap being 6-8% for working days and 9-10% for time off. Then, small boys are less favored in HAD households than in other families.

In conclusion, HAD groups have a heavy responsibility in that they have the largest number of problematic children (orphanages, disease, lack of access to healthcare, withdrawal from school). Maybe this responsibility was imposed on this group by the extended family, at the same time, it induces pressure on resources thus preventing the household from receiving treatment and improving its production capacities.

**Educational attainment of household heads and welfare of household children :** In most case, (not in all cases), the situation of children living in illiterate households surpasses that of other levels of educational attainment in HAD groups as well as than in other households. In HAD households, the number of children varies according to the level of education. Elementary school educated households have less than others representing 25-28% less than other illiterates. This situation is observed also in other types of households with fluctuating proportions: elementary school educated households have 120-16% less than secondary /higher education and illiterate household respectively. The gap is wider for HND households where elementary school educated families had a greater number of children who represent only 44% and 21% of the number of children from illiterate families and secondary/higher education respectively. Obviously, the issue at stake is to know why elementary educated households generally have less children than others. There is not sufficient information to explain this situation.

The distribution of boys follow the same trend as the previously mentioned trend, notably that the proportion of boys is lower in elementary school educated HAD families than in other HAD families, about one-third at least. The level of education does not affect the distribution of boys in HDDA families but it has an impact on the internal distribution of

boys in HDDA families. In summary, the distribution of boys is affected by the level of education in HAD and HND families with the exception of HDDA families.

In illiterate HAD families, more children are fatherless and motherless orphans, they die, fall sick and have problems having access to health centers as they are withdrawn from school compared to illiterate HDDA and HND families. More children living with elementary school educated, secondary /higher education HAD families have the mentioned characteristics than their counterparts in HDDA and HND families of equivalent educational level. More children living with illiterate HAD families have a professional activity than HDDA and HND families of the same status. The level of education of HAD families does not influence the children's use of their time.

The asset portfolio and income of household heads is a differentiation factor of children welfare in the three types of households under survey. (table 31 and 32 of annex A).

**Asset portfolio of household heads and children welfare:** Households having household appliances have a greater concentration of children and boys than those who only have their homes or do not have any. In HAD families, fatherless and motherless orphans are more in number than families with a home than in other families. The situation is the same in HDDA families but not in HND families. In general, in HAD and HND families, children living with families without assets are more in number as they: die, get ill, lack access to healthcare, are withdrawn from school.

**Income of household income and children welfare:** In HAD families, the number of orphans increase with income level while it is the opposite in other types of households. Meanwhile, the influencer of income does not show a uniformly discernible trend over the other characteristics of the child.

Moreover, the average daily time of children, the aids and donations received by households have an impact on the children welfare according to the type of household under survey (table 33 -36 of annex A).

**Average daily time and children welfare:** The majority of children and boys living in households who as a whole, whatever the type, dedicate minimum time to child care. In HAD families, it is in the families where an average time for child care that we find a large proportion of orphans, deceased children, children who did not have access to health centers. Conversely, it is in families where maximum time is dedicated to child care that we found the greatest number of sick children who have a job, do not have access to health centers and where children are withdrawn from school. It is in HAD and HND families where a lot of time is dedicated to children while the latter have more personal activities though is not true of HND families.

**Aids and donations received by families and children welfare:** The majority of children and boys live in families who benefit from assistance from CBOs/EFN in HAD and HDDA families. Conversely, the majority of children receive no aid. In HAD families, it is in families benefiting from CBO/EFN aid that there are more children who

have a professional activity. It is in families benefiting from NGO and Religious organizations (ROs) aid that more orphans, children deprived of access to health centers, children withdrawn from school are found. Sick children are found more in families benefiting from Government aid. In HAD families, the time dedicated to personal activities of children do not seem to be affected by the type of assistance or aid. Moreover, the number of households and people concerned with aid or transfers is too low for a serious analysis to be conducted based on this criteria.

In conclusion, the factors influencing children welfare are clearly discernible. They are, level of education, possession of durable assets and the time dedicated to child care. Illiterate HAD families who do not own any property and dedicating average time to child care are those having problematic children. Conversely, income, aid and donations do not have a discernible and systematic influence on children welfare.

#### **5.4.2.3. Strategies adopted by households**

Table 9 of the following page reveals the various types of strategies (sustainable, partially sustainable and unsustainable) which the three types of households under survey in view of the problems.

- (i) Apart from the sale of non productive assets, HAD families were many who adopted sustainable strategies. Indeed, they are less in number those who reduced their savings, investments, asset and consumer goods expenditure. They are also less in number than those who increased the time dedicated for productive and family-oriented activities. Thus, it is crystal clear that if HAD families did not reduce savings and investments, for lack of adequate funds, they do not have either the means to increase work time which was taken up by the concern to seek for treatment and take care of family issues, obviously because of family suspicion and also to avoid being stigmatized.
- (ii) There were more HAD families who implemented partially sustainable strategies, by inducing their family members to migrate and placing their children with the care of far-away relatives both for giving these children more opportunities and for easing the burden of food, medical and education expenses. More frequently than in other households, HAD were pushed into leaving their jobs to take care of sick family members.
- (iii) Clearly, more HAD families than other households, notably HND families, adopted unsustainable strategies such as relying on external aid, selling properties, reducing basic feeding expenses, withdrawing children from school, and also they could not have access to health centers. These strategies are motivated by low income while health expenditure is high and permanent.

In conclusion, there were numerous HAD families who adopted sustainable strategies. Conversely, they were obliged to adopt partially sustainable and unsustainable strategies

undoubtedly because of low income while health expenditure was on the increase and community assistance remained limited.

**Table 9:** Type of strategies adopted by households ( Type 1, Type 2 and Type 3)

	Households having AIDS related deaths (type 1)	Households having deaths due to another disease (type 2)	Households without deaths (type 3)
<b>Sustainable coping strategies</b>			
% Households having reduced savings	67,6	71,2	64,7
% Households having reduces investments(need-based) (1)	6,3	12,5	11,1
% Households having reduced durable consumer goods expenditure	9,7	17,3	18,2
% Households having sold un-productive goods(jewelry, other non-essential objects )	6,7	4,0	0
% Households having increased the Average Daily Time dedicated to productive activities (2)	12,4	13,8	16,8
% Households having reduced Average Daily Time dedicated to family activities and other activities (3)	15,8	25,5	17,3
% Household having adopted other sustainable strategies (please, specify)			
<b>Partially sustainable coping strategies</b>			
% Households having members who migrated to another place in the search for employment opportunities far off from place of residence	12,4	12,8	11,4
% Households having placed children in far off families	16,8	12,8	8,7
% Households having a member who left his employment to care of other household members who are sick	2,0	0,5	1,0
% Households having adopted other partially sustainable strategies (please, specify)			
<b>Unsustainable coping strategies</b>			
% Households having received substantial aid(in cash or in kind)from any source whatsoever (4)	73,3	63,3	35,7
% Households having borrowed money at unfavorable conditions	4,5	6,6	11,2
% Households having increased their income through the sale of heritage properties (1)	14,9	12,8	10,7
% Households having reduced their basic feeding budget	27,0	23,8	11,3
% Households having withdrawn children from school	25,7	15,3	14,8
% Households having members who could not have access to health centers though they had a need for healthcare services	45,5	25,0	27,0
% Households having adopted other unsustainable strategies (please, specify)			

#### 5.4.2.4. Factors influencing the coping strategies adopted by households

Tables 37-42 of Annex A ensure the understanding of major factors influencing the strategies adopted by each household type under survey.

**Level of education and household strategies:** The level of education of HAD family members influence their strategies though it was not possible to establish a precise trend. Thus, more families with secondary/higher education reduced their savings while illiterate families reduced their investments and durable consumption expenditure,

probably because of lack of money or simply as a result of ignorance of the importance of the investment for future well-being. Moreover, it was elementary school educated families who increased their affected work time both for productive and family-oriented activities. Concerning sustainable strategies, the level of education does not give the orientation of household behavior towards a particular direction. More elementary school educated families adopted partially sustainable coping strategies and this is true for HAD and HDDA families but not for HND families. Concerning unsustainable strategies, more illiterate families depended on external aid and the sale of asset-based properties while more elementary school educated families reduced their feeding expenses and did not have access to health centers. It was discovered also that in HDDA and HND families, more illiterate families adopted unsustainable coping strategies. Thus, it seems that unsustainable strategies are adopted more in households where the household head has a low level of education or no education at all.

**Income level and household strategies:** The income level of the household head plays a decisive role in the adoption of coping strategies. Thus, it is observed that in HAD families, families whose head had an average income were more inclined to adopt sustainable strategies. Conversely, the situation is more diversified for partially sustainable strategies. Concerning unsustainable coping strategies, more average and low income families shared the initiatives. In HDDA families, more low income families adopted sustainable strategies and it was rather high income families who used unsustainable strategies. In HAD families, it was low income families who used sustainable strategies while low and average level income families used unsustainable strategies. Thus, it is clear that sustainable strategies were basically used by low income families while unsustainable strategies were implemented by average and high income families, except in the case of HND families where it was high income families who used unsustainable strategies.

**Aids/donations and household coping strategies:** In HAD families, as far as sustainable strategies are concerned, the role of aids/donations of various aid organizations did not appear clearly. Partially sustainable strategies were adopted by families who received aid from NGOs and Religious organizations(OR). Unsustainable coping strategies were adopted by families who received aid from NGOs/ROs and CBOs/EFN. The Government did not play a decisive role. In HDDA families, there is no precise picture of aid organizations' influence with regards to sustainable coping strategies. Concerning partially sustainable coping strategies, more families who used this type of strategies were aided by the Government and CBOs/EFN. Concerning unsustainable strategies, they were mainly used by families who benefited from aid provided by NGOs/ROs, CBOs/EFN but these strategies were also adopted by families who did not receive any aid. In HAD families, more families aided by NGOs/ROs used sustainable strategies. The families who used partially sustainable coping strategies received aid from the government. More families who received aid from NGOs/ROs implemented unsustainable coping strategies.

In conclusion, factors influencing sustainable strategies could not be clearly identified as partially and unsustainable strategies were implemented by illiterate and elementary

school educated households, on the one hand, and average and high income households on the other hand. The possession of property and aid/donation did have any influence on strategies implemented. However, it is clear that the government did not play a significant role in the adoption of a particular strategy.

## **6. Analysis of measures and policies for reducing the impact of HIV/AIDS**

### **6.1 Introduction**

- *Methodological Issues and Considerations*

The increase in the number of AIDS cases and deaths caused by this disease raises many health, economic and social problems both to State institutions and families. Logically, it is expected that the State and the various communities implement measures to reduce the impact of this disease. In order to reveal the current situation in Côte d'Ivoire, qualitative interviews were conducted among resource persons within various Ministries that had been pre-selected by the Inocenti Research Center (IRC).

The Ministries initially aimed at were three in number: Ministry of Public Health, Ministry of Education and Ministry of Social Welfare and National Solidarity. But in view of the nature of the data to be collected and the current social context, this survey was extended to other Departments, notably those of the Ministry under the Prime Minister in charge of HIV/AIDS, the Public Servants' Mutual Fund (MUGFCI) and other services.

**The Overall Objective** of the surveys in the Ministries was to *analyze the policies and programmes in the areas of prevention, treatment and long term reduction of the impact of HIV on the wellbeing of children*. Specifically this entails the following:

- Measure and evaluate the impact of HIV/AIDS on various Ministries.
- Describe the measures taken to mitigate the impact of HIV/AIDS at individual, family and group levels.
- Evaluate the financing and institutional changes for guaranteeing an effective application of measures taken to overcome the growing poverty caused by HIV/AIDS.

The questionnaires designed by the Inocenti Research Center (IRC) include both tables of statistical data and open questions or interview guides. These survey tools were adapted to areas relating to measures taken.

In view of the fact that HIV/AIDS spread during the 1990-2000 period, questionnaires covered the last 10 years (1990 to 2000). However, in cases where the information requested was not available, the available data was noted. In this section, the analysis of

responses to the AIDS threat is therefore based on all the information gathered as well as all the data from various other studies.

## 6.2. Impact of HIV/AIDS infection on the response capacities of social ministries

### 6.2. 1. Impact of HIV infection on structures of the Ministry of Health

The Ministry of Public Health is the Ministry directly and mainly concerned by the therapeutic and psycho-social care and treatment of persons infected by the HIV and AIDS diseases. Since Côte d'Ivoire is a country that is severely affected by this pandemic, its system of health has been hard hit by it, notably by the increase in reception structures (health establishment: hospital beds) and by the increase in the human, material and financial resources (recruitment of health workers, availability of drugs and screening tests, etc.). What, therefore, is the impact of HIV/AIDS on the structures of this Ministry?

**Table 10:** Number of Health Establishments According to Level of Intervention Between 1993 and 2000

	1993	1995	1996	1997	1998	1999	2000
Primary Care	1 060	1 055	1 107	1 107	1 107	1 107	1 107
Secondary Care	83	88	96	96	96	96	96
Tertiary Care	08	09	09	09	09	09	09

**Source :** Ministry of Health, 2001

The increase in the number of health establishments from 1993 to 2000 indicates that 40 new health services were created at the primary level and a hospital center was created at the tertiary level. One can therefore state that the number of health services increased over the period considered. However, it cannot be affirmed that all these new health centers were constructed as a result of HIV/AIDS. For, the health structures constructed or specially created for the care and treatment of HIV/AIDS in the public sector are known. These are:

- USAC, and, to some extent,
- The Day Hospital of Bouaké,
- The Day Hospital of Korhogo
- The CAT Unit of Adjamé
- CAT Unit of Treichville (not very operational).

The Infectious Disease Services (SMIT) of the Treichville Teaching Hospital, the PPH, Pediatric and Medicine Departments of the Cocody and Treichville Teaching Hospitals also received many AIDS patients (children and adults). But these were not created because of AIDS. It is consequently essential to determine the extent to which the reception capacities of health services have been influenced by the HIV/AIDS infections.

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**Table 11:** Number of Hospital Beds by Level of Intervention Between 1993 and 2000

	1993	1995	1996	1997	1998	1999	2000
Primary Care	3249	3300	3300	3750	3750	4600	4650
Secondary and Tertiary Care	9682	9682	9682	9682	8382	9032	9832

**Source :** Ministry of Public Health, 2001

The analysis of the growth in the number of hospital beds by level of intervention between 1993 and 2000 points to two factors. At the primary level, there was an increase of 1401 beds in 14 years (that is an increase of 200 beds a year on average) and at the secondary and tertiary levels, an increase of 150 beds (that is, 21 beds per year on average) between 1997 and 2000.

The data indicates that the reception capacity in terms of hospitalization increased more significantly at the level of primary intervention and less at the two disease referral levels in terms of hospitalization.

Knowing that AIDS patients are not hospitalized at the primary level but rather at the secondary and tertiary levels, it can be concluded that the increase in the number of beds noted is certainly not due to AIDS. Moreover, this is all the more true as the SMIT of which over 80% of the 120 beds were occupied by AIDS patients only had 50 beds in 1998 prior to the closure of all AIDS hospitalization units from 1999 to 2001 for various reasons: lack of maintenance of buildings and inadequate human resources (notably nurses), etc. In fact, not only did many nurses at the SMIT transfer to other health services, where they felt less exposed to the risks of contamination at work, but several generations of nurses refused to take the Public Services Entrance Examinations with the result that it has not been possible to assign nurses to this department in the last two years. Therefore, given the increase in the number of health establishments and the reception capacity in terms of hospital beds, what was the situation in the recruitment of human resources?

**Table 12 :** Number of Salaried Staff of Health Services by Category Between 1993 and 2000

	1993	1995	1999	2000
Doctors	1 282	1 400	1 422	1 605
Male/Female Nurses	4 368	4 642	7 265	6 583
Midwives	1 593	-	-	1 802
Administrative and Office Staff	-	51	1 737	1 737

**Source :** Ministry of Public Health, 2001

The observation of data on the growth in the number of salaried workers indicates that between 1993 and 2000, the number of doctors increased by 323, that of nurses and midwives by 225 and 209 respectively. Hence, there was an increase in the number of the salaried personnel in the Ministry of Health.

CHAPTER 5: HIV/AIDS LAGGING POLICY RESPONSE AND IMPACT ON CHILDREN:  
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Essential drugs were available in nearly all the health structures from 1995 onwards. To date, the rate of availability hovers around 100% in the health centers. However, essential drugs for opportunistic diseases are yet to be identified using algorithms existing since 1999-2000. This would mean revising the list of essential drugs and adding those for HIV such as AZT, an essential product for the prevention of mother-to-child transmission (MTCP) of HIV.

Lastly, HIV screening tests are currently scarce in the public sector health services. Until 1992, the tests used were provided by WHO (4000 free tests provided annually since 1989). The screening and biological diagnostic strategy adopted was based on the fact that the Elisa tests must be used for asymptomatic persons and the rapid tests among patients showing clinical signs similar to AIDS.

The prices of the tests to the patients rose from CFAF 500 to CFAF 1000 between 1989 and 1998. Rapid tests were sold by the PSP at CFAF 3,300 per unit to the FSUs who have been selling it at CFAF 1000 to patients since 2000. This means that the FSUs must subsidize rapid tests for the biological diagnosis of HIV/AIDS. This situation has resulted in the halting of HIV screening tests in the Urban Health Centers (FSU). However, it must be noted that at the Anti-TB Centers (CAT), the clinical trials, the SMIT and the CNTS for blood donors, the tests are provided freely to the patients (R Aka et al. 2000).

On the whole, since 1993, there has been an increase in health services, hospital beds and health workers. Essential drugs are available in health departments or districts except the HIV screening tests, which are unavailable. It is certain that this progress is not merely due to HIV/AIDS, but rather related to the desire to improve the access by the people to health care in general. The creation of new health structures is not related to the development of HIV, but rather is geared towards strengthening maternal and child health through Primary Health Care (PHC). The evidence for this is that the UNICEF investment projects (1997-2001) mainly target the strengthening of primary health care (Bamako Initiative) in 13 districts of Côte d'Ivoire. This is also true of the World Bank project (PDSSI) mainly geared towards reproductive health (CIDEF/UE. 1997).

In view of the foregoing, it can be concluded that the impact of AIDS on the health system is real but difficult to measure to the extent that very few specific services, personnel and material resources are earmarked for HIV/AIDS. Indeed, previous policies had not wished to create special health structures for HIV/AIDS in view of the fact that the fear surrounding this disease could possibly lead to the stigmatization of patients. Today, the Sub-directorate for care and treatment of the Ministry for AIDS Control intends to place an emphasis on specialization. Reasons accounting for the fact that to date, structures have not been specially assigned to HIV/AIDS are related to current official policy.

In terms of victims among the health personnel, the impact of HIV/AIDS is also not sufficiently known. Health workers are indeed exposed to occupational risks of contamination, particularly when they come into contact with the blood of infected

patients. These various risk situations are referred to by the specialists as “Blood Exposure Accidents” (BEA). Indeed, it is known that 45% of the staff of the Yopougon Teaching Hospital have had antecedents of AES, particularly, 31% of nurses and midwives and 19% of surface technicians (Yoboué et al. 1997).

The workers of the Anti-TB Centers (CAT) are considered to be the most exposed in view of the fact that 45% of their patients are infected by HIV/AIDS. However, these workers feel threatened more by TB than by HIV. But such is not the case in the urban health centers of Abidjan where the health workers rather fear infection by HIV in the work place. At the tropical infectious diseases clinic of the Treichville Teaching Hospital, nurses and workers who felt they were highly exposed undertook a strike action to claim risk bonuses in view of the fact that over 80% of the beds were occupied by HIV infected patients.

In terms of the quality of medical services, the duration of hospitalization of patients living with the HIV was found to be longer (25 days) than that of patients uninfected by HIV/AIDS (15 days) at the medicine department of the Treichville Teaching Hospital (CIDEF 1996).

At the pediatric services, which cater for child health, the duration of hospitalization is significantly different depending on whether the children are infected by HIV (3 days) or are HIV negative (5 days).

This study shows that the therapeutic management of HIV infected patients has not resulted in an overload of activities in the referral health services (SMIT, Pediatric Department of Treichville Teaching Hospital), and much less in the peripheral health services. However, AIDS occupies an increasingly important place in the pathologies treated in the health services: AIDS is today one of the major causes of adult death, who attend conventional health services only when their state of health has degraded considerably. Moreover, out of the time health workers spend near patients during care, the share of HIV/AIDS is 15%.

Lastly, consumption of drugs is greater among HIV infected patients than among other patients. On the other hand, in terms of the other clinical examination consumption, there is no significant difference between patients living with HIV and uninfected patients (CIDEF. op. cit.). To conclude, the impact of HIV/AIDS on health personnel is not sufficiently known, but it is probably insignificant: from 1992 to 2000, the number of doctors, nurses/midwives and administrators varies each year between 2/4 and 21. On the other hand, AIDS induces lack of motivation among caregivers, deteriorates somewhat the quality of medical services by increasing the work-time of caregivers. But the impact of AIDS on the lack of work equipment and the degradation of work infrastructure has not yet been objectively studied.

### **6.2.2. Impact of HIV/AIDS at the level of the Ministry of Education**

The consequences of AIDS on teaching personnel were studied for the first time in 1996 (AIDS Impact Project. 1998). The study indicates that out of 641 teachers infected by HIV, 81% are primary school teachers, 15% secondary school teachers and 3% instructors. The studies also indicate that between 1996 and 1997, 64% of deaths of teachers whose causes were known were due to HIV/AIDS. This represents 5 deaths of primary school teachers per school week, whereas there are 43% of deaths caused by HIV/AIDS among secondary school teachers for the same period.

Absentee time for HIV infected primary school teachers was estimated at 6 months whereas it was 10 days for those suffering from diseases other than HIV/AIDS. This absentee rate of HIV infected primary school teachers seriously affected the education of about 1,600 pupils (compared to 1,200 pupils for other diseases). In the families of the teachers, the impact of HIV/AIDS was also determined. Thus, it is known that from 1997 to 1998, 796 AIDS orphans have been identified with 56% of children aged below 15 years.

Lastly, the study indicates that the deficit of teachers with AIDS exceeded by 8% the ones without AIDS and that over 2% of the number of children of school going age had no access to schooling because of AIDS over the 1998-2000 period. As can be seen, AIDS considerably reduces the capacities of the educational system to meet the social demand both quantitatively and from the point of view of the quality of services. It causes new social problems in the families by increasing the number of orphans among teachers and disadvantaged or out-of-school pupils.

However, the impact of HIV on the financial and material resources of the Ministry of Education is not currently objectively known and remains to be studied. This is also true of the cause of possible budget cuts and the degradation of infrastructure.

### **6.2.3. Impact of HIV/AIDS at the level of the Ministry of Social Welfare and National solidarity**

Until 1987, there was an autonomous Ministry of Social Welfare. Subsequently, this Ministry was dissolved and integrated with other Ministries: Public Service, Public Health, etc. In 2001, the new Social Welfare and National Solidarity Ministry was created. It is therefore an entirely new Ministry, which is being put in place. As a result, it is difficult to speak of the impact of AIDS on this Ministry. At least, currently, there is not enough information that would help assess the impact of AIDS on the staff as well as the infrastructure of the Ministry.

### **6.3. State Responses for reducing the impact of HIV/AIDS**

#### **6.3.1. Analysis of State measures aimed at building capacities to face the consequences of HIV infection**

In order to deal with the AIDS pandemic, the Government had given priority to mass information and educational activities. Following this, and with the increasing number of persons infected and affected, therapeutic management was identified as a priority from 1994. The social assistance of disadvantaged patients, strategies for combating the stigmatization of persons living with HIV constitute concerns in AIDS control policy. But these are problems that the Government was unable to address effectively. This is also true of the diagnosis and medical treatment of HIV infection: not only are the current resources centralized in the cities (Abidjan, Bouaké, Korhogo and Daloa), but the psycho-social care (pre-testing and disclosure) is hardly undertaken in most of the State health services, and laboratories that currently conduct HIV tests belong to foreign institutions (or projects). This dependency on external support requires that steps be taken to provide all the referral health services (CATs, USACs, SMITs, CIPS, etc.) with laboratories capable of undertaking HIV infection tests.

Many health personnel (doctors, social assistants, nurses and midwives) receive two to three day training on the therapeutic and psycho-social management of HIV infection. This is also the case for biologists and laboratory technicians. But the vast majority of health workers have never been provided such training. It is therefore essential to train all health workers (without exception) in a regular manner (every two years for example) in order to improve the management of HIV patients in most of the health services of Abidjan and elsewhere.

#### **6.3.2. Strategies for Adjustment to the Consequences of AIDS**

The management and prevention of HIV infection require a minimum of material resources and appropriate infrastructure (meeting rooms, audio-visual apparatus, biological diagnostic tests, etc.). Through research projects such as DITRAME and RETRO-CI, some health centers have been rehabilitated (maternity and MCH Centers of the FSU of Koumassi, Marcory, Yopougon, the Port Bouet General Hospital, Community FSU of Abobo Sagbé, etc.) This rehabilitation of infrastructure is an adjustment strategy insofar as it allows the management of HIV in these health centers where it previously did not exist.

A major adjustment brought about by the development of the HIV/AIDS pandemic is the creation of a Ministry specially and only in charge of AIDS control (MLS). The current AIDS control strategy is based on the multi-sectoral approach (between all the Ministries) and decentralization (at level of NGOs and CBOs) coordinated by the MLS through its policy and strategy, coordination and partnership, research, training, monitoring, and evaluation structures. As can be seen, this Ministry is in charge of defining the major orientations of the fight against AIDS. It also conducts advocacy with all the national and international institutions aimed at seeking their assistance in the funding of activities,

coordinates the monitoring and evaluation of strategies and actions and reports to the Prime Minister. The other Ministries must allocate 10% of their budget to AIDS control activities. As for the Ministry of Public Health, it remains the major provider of health services, as in the past. Conflict of interests may be avoided at the level of these two Ministries if the MLS remains a coordination and not an executing structure, thus leaving each Ministry and the NGOs the responsibility for prevention, care and treatment and research activities.

### **6.3.3. Social Policy and Management of the Consequences of HIV/AIDS**

The desire by Ivorian authorities to pursue a rigorous social policy dates from the first Republic. One of the major institutions for training social workers in the sub-region was built in Côte d'Ivoire in the 1960s. Orphanages, day care centers, social centers and health social services have been established in the country. Their number is insignificant today in view of the needs, but this is evidence of the desire of the authorities to address as much as possible the social problems of the poor communities. It needs to be recalled that a third of the population lives below the poverty line. Consequently, Government assistance becomes very important for the management of the consequences of social problems, notably those caused by HIV/AIDS.

The social services of the hospital centers do not have any budget and only exist in name. Social Assistants are reduced to begging from Chief Medical Officers or Hospital Directors in their efforts to provide assistance to needy patients. Access to ARV treatments is conditioned by a number of socio-economic criteria that determine financial access, understanding of the disease and the necessary treatment (Coulibaly, 1997). These various criteria, notably economic ones, constitute obstacles to access to ARV treatment, even though their usefulness can be justified.

The Ivorian Solidarity Fund was set up to provide subsidies for the treatment of patients unable to pay for the cost of the latter and meet biological eligibility criteria. For disadvantaged patients or members of associations of persons living with HIV, the management committee defines the nature of the subvention in terms of socio-demographic criteria. Thus, for certain patients, the reduction is 50% or 75% with the consent of the management committee, whereas with others, it varies between 95% and 100% (Solidarity Fund plus FSTI).

Apart from the social measures and structures mentioned above, there are not others presently. There is also a lack of social policy for the staff of the Ministry of Education, Social Welfare and Health: for example, a nurse, a doctor or a social assistant who is ill does not have a reduced rate for consultation, laboratory tests or hospitalization. They do not enjoy any exemptions. This can be a demotivating factor for some personnel. There is no arrangement enabling a disadvantaged child to gain access to education. This weakness in the educational system will be remedied if the policy of free education advocated by the authorities is implemented successfully.

#### **6.3.4. State Support to Community Initiatives for the Care of Orphans**

As the Ivorian Minister of Health recognized, “in the area of the psycho-social management of patients, in the area of counseling and support to partners and to families of persons infected or ill, communities and associations have been working and continue to work in the various areas of the country. Associations are created and strive to provide relief to the moral, physical, psychological, economic and legal distress of patients. This is the time to pay homage to them.” (Glen W. Blibolo AD. Kérouedan D. 1995). This statement translates the official recognition of the importance of the work of NGOs and highlights the importance of the role the latter play in the fight against AIDS.

It is certainly for this reason that the health authorities have grouped NGOs for combating AIDS into an association, namely the COS-CI. One of the questions that comes to mind is whether the NGOs are financially supported by the Government. The answer to this is that Government assistance to NGOs was not systematic until 1999: a few were subsidized and most were not. Between 1999 and 2000, out of 20 NGO/CBOs subsidized by the Government, 10 are involved in family planning, 8 in the area of STD/AIDS, one in the fight against alcohol and drug abuse and another in the area of disabled persons. The amounts of subventions received by the NGO/CBOs for the fight against AIDS vary between CFAF 3,997,000 and CFA F80,000,000 per year.

The SAS Center, “Center des Sœurs d’Ayamé”, OASIS of Koumassi and the NGOs that cater for AIDS orphans are not among the 8 NGOs subsidized. In fact, they are foreign financed NGOs and therefore, the survival of their activities depends on the goodwill of their donor and development partners. Some NGOs (e.g. CIPS) have managed to survive despite the withdrawal of support by donors, thanks to the assistance provided by the Government in the financing of its operation. This is not the case for many other NGO/CBOs that have undertaken AIDS control activities. This dependency on external resources raises the eternal issue of the sustainability of initiatives undertaken. If nothing is done at the national level, the situation will be far from improving in a sustainable way.

### **6.4. Responses by Families, NGOs and Communities to HIV/AIDS**

#### **6.4.1. At Family and Community Level**

The scale of the AIDS pandemic is such that in each family has a case of a member or a close relative infected or affected by HIV. The care and treatment of such persons at family level is difficult: often, the persons infected keep their disease a secret. As a result, even where parents could assist them, they do not do so because they are not informed about the nature of the disease. This problem of sharing information about the disease with relatives is so serious that it constitutes an obstacle to the proper observance of ARV treatments. Indeed, many patients undergoing ARV treatments have not informed their partners/spouses and hide each time when they must take their drugs. Where they do not have the possibility of hiding, they postpone the taking of their drugs to later (Blibolo AD. 1999). The fear of stigmatization is one of the reasons that favour

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this type of behaviour. But it is also a fact that AIDS is seen as a disgraceful disease that no-one wishes to be identified with.. This situation and others indicate that it is difficult to apply measures that help control the impact of HIV at family level.

Currently, there are few initiatives for assisting infected persons and their families. The CASM, which provided the medical treatment (free care for opportunistic diseases) and social care (food, education of children, payment of rent, psychological support, home visits and spiritual support) of patient living with HIV was compelled to put an end to its assistance in view of the heavy financial burden.

There is also the RSB NGO that has been implementing a home-based care programme for people living with HIV in Bouaké. The difficulties encountered are certainly related to the lack of resources to meet the needs, but also to the denial of the disease in some families. Indeed, some patients were rejected by their relatives because they publicly admitted to being persons living with HIV or because the members of “care providing” NGOs cater for them at home. The relatives deduced that the secret of the disease had been spread by the patient and saw him as a disgrace for the family. In fact, they would have preferred that no-one knew that a member of their family was infected by HIV/AIDS. They consequently become displeased with the disclosure of the secret.

Lastly, the SAS Center of Bouaké, an NGO created after the “Socio-economic Future of AIDS Orphans in Côte d’Ivoire” study, which caters for AIDS orphans also tries, as much as its resources will allow, to collaborate with guardian families of these children. The assistance , which is mainly medical, also includes social support: food, education and income-generating activities.

These various experiences in the management of the consequences of AIDS make it possible to conclude that despite the problems that the consequences cause to families, they can be controlled. Apart from these highly useful, but insufficient initiatives, for the moment, there is no State activity for managing the impact of HIV that covers families. In 1999, a guide on home care was developed, but it remains to be published and disseminated after training sessions on its use.

In this situation, several associations of persons living with HIV/AIDS were created. The aim was to provide mutual support in the face of the social marginalization tendencies. The associations contribute to efforts to combat HIV/AIDS. But they are affected by problems of individual interest that risk creating an image of self-seeking persons under the cover of the disease.

Certainly, there are a few State-owned orphanages that cater for primary school orphans. But these institutions are inadequate in view of the increasing number of HIV/AIDS orphans. Moreover, they also cater for children who are not orphans (whose two biological parents are alive) and this affects their reception capacity. All these problems and the lack of official social coverage, account for the high hopes that the people place in the social security project and the free school education policy envisaged by the Government.

With regard to assistance to orphans and guardian families, the wish of the actors is to develop income-generating activities for such families and assist in educating disadvantaged orphans.

#### **6.4.2. Reactions of Communities in the Face of the HIV/AIDS Menace**

Reactions of communities to HIV/AIDS have changed with time. Thus, whereas religious leaders formerly systematically opposed any AIDS control effort, in the last three years, various religious communities have been participating actively in the awareness raising and prevention of AIDS. Currently, priests, pastors and imams are associated with most of the meetings to define strategies for action. During their prayer sessions, they often sensitize their flock about AIDS. There are even religious communities that have included AIDS in their marriage rules: members who wish to get married are made to undergo an HIV screening. This indicates that the religious leaders have moved from the stage of mistrust to that of involvement in the fight against AIDS..

Traditional Healers took ownership of the AIDS problem early by stating, in some cases, that they were capable of curing the disease. Such statements were often condemned by practitioners of official medicine and other scientists. Currently, it can be observed that such healers are featured less often in the press. Public opinion will have the health authorities assist these traditional healers to develop their findings, which can undoubtedly save humanity. Such views are often expressed by Africans in conferences, symposia and other public meetings dealing with HIV/AIDS infection.

It is often said that AIDS is putting African solidarity is being put to the test. This is probably true. When people are sick, they are hardly assisted by their relatives to a meet their care expenses. But as soon as they die, grandiose ceremonies are organized for them. Such behaviour is condemned by all and yet is quite widespread. However, it is not a treatment that is only reserved for people living with HIV, it also applies to sick people who are uninfected by HIV. Clearly then, solidarity is undermined by the increased pauperization of households and the high cost of living. (high cost of drugs and care). All this leads people to conclude that African solidarity is being put to the test by AIDS. But it is perhaps the patients (in general) who are being put to the test by another form of solidarity that is only expressed at funerals.

It may be stated that although the reactions of communities are improving, a lot still remains to be accomplished in raising the awareness about the need to involve people even more in the management of the effects of ;HIV/AIDS.

#### **6.4.3. Health insurance in the context of AIDS.**

There are many health insurance companies in the private sector. They provide coverage for people with a relatively low risk of often falling ill. They therefore take the precaution, with their consulting doctors, to reject applicants who are affected by chronic diseases. Obviously, people living with HIV are in this class of applicants.

The public sector has a health mutual fund (Mutuelle Générale des Fonctionnaires de Côte d'Ivoire- MUGEFICI) to which all public servants belong, except a group of doctors who withdrew from this fund at the behest of their union. The other doctors who have not responded to this continue to contribute to the MUGEFICI, like the personnel of the Ministry of Education and those of the Ministry of Social Welfare.

In 2000, 842 doctors, 94 dentists, 35 pharmacists, 3842 nurses, 1792 mid-wives, 12 assistant heads of clinics, 10 bio-medical engineers, 82 laboratory technicians were members of the MUGEFICI. There were 448 social assistants, 184 social assistant aids and 79 social security aids. Not all public sector teachers are members of the MUGEFICI. But the MUGEFICI has no specific measures for the provision of care and treatment of HIV. Consequently, a teacher or a social worker infected by HIV cannot have any insurance coverage.

### **6.5. Assessment of the capacity to reduce poverty caused by HIV**

It needs to be stated that at the level of the educational system, the health and social consequences of AIDS are better known than the economic impact in view of the lack of adequate studies in this area. Thus, currently there is considerable information on morbidity and mortality of teachers due to HIV/AIDS infection and the effect of this disease on families (orphans) and the quality of teaching. But the Ministry of Education has no special measures for the therapeutic and social management of infected teachers and their families. The measures that consist in redeploying teachers, regrouping several classes in the same classroom when there is a shortage of teachers, post teachers orphanages, etc. do not take into consideration the problem of ; HIV/AIDS. It can be said that the Ivorian educational system is heavily affected by HIV/AIDS, but very few effective measures have been taken by the Ministry of Education to combat the disease.

The Ministry of Social Welfare has a relief fund for assisting people to develop income-generating activities. (CFA F 50 000 to CFA F 200 000 /person), to cover the fees of needy pupils and purchase prescribed drugs apparatus' (for disabled persons). There is an unemployment benefit for the unemployed financed with a public servants solidarity fund (1% of salaries deducted each month). But currently there is no allocation to orphans, nor a policy for the prevention, care and treatment of HIV/ AIDS although some social workers of health social services have been provided with training for the psychosocial management of HIV infection.

#### **6.5.1. Fighting AIDS through poverty reduction**

One of the concerns of the Ivorian Government is to reduce the level of poverty. This concern is considered to be a strategy for combating HIV/AIDS (1994-98 medium term plan). The realization of this aspiration mainly depends reducing the scale of the HIV infection and improving medical care for patients. Unfortunately the current situation of public finances constitutes a major constraint on the Government s effort to reduce the

level of poverty. Here and there, there are funds for supporting micro projects and activities. But such funds run out fast, in view of the high demand of applicants.

In the area of AIDS, UNICEF has initiated a project for catering for orphans (Ouattara Yafflo et al 1999). The evaluation of the project highlighted the significance of the project and recommended the strengthening of income-generating activities that must be managed by NGOs since the management of beneficiaries has its limitations. A similar project supported by UNDP has also only achieved limited success. The major difficulty resides in the fact that the use of funds needs to be monitored in order to avoid that is misappropriated. Moreover, assistance given to beneficiaries sometimes fall short of needs and do not always allow for the implementation income-generating activities.

### **6.5.2. Resources or potential for combating AIDS in various ministries**

The issue of human resources for combating AIDS in the ministries of health, of education and of social welfare relates to quantity and quality. From a quantitative viewpoint, it is known that high population growth increases demands on these ministries to the extent that the number of staff is inadequate to cope. In 1988, illiteracy rate was 79% for adults, 73% for males and 86% for females. This rate fell to 58% for adults, 48% for males and 68% for females. (Social performance chart. 1998). This relative improvement of the illiteracy situation should not make one lose sight of the need to pursue efforts for the education of children. Indeed, between 32 and 52% of the population needs to be trained in literacy before being capable of understanding the ; HIV/AIDS messages that are to be delivered in French.

One of the problems affecting the educational system is the uneven distribution of educational resources and, consequently of teachers between the major urban centers (notably Abidjan) and the rest of the country. This unequal distribution is associated with regional disparities in enrolment rates. Thus, in 1996 there was an average of 83% of enrolment rate in urban areas and 42% in rural areas. The deficit in teachers is estimated at 1800 for the primary and over 500 for the secondary level.

In qualitative terms, the Ivorian system is inefficient: it takes much longer to obtain the end-of-cycle qualification and the unemployment rate after the training is 15%. This ministry therefore needs human resources to meet the education and sensitization needs of the population in HIV/AIDS.

The Ministry of Social Welfare does not have a large number of personnel: 488 social assistants, 184 social assistant aids and 79 social aids. To this may be added the administrative personnel. This personnel is technically under-utilized and ill-equipped to cope with the demands of the disadvantaged communities. Social assistants are in high demand for the psychosocial management of HIV patients, but their effective involvement in the process is still weak on the whole. There is also the problem of the deficit of social assistants in health services in Abidjan and a total lack of such personnel in all the small health centers of the towns in upcountry. There is also an increased need

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of human resources. It is difficult to speak of insufficient number of health workers when it is known that many doctors cannot be recruited into the public service.

It is in this social context that the Government expressed a strong political desire to combat AIDS by creating a ministry attached to the Prime Ministers office in charge of AIDS. It is the concrete manifestation of a political will to combat AIDS.

The contribution of the State to the financing of AIDS which dates from 1987 and has been in various forms. From 1987 to 1992 the State contribution was limited to the salaries of public servants assigned to the Program as well as the maintenance of the offices of the program. In 1997, CFA F11 400 000 FCFA. (UE. 1997). From 1993 onwards, the Government included an allocation for HIV/AIDS in the operating budget of the Ministry of Health.

**Table 13** : Evolution of Financial Contribution of the State to the Financing of HIV/AIDS control activities.

In millions of CFA F	1993	1994	1995	1996	1997	1998	1999	2000	2001
Health Budget (MSP) in billions	38.64	47.79	51.12	52.13	52.12	77.52	68.11	66.11	30.36
AIDS allocation under Health Budget (in millions)	60	160	450	650	679	335	348	-----	850
Weight in %	0.15%	0.33%	0.9%	1.25%	1.30%	0.43	0.51	-----	2.80

Source : Ministry of Health

This table indicates a significant reduction in the contribution of the State in the financing of AIDS control activities in 1998 and 1999, and a complete lack of financing in 2000. It is worth recalling that in 1998, the process of cocoa and coffee began to fall and international financial assistance (World Bank and IMF) was suspended. The year 1999 on the other hand was marked by the military take-over and 2000 the period of military. In 2001, for the first time,

The government contribution amounted to over 2% of the budget outturn.

The new ministry has a budget allocation of CFAF 850 000 000 of which 700 000 000 is earmarked for the purchase of ARV drugs. The general idea is that each ministry will devote 10% of its budget for the fight against AIDS. This means that henceforth, each ministry is expected to finance its own AIDS control activities. This will result in the significant increase in financial contribution of the Government.

Even though the health authorities were reluctant to admit the existence of AIDS in the 1985-86 period, this was not necessarily tantamount to a denial in view of the fact that what was said then was true and that there was the need to reassure the already frightened population: « AIDS is not any more worrying than malaria ... ». (Blibolo AD. 1998).

Today a multisectoral approach has been adopted as the fundamental strategy for the simple reason that it has now been understood that AIDS is a problem of development and only of health.

## **6.6 Conclusion**

One of the major difficulties in the appropriate management of people living with HIV in their families is the lack of sharing of information on the disease. Indeed, many patients have been keeping the status a secret. Because of this they are treated as any other patient when problems emerge. The considerable health expenditure caused by HIV/AIDS infection creates a feeling of exclusion, especially in poor families when the expenses become unbearable.

In this socio-economic context devoid of any assistance policy to meet the needs of disadvantaged patients, care and treatment of AIDS orphans is wishful thinking. In the first two years, however, the World Bank has shown the desire to break the silence in favor of orphans. It is worth recalling that the CIDEF (ex CIE) is the first and only institution whose study on the socio-economic future of AIDS orphans has resulted in the creation of the SAS center.

Every ministry, every family, enterprise and the agricultural sector are concerned by the problem of HIV/AIDS. A lot is accomplished by these various partners but the limited human, material and financial resources render the task difficult. It is essential that the MLS organizes all the actors, mobilizes resources required for the implementation of more vigorous action aimed at reducing the economic and social impact of HIV in the country.

## **7 Perceived impact of HIV/AIDS policy responses and measures among key stakeholders**

### **7.1 Introduction-Methodology**

The way the stakeholders perceive the impact and steps taken to cope with HIV/AIDS was analyzed in order to get a better understanding of their viewpoints about the strengths and weaknesses of the responses to the pandemic. The term 'stakeholder' refers to different categories of people: NGO, CBO representatives, and representatives of infected people and HIV/AIDS-affected families.

Three main goals were set:

- Identify the fields where stakeholders perceive the HIV as being the most devastating;
- Assess the degree of success the stakeholders give to the policy put in place to mitigate the impact of HIV/AIDS;

- Determine the fields the stakeholders perceive as being neglected.

These goals are the key topics of the interview guide used.

The survey is a qualitative one. As a consequence, quantitative representation did not play a major role in the selection of the sample, which is rather judgment sample. The sampling procedure follows the instructions given by the Center de recherche d'Inocenti (CRI), in the initial documents, that is:

- the questionnaire must be administered in a single setting (rural or urban) indicated from the beginning
- the selection of the accurate number of stakeholders to be interviewed is left to the judgment of the interviewer within the general limits set forth hereafter: 3-6 NGO representatives, 8-12 representatives of infected people, and affected families, 2-5 CBO representatives.

In all, it was agreed to interview a total number of 25 stakeholders in Abidjan and 10 in Bouake, the second largest city upcountry, that is 35 stakeholders overall. In Abidjan, 9 NGO representatives, 4 CBO representatives, 6 HIV-infected people, and 6 representatives of affected families or 25 individuals. In Bouake, the interviews involved 2 NGO representatives, 2 CBO representatives, 3 HIV-infected people and HIV-affected people, or 10 people interviewed.

## **7.2. Perceived impact of AIDS among some stakeholders**

In the Ministries of Education, Health, and Social Welfare, AIDS has an impact on various sectors. But for this survey, a number of sectors were given a priority. These are related to human/staff resources (lack; absenteeism, qualification and performance; attrition; credibility), to financial and material resources (lack of working material; budget restriction and degradation of facilities; quality of care. The survey also focused on the economic and social consequences in family settings (poverty, poor pupils, orphans).

The survey helps measure stakeholders' level of awareness as well as their perception of HIV/AIDS in the various sectors listed above.

### **A. Fields of the Ministry of National Education where the impact of AIDS is perceived as devastating**

At the level of the Ministry of National Education, the fields where the stakeholders interviewed consider the impact of AIDS to be the most devastating are as follows, in order of precedence (that is the most frequently mentioned fields among suggested ones):

- (1) within families, AIDS brings about new problems: stigmatization of infected/affected members, increase in the number of orphans (89%).

- (2) AIDS exacerbates long-standing problems: rise in the number of resource-poor pupils (71%)
- (3) shortage of educational documents and materials because of budget restrictions (32%).

**Table 14:** Fields of the Ministry of National Education where the AIDS is perceived as being the most devastating

	INF	AFF	NGO	CBO	Average
Lack of teachers	33%	11%	9%	50%	25.9%
Frequent absenteeism of teachers	0%	11%	0%	0%	2.8%
Low staff qualification	0%	11%	0%	17%	6.9%
Attrition/poor performance	11%	11%	18%	0%	10.1%
Low credibility of teachers	33%	0%	0%	0%	8.3%
Shortage of educational documents and materials.	22%	22%	36%	50%	32.7%
Degrading facilities	11%	0%	36%	17%	16.0%
Exacerbation of existing problems	78%	78%	64%	67%	71.5%
Emergence of new problems (stigma.)	100%	78%	82%	100%	89.9%
Other	0%	11%	0%	0%	2.8%

This table also indicates that all infected people and CBO representatives pointed out the new problems induced by AIDS within families. Among NGO representatives and those of affected families, the same impact was mentioned in proportions of 82% and 78%, respectively. This means infected people and CBOs interviewed as well as the other stakeholders were more sensitive to the social consequences of AIDS. Concerning the impacts of AIDS on the lack of educational material mentioned by some stakeholders, one has to admit that no survey has yet been conducted in Côte d'Ivoire to measure them. Therefore, the stakeholders mentioned them as possible consequences.

The problems to be retained here are the increase in the number of orphans and the stigmatization of infected/affected people.

#### **B. Fields of the Ministry of Public Health where the impact of AIDS is perceived as being the most devastating**

The fields of Ministry of Public Health where the stakeholders of the survey perceive the impact of AIDS as being the most devastating are as follows, in order of precedence (that is the most mentioned fields among suggested ones):

- (1) AIDS entails new problems in the country: great number of HIV/AIDS-infected patients; reduced availability of care for former diseases (87%).
- (2) AIDS exacerbates long-standing problems: increase in the number of patients concerned, TB and other worsened infections (63%)
- (3) health workers are demoralized because of AIDS: they wish they had allowances related to the risks of getting HIV-infected while giving care to patients living with HIV/AIDS. (46%).

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**Table 15:** Fields of the Ministry of Public Health where the impact of AIDS is perceived as being the most devastating

	INF	AFF	NGO	CBO	Average
<b>Shortage of staff</b>	11%	0%	9%	0%	5.1%
Frequent staff absenteeism	0%	22%	0%	33%	13.9%
Low staff qualification	0%	0%	0%	17%	4.2%
Lack of motivation/poor performance of the medical staff	44%	56%	18%	67%	46.2%
Low credibility of the medical staff	0%	0%	0%	0%	0.0%
Low level of current expenditures	22%	33%	36%	33%	31.3%
Hospital facilities	44%	11%	36%	17%	27.1%
<b>Increased needs exacerbating existing ones</b>	<b>100%</b>	<b>56%</b>	<b>64%</b>	<b>33%</b>	<b>63.1%</b>
<b>Emergence of new problems</b>	<b>78%</b>	<b>89%</b>	<b>82%</b>	<b>100%</b>	<b>87.1%</b>

Table 15 shows also that the increase in the number of patients concerned, the exacerbation of TB and other infections were selected by all infected people while all CBOs selected new problems induced by AIDS. Among the representatives of affected families and NGOs, the same impact resulting from new problems was mentioned in the ranges of 89% and 82%, respectively. The problems to be retained are the great number of HIV/AIDS-infected patients and the reduced availability of care for former diseases.

**C. Fields of the Ministry of Social Welfare and National Solidarity where the impact of AIDS is perceived as being the most devastating**

The fields of Ministry Welfare and National Solidarity where the stakeholders of the survey perceive the impact of AIDS as being the most devastating are as follows, in order of precedence (that is the most frequently mentioned fields among suggested ones):

- (1) AIDS entails the emergence of new problems in the country: rapid increase in the number of orphans (55%);
- (2) AIDS exacerbates long-standing problems: increase in the number of poor people (52%);
- (3) The levels of current expenditures have been reduced because of AIDS: reduces funds available for transfers.

**Table16 :** Fields of the Ministry of Social Welfare National Solidarity where the impact of AIDS is perceived as being the most devastating

	INF	AFF	NGO	CBO	Average
<b>Shortage of staff</b>	0%	11%	0.0%	0.0%	2.8%
Frequent temporary staff absenteeism	0%	0%	0.0%	0.0%	0.0%
Low staff qualification	0%	0%	0.0%	0.0%	0.0%
Loss of motivation/poor staff performance	11%	11%	0.0%	33.3%	13.9%
Budget restriction	11%	0%	36.4%	33.3%	20.2%
<b>Low level of current expenditures</b>	<b>22%</b>	<b>44%</b>	<b>9.1%</b>	<b>16.7%</b>	<b>23.1%</b>
Low level of expenditures/facilities	22%	0%	0.0%	0.0%	5.6%
<b>Exacerbation of existing</b>	<b>67%</b>	<b>56%</b>	<b>36.4%</b>	<b>50.0%</b>	<b>52.1%</b>
<b>Emergence of new problems</b>	<b>67%</b>	<b>44%</b>	<b>45.5%</b>	<b>66.7%</b>	<b>55.8%</b>

This table also shows that the emergence of new problems was selected by 67% of infected people. The representatives of affected families give 56% of their votes to long-standing problems worsened by AIDS. Among NGOs and CBOs, the same impact relating to new problems was mentioned in the ranges of 45% and 66%, respectively. At the level of the Ministry of Social Welfare, the rapid increase in the number of orphans was considered as the key problem engendered by HIV/AIDS.

### 7.3. Anti-HIV/AIDS policies perceived by stakeholders as positive

To cope with the impacts of AIDS, the Ministries of Education, of Health, and Welfare should take specific actions. Among the actions taken actually, the interviewed indicated those which seem the most significant to them or which they anticipate as a priority.

#### 7.3.1. Perception of actions taken at the Ministry of National Education

Among suggested measures, three were mentioned many times by the interviewed.

- firstly, the measure concerning the redeployment of teachers or the regrouping of same level classes in the course cycle, which was the most frequently mentioned (65%);
- secondly, support to institutions caring for orphans through the secondment of teachers in orphanages; and
- finally, the recruitment of new teachers.

These three measures are perceived as being the most positive ones which help address, the impacts of HIV/AIDS at the level of the Ministry of National Education.

**Table 17** : Measures considered positive at the level of the Ministry of National Education.

	INF	AFF	NGO	CBO	Average
Redeployment of teachers	67%	67%	45%	83%	65.5%
Recruitment of new teachers	67%	67%	45%	67%	61.4%
Support to monitoring and caring institutions for orphans through the secondment of teachers	78%	67%	45%	67%	64.1%
Other	0%	0%	27%	17%	11.0%

Table 17 shows that the redeployment of teachers was the action most frequently mentioned (83%) by CBO representatives; support to monitoring centers for orphans was most frequently mentioned by HIV-infected people (78%) and the recruitment of new teachers selected by the representatives of affected-families, and CBOs (67%). Here, the measure retained as positive is the redeployment of teachers and class regrouping. Although this measure is appropriate to cope with the disease and deaths among teachers, it is not related to any consideration in connection with HIV/AIDS.

### 7.3.2. Perception of actions taken at the Ministry of Public Health

Among the measures taken by the Ministry of Public Health to cope with the impacts of HIV/AIDS, three were most frequently mentioned by the persons interviewed.

- Firstly, the measure relating to the introduction of new forms of care: ARV treatment was topmost (77%);
- Secondly, measures aimed at ensuring the availability of drugs and condoms;
- Finally, the development of HIV testing programs.

These three measures are perceived as being the most positive ones, which help cope with the impacts of HIV/AIDS at the level of the Ministry of Public Health.

**Table 18:** Positives measures at the level of the Ministry of Public Health taken with a view of coping with the impact of AIDS

	INF	AFF	NGO	CBO	Average
Introduction of new forms of care	100%	78%	100%	33%	77.8%
Training courses	44%	11%	33%	33%	30.6%
Targeted programs	11%	0%	22%	0%	8.3%
Measures/drug availability	78%	67%	11%	22%	44.4%
Development of HIV testing programs	33%	22%	67%	33%	38.9%
Prevention of mother-to-child transmission	11%	33%	0%	0%	11.1%
Health insurance/doctors	0%	11%	0%	0%	2.8%
HIV/AIDS prevention- health workers	0%	11%	0%	0%	2.8%
Other	0%	11%	44%	22%	19.4%

Table 18 shows that all the representatives of infected people as well as NGO representatives selected the introduction of ARVs. As for the representatives of affected people and CBOs, they selected this measure at 78% and 33%, respectively. The three actions taken by the Ministry of Health and identified by stakeholders as positive are medical, with the UNAIDS initiative for access to ARV therapies being unanimously (quantitative assessment) selected.

### 7.3.3. Perception of actions taken at the Ministry of Social Welfare and National Solidarity

Among the measures taken by the Ministry of Social Welfare and National Solidarity to cope with the impacts of HIV/AIDS, three were most frequently mentioned by the interviewed. They include:

- the reduction of ARV treatment cost for some categories of patients;
- the establishment of monitoring centers for HIV/AIDS-infected or affected people;
- the coverage of care expenditures of poor patients.

These three measures were referred to as being the most relevant in coping with the impacts of HIV/AIDS at the level of the Ministry of Social Welfare and National Solidarity.

**Table 19** :Actions of the Ministry of Social Welfare and National Solidarity perceived as the most positive

	<b>INF</b>	<b>AFF</b>	<b>NGO</b>	<b>CBO</b>	<b>Average</b>
Coverage for care expenditures	33%	56%	9%	33%	32.8%
Establishment of monitoring centers for HIV/AIDS-infected and affected people	33%	56%	9%	33%	32.8%
Reduction of treatment cost	33%	56%	9%	33%	32.8%

Table 19 indicates that the representatives of affected people were the ones who mostly voiced their views about the actions taken by the Ministry of Social Welfare and National Solidarity. As for NGO representatives, they almost refrained from answering this question. The same applies, to a lesser extent, to infected people as well as CBO representatives.

This is due to the fact the Ministry of Social Welfare was not the originator of the ARVT cost reduction and there is no monitoring center for the socialization of infected or affected people in that Ministry. Stakeholders think that the reduction of the cost of ARVT for some categories of patients is the most significant measure attributable to the Ministry of Social Welfare. In fact, we are dealing here with desired measures rather than specific existing measures related to HIV/AIDS. For, the Ministry of Social Welfare did not initiate the ARVT cost reduction.

#### **7.4. Evaluation by stakeholders of the degree of success of policy measures aimed at coping with the impacts of HIV/AIDS**

The interviewed stakeholders selected measures which seem to them to be most relevant to cope with the impacts of HIV/AIDS. They evaluated the overall level of success of these measures and assessed some of their specific aspects. Their evaluation consists in determining if each measure is very satisfactory; satisfactory, appropriate; unsatisfactory or quite unsatisfactory. There are 7 other aspects of the measures to be evaluated and they include: (a) Timing appropriately selected with respect to needs; (b) Incentive mechanisms; (c) Widely disseminated information; (d) low administrative costs; (e) suited people's needs; (f) Respect of the rights of targeted people and sympathy for their suffering (g) other. Scores ranging from 100 to 500 were given to each measure: the bracket from 100 to 199 stands for very satisfactory; from 200 to 299 stands for unsatisfactory; 300 to 399 means appropriate; 400 to 499 stands for satisfactory, and 500 means very satisfactory (see Computation method in the Appendix).

### 7.4.1 Evaluation of the degree of success of measures taken at the Ministry of National Education by stakeholders in decreasing order

**Table 20** :Evaluation of the topmost measure “redeployment of teachers” in relation to the number of teachers

	INF	AFF	NGO	CBO
<b>Overall degree of success</b>	222.22	222.22	181.82	183.33
Timing with respect to needs	0	0	154.55	250
Incentive mechanism	0	0	263.64	216.67
Information	0	0	127.27	233.33
Administrative costs	0	0	245.45	300
Suiting the needs of people	0	77.78	209.09	300
Respect for rights and.....	0	0	254.55	250
Other	0	44.44	27.27	50

This table shows that all of the stakeholders in the survey have a negative judgment of the said measure: the average score given by all four categories of stakeholders is 202.39, which corresponds to the rating of an unsatisfactory measure while the representatives of infected, and affected persons deem this measure unsatisfactory (222.22), NGOs and CBOs find it quite unsatisfactory (181.82 and 183.33, respectively).

One can notice that parts falling under “low administrative costs” and “suited to people’s needs” are deemed appropriate (300 and 300) for this measure. This means that the measure involves low administrative costs and suits people’s needs.

**Table 21** :Evaluation of the second topmost measure “support to orphan monitoring centers through the secondment of teachers to orphanages” in relation to "new problems caused by HIV/AIDS- stigmatization of infected/affected people, increase in the number of orphans"

	INF	AFF	NGO	CBO
<b>Overall degree of success</b>	222.22	211.11	172.73	300
Timing with respect to needs	0	66.67	45.45	83.33
Incentive mechanism	0	0	9.09	66.67
Information	0	0	0	16.67
Administrative costs	0	55.56	0	83.33
Suiting the needs of people	133.33	0	45.45	150.00
Respect for rights and.....	66.67	0	0	16.67

This table shows that all the stakeholders in the survey have a negative judgment of the second measure: the average of scores given by all four categories of stakeholders is 226.51, which corresponds to an unsatisfactory measure. NGOs find it quite unsatisfactory (172.73) while CBOs deem it appropriate (300).

For this measure the specific aspect “suit people’s needs” was deemed unsatisfactory (133.33 or 150). This means the said measure does not suit people’s needs or does not enable them to cope with needs engendered by AIDS.

**Table 22** : Evaluation of the measure ranking third “recruitment of new teachers” in relation to the number of teachers

	INF	AFF	NGO	CBO
Overall degree of success	233,33	233,33	154,55	166,67
Timing with respect to needs	44,44	66,67	0	216,67
Incentive mechanism	0	33,33	0	66,67
Information	0	0	0	66,67
Administrative costs	0	0	0	66,67
Suiting the needs of people	88,89	0	0	100,00
Respect for rights and.....	44,44	0	0	50,00
Other	0	0	0	0

It is a measure all the stakeholders surveyed describe negatively: the average of scores given by all four categories of stakeholders is 196.97, which corresponds to the rating for an unsatisfactory measure.

Infected people and the representatives of affected people consider the measure unsatisfactory (233.33), NGOs and CBOs find it quite unsatisfactory (154.55 and 166.67, respectively). Except for the “timing appropriately selected with respect to needs” deemed unsatisfactory (216.67) by CBOs, all other aspects are perceived as quite unsatisfactory. NGO representatives refrained from evaluating this measure because it has no bearing on the impacts of HIV/AIDS.

#### 7.4.2. Evaluation by stakeholders of the degree of success of measures taken at the Ministry of Public Health, in decreasing order

**Table 23** :Evaluation of the topmost measure « introduction of new care method» with respect to “the great number of HIV/AIDS-infected patients, etc.”

	INF	AFF	NGO	CBO
<b>Overall degree of success</b>	<b>311,11</b>	<b>177,78</b>	<b>290,91</b>	<b>200</b>
Timing with respect to needs	155,56	177,78	227,27	50
Incentive mechanism	88,89	177,78	181,82	66,67
Information	55,56	277,78	136,36	16,67
Administrative costs	111,11	211,11	127,27	66,67
Suiting the needs of people	88,89	211,11	236,36	83,33
Respect for rights and.....	44,44	211,11	181,82	50
Other	122,22	111,11	54,55	83,33

We can see in this table that all the stakeholders in the survey have a negative appreciation of the second measure: the average of scores given by all four categories of stakeholders is 244.95, which corresponds to an unsatisfactory measure. CBOs, infected people and the representatives of affected people deem it quite unsatisfactory (50; 155.56; 177.78, respectively).

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**Table 24 :** Evaluation of the second topmost measure “ensure the availability of drugs and condoms” in relation to “the great number of HIV/AIDS-infected patients and the reduced availability of care for other diseases”

	INF	AFF	NGO	CBO
<b>Overall degree of success</b>	244.44	266.67	190.91	266.67
Timing with respect to needs	100	0	145.45	133.33
Incentive mechanism	11.11	0	81.82	66.67
Information	55.56	33.33	100	50
Administrative costs	11.11	0	145.45	66.67
Suiting the needs of people	44.44	33.33	172.73	50
Respect for rights and.....	11.11	0	154.55	66.67
Other	33.33	22.22	72.73	83.33

This table shows that globally the stakeholders interviewed have a negative judgment of the second measure: the average of scores given by all four categories of stakeholders is 247.17, which corresponds to an unsatisfactory measure. NGOs were harsher, considering this measure as quite unsatisfactory (190.91). This negative evaluation is also valid for various specific aspects of this measure.

**Table 25 :** Evaluation of the measure ranking third “development of HIV testing programs” faced with the increase in the number of patients.

	INF	AFF	NGO	CBO
<b>Overall degree of success</b>	288.89	200	200	166.67
Timing with respect to needs	0	66.67	127.27	66.67
Incentive mechanism	0	0	45.45	50
Information	0	11.11	81.82	16.67
Administrative costs	44.44	0	18.18	50
Suiting the needs of people	11.11	0	100	66.67
Respect for rights and.....	0	0	45.45	66.67
Other	144.44	11.11	63.64	50

This table shows that the stakeholders interviewed have a negative judgment of the third measure: the average of scores given by all four categories of stakeholders is 213.89, which corresponds to an unsatisfactory measure. CBOs were harshest, describing this measure as quite unsatisfactory (166.67). Except for the specific aspects that were not assessed, all stakeholders found these dimensions quite unsatisfactory.

### 7.4.3 Evaluation by stakeholders of the degree of success of measures taken at the Ministry of Social Welfare and National Solidarity

At the level of the Ministry of Social Welfare and National Solidarity, the measures described as being most positive to cope with the impacts of HIV/AIDS are as follows: (a) coverage of the health care expenditures of poor patients; (b) reduction of ARV treatments for some categories of patients, and (c) the establishment of monitoring centers in view of the socialization of HIV/AIDS –infected or affected people. It should be remembered that these three measures were mentioned the same number of times.

**Table n°26** : Evaluation of the measure relating to the coverage of health care expenditures of patients faced with the increase in the number of poor.

	<b>INF</b>	<b>AFF</b>	<b>NGO</b>	<b>CBO</b>
<b>Overall degree of success</b>	<b>100</b>	<b>111.11</b>	<b>9.09</b>	<b>83.33</b>
Timing with respect to needs	0	0	0	0
Incentive mechanism	0	0	0	0
Information	0	0	0	0
Administrative costs	<b>33.33</b>	<b>0</b>	<b>0</b>	<b>0</b>
Suiting the needs of people	0	0	0	0
Respect for rights and.....	0	0	0	0
Other	<b>11.11</b>	<b>0</b>	<b>0</b>	<b>0</b>

As a whole, the persons interviewed have a negative judgment of this measure: the average of scores given by all four categories of stakeholders is 75.88, which corresponds to the rating for a quite unsatisfactory measure. However, infected people and the representatives of affected people are less critical than the other stakeholders: they deem the measure unsatisfactory (100 and 111,11, respectively). This negative assessment applies to other specific aspects of this measure, especially the aspect concerning administrative costs whose degree was deemed worse. In fact, these stakeholders were so hard as not to refrain from making comments on this measure. For the coverage of the health care expenditures of poor patients is a measure that does not concern HIV-infected people specifically, and which moreover is nonexistent. This is the reason why most stakeholders in the survey said little about the different measures suggested to them.

**Table 27** :Evaluation of the measure relating to the establishment of monitoring centers for HIV/AIDS-infected people with respect to the increase in the number of orphans;

	<b>INF</b>	<b>AFF</b>	<b>NGO</b>	<b>CBO</b>
<b>Overall degree of success</b>	<b>33.33</b>	<b>100</b>	<b>36.36</b>	<b>33.33</b>
Timing with respect to needs	0	33.33	0	0
Incentive mechanism	0	0	0	0
Information	0	0	0	0
Administrative costs	0	0	27.27	0
Suiting the needs of people	0	0	0	0
Respect for rights and.....	0	0	0	0
Other	11.11	0	0	0

This table shows that all the stakeholders surveyed have a negative judgment of the measure relating to the “establishment of monitoring centers for HIV/AIDS-affected people”: the average score is 50.75, which is the score for a measure deemed quite unsatisfactory. The same applies to aspects, such as appropriate timing (33.33 for the representatives of infected people), and administrative costs which is 27.27 for NGOs), which were evaluated. Concerning this measure, it should be remembered that there are only a few monitoring centers for AIDS-orphaned children. But these are not state-owned institutions under the supervision of the Ministry of Social Welfare. Furthermore, stakeholders deem their number quite inadequate (less than three private centers).

Therefore, by declaring this measure quite unsatisfactory, the interviewed mean this ministry has done nothing towards creating specific facilities for the social and economic management of AIDS victims and that this must be done.

**Table 28** :Evaluation of the measure relating to the reduction of ARV treatment cost for some categories of patients with respect to the increase in the number of poor people

	INF	AFF	NGO	CBO
<b>Overall degree of success</b>	33.33	100	36.36	33.33
Timing with respect to needs	0	33.33	0	0
Incentive mechanism	0	0	0	0
Information	0	0	0	0
Administrative costs	0	0	27.27	0
Suiting the needs of people	0	0	0	0
Respect for rights and.....	0	0	0	0
Other	11.11	0	0	0

Just like the first and second measures, stakeholders as a whole have a negative view of the measure ranking third: the average score for all four categories of stakeholders is 74.49, which corresponds to the rating for a measure deemed quite unsatisfactory. Administrative costs were described as quite unsatisfactory. In short, most stakeholders interviewed did not assess the measures described as positive at the level of the Ministry of Social Welfare because no specific measure was taken by that Ministry to address the impacts of HIV/AIDS, the pandemic having so far been considered as a fact only concerning the Ministry of Public Health.

### **7.5. Problems stakeholders perceive as being neglected**

To neglect something means not to take care of it adequately. That's is to say to give partial or very little attention to it. What do stakeholders think of what the different ministries did to cope with the impacts of HIV/AIDS?

Generally, the representatives of HIV-affected/infected people, NGOs and Community-based Organizations (CBO) surveyed consider that all fields/problems are neglected at the levels of the Ministries of National Education, and Welfare.

For these stakeholders, nothing specific is undertaken by these ministries to address the aftermath of HIV/AIDS infection. They deem the assistance and coverage of HIV/AIDS-infected teachers as well as voluntary testing in schools neglected. The stakeholders surveyed think that the social services of health centers lack material (drugs) and financial resources to provide needy patients with assistance and wish that more power and means were given to social workers whom they deem very little involved in the fight against AIDS. It should be noted that the persons interviewed stressed the very important role played by social workers in the process of AIDS control, mainly in the management of the impacts of the disease.

At the level of the Ministry of Health, the multiplication/decentralization of specific medical services for HIV/AIDS and HIV/AIDS prevention among the staff of the Ministry of Health are problems that stakeholders deemed insignificant.

As proposals for solutions, stakeholders think that the mobilization of funds locally and abroad in order to develop training programs and subsidize NGOs, mainly for people living with HIV/AIDS, for the implementation of income generating activities, and the monitoring of orphans and their host families should be emphasized.

## **7.6 Conclusion**

There are numerous fields where stakeholders perceive the impact of HIV/AIDS as being the most devastating, but we can retain three that were more frequently mentioned than others. These include:

- the increase in the number of orphans and the stigmatization infected/affected people.
- the reduced availability of care for former diseases because of the great number of HIV-infected patients
- the exacerbation of poverty due to the increase in the number of poor people.

Besides these fields, there are other social problems raised by the stakeholders surveyed: disruptions of marital ties, loss of sources of income, dropping out of the school system, family disintegration, increase in health care expenditures, lack of motivation of health workers.

Whatever the Ministry, all the positive measures taken were all deemed unsatisfactory in their implementation. In other terms, despite their relevance and adequacy, measures recognized as positive are not perceived as adequately implemented (very limited in space and time) or untapped. The stakeholders surveyed are thus sensitive to the various efforts effectively made or planned, but say they are dissatisfied.

Analysis of the problems mentioned show that the stakeholders retained social, health and economic impacts. These impacts are in line with the reality of AIDS in Côte d'Ivoire. This is why the stakeholders surveyed suggest social, economic and health options, that is:

- decentralize specific medical service delivery for HIV/AIDS;
- develop income-generating activities for host families of AIDS-orphaned children and provide for the school fees of the latter.

The last proposal helps fight against the impoverishment of HIV/AIDS-infected and affected people and promote the social integration of AIDS-orphaned children. In their opinions, all this must be done with the effective participation of social workers.

## 8. Conclusions

Faced with the threat posed by HIV/AIDS, the Government and NGOs/CBOs have had varying responses. The analysis of these responses shows that the efforts made focused basically on the medical and health dimensions of AIDS (prevention and therapeutic care). The Government has not yet specifically addressed the management of the social, legal, and economic impacts. Some NGOs are trying their best to assist infected people and affected families. One of the reasons to this is that the social, legal and economic impacts have hitherto hardly been assessed and are still unknown.

It is hard to assess policy and community responses in terms of risky behavior change. However, despite their limitations, there are some pockets of success, which provide incentives to proceed with what has been done so far.

- Through IEC campaigns, more than 91% of the population have been informed of the existence of HIV/AIDS and are aware that disease is mainly transmitted through sexual intercourse.
- The quantity of condoms sold by NGOs in charge of social marketing increased from 1,800,000 in 1991 to 20,000,000 in 2000. This means that demand is increasing, though when compared with the population of sexually active unmarried youths, this is not much in terms of quantity used (1 condom by person per term).
- HIV prevalence among sex workers has decreased from 86% in 1992 to 30% currently at RETRO-CI Project's Clinique de Confiance. This is due to the fact that women are more and more using condoms with their clients (affirmed by 92% of clients) and they are treated as soon as they develop an STI.
- In brothels, the effective use of condoms was measured objectively for the first time in 1998 in the framework of West African Initiative (IOA), which enabled us to find out that 22% of brothel clients actually used the condoms they were offered (Blibolo AD et al. 1998). But this pilot experience was abandoned.

Apparently, the use of condoms to protect oneself against the HIV/AIDS infection is still very limited among the general population for sociological reasons.<sup>1</sup>

- The "blood safety" objective has been achieved by more than 99.94 % throughout the country and a law was passed in 1993 to regulate the sampling and utilization of human blood (law n° 93-672 of 9 August 1993).
- The systematic use of disposable syringes/needles in all health services (both public and private) has now become a habit and is assessed to be successful at 99%.
- From reluctance to be tested, we have moved to a 72% rate of acceptance of the test proposal, and monthly voluntary testing requests increased from 272 to 489 at CIPS in 1994-1997.

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<sup>1</sup> One of the reason accounting for this is that condom is recommended for casual risky sexual intercourses for contraceptive purposes. Consequently, all people who do not want to be considered as risky sexual partners or casual ones refuse to use condoms. These are also the reasons why condoms are used during the first sexual intercourses and are dropped as soon as the relationship is sustained.

These few cases of success must not obliterate the enormous inadequacies of prevention efforts that are as follows:

- prevention activities are occasional and limited to a few major towns due to a lack of (qualified) human and financial resources
- innovative and promising actions are abandoned for other actions depending on the mood of each development partner
- funded by foreign donors activities want coordination at the national level. Hence, it is difficult in such a context marked by the lack of effective means to measure risky sexual behavior change (such as a monitoring body for HIV-related risky sexual behavior change).

HIV-related risky behavior change requires frequent sensitization with appropriate messages among reduced groups of people. This implies that there be some people specifically dedicated to this task and substantial financial and material means. Voluntary help being quite inadequate, NGOs/CBOs' work must be professionalized.

### *PMTCT*

Therapeutic trials proved at least two years ago that by using AZT, the vertical transmission of HIV could be reduced by 37-50% in Côte d'Ivoire. Various initiatives (RETRO-CI, DITRAME Plus, UNICEF) have been initiated to scale up and integrate the PMTCT strategy in all antenatal consultation services (CPN).

Most national specialists agree with the idea of using Nevirapine but, for the time, being the main concern is how to identify an appropriate approach to carry out PMTCT at a large scale. Financial and material difficulties (concerning the training of health workers, equipment of medical screening laboratories, the procurement of AZT, and even new equipment for the premises) account for the delay in the generalization process.

### *Medical treatment for seropositive patients and ARVs*

The improvement of the diagnosis of the HIV/AIDS infection and related infections, and the therapeutic and psycho-social management of seropositive patients were targeted as priorities in the national program for AIDS seven years the first cases of AIDS were reported, that is to say in 1994. Ever since, some centers of excellence have been set up in the public as well as private sectors. HIV-infected people are addressed to referral centers. But a therapeutic and psychosocial management specific to the HIV/AIDS infection has not yet been integrated as desired in the activities of health centers. In fact, this integration fails to be achieved because the psychosocial management that goes along with the medical treatment of the HIV/AIDS infection is something unusual for health workers, and also because health centers cannot afford testing reagents.

The UNAIDS initiative for access to ARV treatments has helped put more than 1,013 cases under treatment but different criteria, mostly economic ones whose usefulness is justified, are preventing access of tens of patients to ARVT.

The first on bi therapy-based treatment regimen having proved inadequate, the decision was made to adopt triple therapy henceforward.

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Now, reportedly pharmaceutical companies have increased hopes for more significant price reductions to the Ivorian authorities. As a result, patients will pay either CFAF 10,000 or CFAF 5,000 for triple therapy from CFAF 300,000 as in 1998. To reach this goal, a strategy must be developed to supply the Public Health Pharmacy with generics, and eventually explore all possibilities to produce them locally at a reduced cost.

AIDS has devastating impacts on the educational system owing to a high morbidity and mortality among teachers. The Government and NGOs must start to cope with the social, economic and legal consequences of the disease in all sectors, especially in the education sector. Actions to be taken include certainly the sensitization and education of teachers and pupils/students.

At the level of the Ministry of Health, the fact of informing all health workers in order to involve them in the prevention, therapeutic and psychosocial management process is another way to sensitize them and to bring them to protect themselves against the disease.

AIDS is a disease that differs from others and to put it on the same footing as malaria, TB, etc. does not promote the improvement of its management. Specific teams and facilities are required to ensure adequate medical treatment and psychosocial follow-up of HIV-infected people.

To provide an answer to the question of whether other diseases are neglected because of AIDS, a survey must be conducted. But on the other hand, various specialists frequently present AIDS as a factor that exacerbates other diseases. AIDS is thus present in almost all health problems and becomes an indicator of a distortion of the health system and even of social relationships.

*Policy for orphans*

There is currently no formal management policy for affected people, mainly AIDS-orphaned children. Public facilities taking care of orphans in general can handle the social management of AIDS-orphaned children if their number decreases. But, ideally these children should grow in their family backgrounds. To that end, their tuition and school supplies should be provided for and their guardians should be helped to create income-generating activities.

In sum, strong political will has been displayed with the establishment of a Ministry specifically in charge of HIV/AIDS. The First Lady is personally involved in prevention and social mobilization activities for HIV/AIDS control. Let us hope that decision-makers will find the necessary resources and that the new Ministry for AIDS will determine appropriate strategies to cope with the challenge of survival to this plague.

• **LESSONS LEARNT AND RECOMMENDATIONS**

*Lessons*

- The survey revealed that the efforts the Government has made were focused on the medical and health dimensions of HIV/AIDS (prevention and therapeutic care).
- The social, legal and economic consequences still require specific policy responses.

One of the reasons why these social, legal and economic impacts have been put in the background is that they have hitherto hardly been surveyed and remain unknown. Therefore, we make the following recommendations so as to help improve the management of the socio-economic, and legal impacts of AIDS.

*Recommendations*

- 1) Create several health departments/districts in charge of the social management of HIV-affected families, notably AIDS-orphaned children, like the SAS center in Bouaké.
- 2) Extend the PMTCT strategy to all health centers in the country in order to ensure specific therapeutic and psychosocial management of HIV-infected children and mothers.
- 3) Ensure free education for HIV-affected children, in particular, and for all children, in general.
- 4) Develop a genuine and formal assistance policy for needy patients in sanitary settings.
- 5) Initiate more income-generating activities in favor of HIV-affected families.
- 6) Set up referral clinics capable of ensuring biological diagnosis, and therapeutic and psychosocial management of HIV/AIDS in health districts.
- 7) Allocate more resources to NGOs and community-based organizations effectively involved in the management of the consequences of HIV/AIDS.
- 8) Establish a monitoring body for HIV/AIDS-risky sexual behavior
- 9) Better coordinate the actions for AIDS control
- 10) Scale up pilot actions, which have yielded satisfactory outcomes in view of improving them.



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## **ANNEXE A : Data of the socio-economic survey**

### **ACRONYMS**

In the conception of the tables presented below, the following acronyms have been used: T1HH = Type 1 households = "households with a HIV/AIDS-related death", T2HH = Type 2 households = "households with a non-HIV/AIDS-related death", T3HH = Type 3 Households = "households with no deaths", CM = "Children members of the households", N = "number", ADT = "average daily time", NGO = " non-governmental organizations", RO = " religious organizations ", EFN = "extended family or neighbors", CBO = " community-based organizations" ; OVPO = Overall Population ; HHh = Household head

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**Table 29** : Summary statistics of sampled HH

	HH with AIDS death (type 1)	HH with non AIDS death (type 2)	HH with no deaths (type 3)
1. N. HH headed by an illiterate person	60	63	49
2. N. HH headed by a person with primary or secondary education level	104	105	109
3. N. HH headed by a person with higher education level	18	25	35
4. N. HH with no oxen and no farming lands *	155	147	152
5. N. HH with no oxen *	5	12	8
6. N. HH owning farming lands*	46	47	43
7. N. HH owing farming lands and oxen*	3	5	4
8. N. HH owning urban lands	54	61	47
9. N. HH with a low income level	71	49	70
10. N. HH with median income level	53	92	59
11. N. HH with high income level	74	51	65
12. N. HH devoting a small average daily time to child care (<6hrs)	155	160	167
13. N. HH devoting a medium average daily time to child care (6-12hrs)	30	21	14
14. N. HH devoting a large daily time to child care (≥12hrs)	6	1	4
15. N. HH having received no type of help	59	74	114
16. N. HH having received help from the Government	31	34	20
17. N. HH having received help from civil society (NGOs or religious organizations)	39	16	10
18. N. HH having received help from community (extended family, neighborhoods or CBOs)	100	105	53
19. N. HH having received old age pensions from the Government	NA	NA	NA
20. N. HH having received unemployment from the Government	1	0	1
21. N. HH having received allowances for child/orphan from the Government	6	9	2
22. N. HH having received disability allowances from the Government	14	18	16
23. N. HH having received other public transfers from the Government	11	10	1
24. N. of HH having received credits from the Government	2	0	2
25. N. of HH having received public transfers publics from the Government	9	13	2
26. N. of HH having received food from the Government	0	0	0
27. N. of HH having received other help in-kind from the Government	2	1	0
28. N. of HH having received jobs from the Government	0	0	0
29. N. of HH having received any other forms of help from the Government	1	1	0

This Table should help understand the relative importance of HH coping strategies described in tables 3-17:

\* If the sample basically includes urban HH, please measure their positions in terms of assets, using the appropriate assets categories (housing, productive assets, urban lands, other assets). It is the case of Côte d'Ivoire survey sample with 594 urban HH.

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**Table 30 :** Indicators of children well-being by HH type according to the level of education of the HH

	HH with AIDS death (type 1)			HH with non AIDS death (type 2)			HH with no deaths (type 3)		
	Illiterate	Primary	Secondary/ Higher	Illiterate	Primary	Secondary/ Higher	Illiterate	Primary	Secondary/ Higher
N. of children in the HH (CM) (1)	253	202	258	269	232	255	190	84	390
N. of male children in the HH (2)	125	94	127	131	113	125	96	45	190
% of children having lost both parents (orphan rate)	13.0	5.9	9.7	4.1	5.2	2.7	3.7	2.4	1.3
% of CM who died (over total CM in the HH) from any cause during the observation period (3)	3.1	2.4	2.3	1.1	0.4	0.4	0	0	0.2
% of having been sick, due to whatever disease, during the observation period (disease prevalence) (4)	40.7	51.5	46.5	38.3	43.5	39.6	37.4	31.0	41.0
% CM who had a professional activity during the observation period	6.3	3.5	3.5	6.7	4.3	3.9	7.9	3.8	3.6
% CM not having been able to gain access to health centers while in need of health care services	47.8	41.5	51.2	34.2	26.3	20.0	46.8	21.8	19.1
% CM having been withdrawn from schools	30.0	26.7	26.4	27.5	15.5	12.2	19.5	17.7	4.8
% CM having experienced other serious deprivation (malnutrition, abuses, other) (5)	NA	NA	NA	NA	NA	NA	NA	NA	NA
Average daily time devoted (on working days) by children to personal activities (playing, studying, sleeping) – boys	21hrs 04min	21hrs 42min	20hrs26min	21hrs 10min	21hrs 50min	21hrs56min	22hrs 14min	20hrs 12min	20hrs52mn
Average daily time devoted (on working days) by children to personal activities (playing, studying, sleeping) - Girls	19hrs 30min	19hrs 45min	19hrs41min	20hrs 24mn	19hrs 42min	20hrs35min	19hrs 44min	20hrs 49min	19hrs45mn
Average daily time devoted (on time off) by children to personal activities (playing, studying, sleeping) - Boys	20hrs 27min	21hrs 35min	20hrs53min	21hrs 05min	22hrs 13min	21hrs12min	22hrs 57min	19hrs 18min	20hrs42mn
Average daily time devoted (on time off) by children to personal activities (playing, studying, sleeping) - Girls	19hrs 47min	18hrs 59min	20hrs10min	19hrs 30min	19hrs 48min	19hrs24min	19hrs 35min	19hrs 45min	19hrs44mn
% of CM having been discriminated against for any reason (6)	0.4	0	0	0.4	0	0	0	0	0

**NOTES.**

(1)= Number of CM in each type of HH

(2)= Number of male children in each type of HH

(3)= This item can be presented in a split way: % of deaths due to HIV/AIDS, and % of deaths due to other diseases

(4)= This item can be presented in a split way: % of deaths due to HIV/AIDS, and % of deaths due to other diseases

(5)= Note the questionnaire only cannot provide this information. Specify other information source used

(6)= Relates to children who have been forced to leave school or prevented from playing with other children because of their HIV-status (or their parents')

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**Table 31** : Indicators of children well-being by HH type according to the assets of the HH and by child gender. For urban HH, please use appropriate assets categories (housing, productive assets, urban lands, other assets for the measurement of their assets)

	HH with AIDS death (type 1)			HH with non AIDS death (type 2)			HH with no deaths (type 3)		
	No asset	Housing	Electric HH appliances	No asset	Housing	Electric HH appliances	No asset	Housing	Electric HH appliances
N. of children in the HH (CM) (1)	26	427	669	18	475	676	15	316	611
N. of male children in the HH (2)	9	216	324	4	244	338	6	158	302
% of children having lost both parents (orphan rate)	7.7	11.7	9.7	5.6	5.7	2.8	0	1.3	2.3
% of CM who died (over total CM in the HH) from any cause during the observation period (3)	3.8	1.9	2.2	0	0.6	0.6	0	0	0.2
% of having been sick, due to whatever disease, during the observation period (disease prevalence) (4)	50.0	49.4	44.2	22.2	40.4	38.9	46.7	38.6	39.3
% CM who had a professional activity during the observation period	0	4.4	3.9	16.7	6.1	4.4	0	6.6	4.9
% CM not having been able to gain access to health centers while in need of health care services	57.7	44.2	46.3	16.7	25.7	26.2	100.0	37.0	26.8
% CM having been withdrawn from schools	46.2	28.1	27.5	38.9	13.4	17.9	26.7	15.8	14.9
% CM having experienced other serious deprivation (malnutrition, abuses, other) (5)	NA	NA	NA	NA	NA	NA	NA	NA	NA
Average daily time devoted (on working days) by children to personal activities (playing, studying) – boys	23hrs 07min	22hrs 19min	20hrs54min	18hrs 27min	22hrs 12min	21hrs36min	21hrs 20min	20hrs 31min	21hrs17min
Average daily time devoted (on working days) by children to personal activities (playing, studying) - Girls	21hrs 23min	21hrs 06min	19hrs40min	17hrs 45min	21hrs 12min	20hrs07min	20hrs 26min	20hrs 17min	19hrs47min
Average daily time devoted (on time off) by children to personal activities (playing, studying) - Boys	22hrs 17min	21hrs 43min	20hrs46min	19hrs 24min	21hrs 43min	21hrs27min	22hrs 40min	20hrs 32min	21hrs15min
Average daily time devoted (on time off) by children to personal activities (playing, studying) - Girls	20hrs 08min	18hrs 55min	19hrs52min	18hrs 38min	20hrs 36min	19hrs24min	19hrs 46min	19hrs 46min	19hrs38min
% of CM having been discriminated against for any reason (6)	3.8	0	0	0	0	0.1	0	0	0

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**Table 32** : Indicators of children well-being by HH type according to HH income

	HH with AIDS death (type 1)			HH with non AIDS death (type 2)			HH with no deaths (type 3)		
	Low income	Median income	High income	Low income	Median income	High income	Low income	Median income	High income
N. of children in the HH (CM) (1)	345	237	177	211	421	116	283	247	145
N. of male children in the HH (2)	170	124	74	108	206	52	149	114	75
% of children having lost both parents (orphan rate)	4.9	11.4	21.5	6.6	3.1	3.4	3.9	0.8	0.7
% of CM who died (over total CM in the HH) from any cause during the observation period (3)	2.6	0.4	4.5	0.9	0.5	0	0.4	0	0
% of having been sick, due to whatever disease, during the observation period (disease prevalence) (4)	42.3	43.9	52.0	37.4	41.3	44.8	38.5	40.9	37.2
% CM who had a professional activity during the observation period	4.6	5.5	2.8	4.3	5.2	6.0	5.7	6.9	0
% CM not having been able to gain access to health centers while in need of health care services	40.0	60.3	42.4	27.0	23.8	30.2	22.3	38.1	27.6
% CM having been withdrawn from schools	24.6	38.0	16.9	9.5	22.8	14.7	7.1	27.9	13.1
% CM having experienced other serious deprivation (malnutrition, abuses, other) (5)	NA	NA	NA	NA	NA	NA	NA	NA	NA
Average daily time devoted (on working days) by children to personal activities (playing, studying) – boys	21hrs 22min	20hrs 23min	20hrs 55min	22hrs 33min	21hrs 23min	20hrs 45min	20hrs 52min	21hrs20min	21hrs 53min
Average daily time devoted (on working days) by children to personal activities (playing, studying) - Girls	19hrs 56min	19hrs 14min	19hrs 28min	21hrs 12min	19hrs 58min	19hrs 54min	20hrs 10min	19hrs26min	19hrs 54min
Average daily time devoted (on time off) by children to personal activities (playing, studying) - Boys	21hrs 39min	19hrs 40min	20hrs 09min	22hrs 34min	20hrs 56min	21hrs 16min	21hrs 03min	21hrs08min	21hrs 32min
Average daily time devoted (on time off) by children to personal activities (playing, studying) - Girls	20hrs 43min	18hrs 50min	19hrs 40min	20hrs 51min	18hrs 50min	20hrs 16min	19hrs 50min	19hrs46min	18hrs 54min
% of CM having been discriminated against for any reason (6)	0	0	0	0	0.2	0	0	0	0

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**Table 33** : Indicators of children well-being by HH type according to the average daily time (ADT) devoted to family activities by HH members

	HH with AIDS death (type 1)			HH with non AIDS death (type 2)			HH with no deaths (type 3)		
	Minimum time	Mean time	Substantial time	Minimum time	Mean time	Substantial time	Minimum time	Mean time	Substantial time
N. of children in the HH (CM) (1)	566	41	26	559	65	27	530	45	17
N. of male children in the HH (2)	286	10	11	292	22	12	280	8	11
% of children having lost both parents (orphan rate)	11.5	19.5	15.4	5.0	1.5	3.7	2.5	2.2	0
% of CM who died (over total CM in the HH) from any cause during the observation period (3)	1.9	12.2	3.8	0.4	1.5	0	0.2	0	0
% of having been sick, due to whatever disease, during the observation period (disease prevalence) (4)	47.5	29.3	76.9	42.6	32.3	11.1	39.4	28.9	5.9
% CM who had a professional activity during the observation period	4.6	4.9	7.7	4.5	15.4	7.4	4.7	11.1	17.6
% CM not having been able to gain access to health centers while in need of health care services	47.0	58.5	61.5	27.5	12.3	29.6	29.6	22.2	23.5
% CM having been withdrawn from schools	24.0	29.3	38.5	16.1	18.5	25.9	15.5	26.7	17.6
% CM having experienced other serious deprivation (malnutrition, abuses, other) (5)	NA	NA	NA	NA	NA	NA	NA	NA	NA
Average daily time devoted (on working days) by children to personal activities (playing, studying) - Boys	21hrs05min	18hrs 00min	23hrs38min	22hrs12min	14hrs 24min	23hrs10min	21hrs31min	17hrs 28min	16hrs50min
Average daily time devoted (on time off) by children to personal activities (playing, studying) - Girls	20hrs09min	17hrs 17min	21hrs50min	21hrs31min	13hrs 41min	20hrs30min	20hrs30min	16hrs 32min	15hrs40min
% of CM having been discriminated against for any reason (6)	0.2	0	0	0	1.5	0	0	0	0

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**Table 34 :** Indicators of children well-being by HH type according to help or gifts HH received from the Government (GOV), civil society (non-governmental organizations (NGOs), Religious organizations (ROs), and community (extended family or neighbors (EFN), and community-based organizations (CBOs)

	HH with AIDS death (type 1)				HH with non AIDS death (type 2)				HH with no deaths (type 3)			
	No help	CBOs EFN	NGOs RO	GOV	No help	CBOs EFN	NGOs RO	GOV	No help	CBOs EFN	NGOs RO	GOV
N. of children in the HH (CM) (1)	231	372	160	65	286	416	54	77	378	179	51	51
N. of male children in the HH (2)	117	183	81	32	139	211	31	31	180	96	29	25
% of children having lost both parents (orphan rate)	10.8	10.8	16.2	4.6	5.6	3.6	0	1.3	1.1	4.5	13.7	0
% of CM who died (over total CM in the HH) from any cause during the observation period (3)	2.2	1.9	5.0	0	1.0	0.5	0	0	0	0	2.0	0
% of having been sick, due to whatever disease, during the observation period (disease prevalence) (4)	45.5	46.2	41.9	53.8	36.4	44.5	55.6	36.4	38.9	41.9	35.3	27.5
% CM who had a professional activity during the observation period	2.2	4.8	3.1	3.1	4.5	5.8	3.7	6.5	4.2	6.1	3.9	2.0
% CM not having been able to gain access to health centers while in need of health care services	45.5	43.5	64.4	61.5	26.9	27.9	29.6	15.6	24.1	42.5	45.1	39.2
% CM having been withdrawn from schools	22.9	23.4	36.3	15.4	16.4	20.0	13.0	10.4	13.2	25.7	29.4	15.7
% CM having experienced other serious deprivation (malnutrition, abuses, other) (5)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Average daily time devoted (on working days) by children to personal activities (playing, studying) – boys	20hrs 18min	21hrs 30min	22hrs 21min	21hrs 10min	20hrs 49min	21hrs 47min	23hrs 14min	23hrs 20min	20hrs 46min	21hrs 06min	22hrs 17min	23hrs 14min
Average daily time devoted (on working days) by children to personal activities (playing, studying) - Girls	19hrs 34min	20hrs 24min	19hrs 43min	20hrs 58min	20hrs 21min	19hrs 50min	22hrs 26min	20hrs 01min	19hrs 21min	20hrs 05min	19hrs 55min	21hrs 39min
Average daily time devoted (on time off) by children to personal activities (playing, studying) - Boys	21hrs 04min	20hrs 52min	21hrs 11min	22hrs 43min	20hrs 57min	21hrs 24min	22hrs 50min	22hrs 48min	21hrs 21min	20hrs 16min	22hrs 04min	22hrs 21min
Average daily time devoted (on time off) by children to personal activities (playing, studying) - Girls	19hrs 53min	19hrs 31min	18hrs 47min	20hrs 32min	19hrs 58min	19hrs 15min	20hrs 48min	18hrs 48min	19hrs 41min	20hrs 20min	19hrs 49min	18hrs 56min
% of CM having been discriminated against for any reason (6)	0	0	0.6	0	0	0	0	0	0	0	0	0

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**Table 35:** Indicators of children well-being by HH type according to the various kinds of transfers HHs received from the Government (dp = disability pension, c/o a = child/orphan allowance, ua = unemployment allowance, opt = other public transfers)

	HH with AIDS death (type 1)				HH with non AIDS death (type 2)				HH with no deaths (type 3)			
	dp	c/o a	ua	opt	dp	c/o a	ua	opt	dp	c/o a	ua	opt
N. of children in the HH (CM) (1)	57	13	8	50	77	34	0	30	48	12	3	6
N. of male children in the HH (2)	26	7	6	24	31	18	0	19	23	7	2	0
% of children having lost both parents (orphan rate)	5.3	30.8	0	4.0	1.3	5.9	0	6.7	0	0	0	0
% of CM who died (over total CM in the HH) from any cause during the observation period (3)	0	7.7	0	2.0	0	0	0	0	0	0	0	0
% of having been sick, due to whatever disease, during the observation period (disease prevalence) (4)	59.6	15.4	12.5	32.0	36.4	41.2	0	36.7	29.2	16.7	0	50.0
% CM who had a professional activity during the observation period	3.5	7.7	0	2.0	6.5	0	0	13.3	2.1	8.3	0	0
% CM not having been able to gain access to health centers while in need of health care services	56.1	7.7	100.0	78.0	15.6	44.1	0	16.7	41.7	0	0	0
% CM having been withdrawn from schools	49.1	7.7	100.0	38.0	10.4	11.8	0	16.7	31.2	0	0	0
% CM having experienced other serious deprivation (malnutrition, abuses, other) (5)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Average daily time devoted (on working days) by children to personal activities (playing, studying) – boys	22hrs 14min	14hrs 20min	-	23hrs 23min	23hrs 45min	21hrs 38min	-	22hrs 58min	23hrs 09min	23hrs 34min	24hrs 00min	-
Average daily time devoted (on working days) by children to personal activities (playing, studying) – Girls	20hrs 58min	11hrs 40min	-	18hrs 59min	20hrs 11min	20hrs 56min	-	21hrs 42min	21hrs 32min	21hrs 24min	24hrs 00min	21hrs 55min
Average daily time devoted (on time off) by children to personal activities (playing, studying) – Boys	22hrs 39min	18hrs 10min	-	22hrs 49min	22hrs 48min	22hrs 07min	-	22hrs 34min	22hrs 21min	21hrs 04min	22hrs 30min	-
Average daily time devoted (on time off) by children to personal activities (playing, studying) – Girls	20hrs 32min	16hrs 50min	24hrs 00min	19hrs 02min	18hrs 48min	21hrs 34min	-	21hrs 55min	18hrs 52min	19hrs 54min	20hrs 00min	19hrs 45min
% of CM having been discriminated against for any reason (6)	0	0	0	0	0	0	0	0	0	0	0	0

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**Table 36** : Indicators of children well-being by HH type according to the various kinds of help HH received from the Government (l = loan, mt = money transfer, f = food, h = other help in-kind , e = employment, h = other form of help)

	HH with AIDS death (type 1)						HH with non AIDS death (type 2)						HH with no deaths (type 3)					
	Help in cash		Help in-kind		Other help		Help in cash		Help in-kind		Other help		Help in cash		Help in-kind		Other help	
	l	mt	f	h	e	H	l	mt	f	h	e	h	l	mt	f	h	e	h
N. of children in the HH (CM) (1)	14	50	0	4	0	7	0	51	0	5	0	4	8	9	0	0	0	0
N. of male children in the HH (2)	4	27	0	2	0	3	0	29	0	4	0	3	3	5	0	0	0	0
% of children having lost both parents (orphan rate)	0	2.0	-	0	-	0	-	2.0	-	0	-	0	0	0	-	-	-	-
% of CM who died (over total CM in the HH) from any cause during the observation period (3)	0	0	-	0	-	0	-	2.0	-	0	-	0	0	0	-	-	-	-
% of having been sick, due to whatever disease, during the observation period (disease prevalence) (4)	21.4	34.0	-	75.0	-	0	-	43.1	-	20.0	-	75.0	75.0	0	-	-	-	-
% CM who worked during the observation period	0	6.0	-	0	-	14.3	-	3.9	-	20.0	-	0	12.5	11.1	-	-	-	-
% CM not having been able to gain access to health centers while in need of health care services	42.9	74.0	-	0	-	100.0	-	7.8	-	100.0	-	0	0	0	-	-	-	-
% CM having been withdrawn from schools	0	48.0	-	0	-	100.0	-	13.7	-	100.0	-	0	12.5	11.1	-	-	-	-
% CM having experienced other serious deprivation (malnutrition, abuses, other) (5)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Average daily time devoted (on working days) by children to personal activities (playing, studying) – boys	24hrs 00min	19hrs 37min	-	23hrs 40min	-	23hrs 45min	-	22hrs 17min	-	23hrs 40min	-	23hrs 00min	24hrs 00min	23hrs 36min	-	-	-	-
Average daily time devoted (on working days) by children to personal activities (playing, studying) – Girls	23hrs 50min	16hrs 07min	-	21hrs 35min	-	21hrs 10min	-	21hrs 58min	-	19hrs 17min	-	22hrs 50min	13hrs 00min	20hrs 45min	-	-	-	-
Average daily time devoted (on time off) by children to personal activities (playing, studying) - Boys	24hrs 00min	22hrs 31min	-	20hrs 30min	-	23hrs 15min	-	21hrs 14min	-	21hrs 57min	-	22hrs 00min	24hrs 00min	21hrs 30min	-	-	-	-
Average daily time devoted (on time off) by children to personal activities (playing, studying) - Girls	23hrs 10min	18hrs 02min	-	18hrs 30min	-	23hrs 00min	-	20hrs 54min	-	19hrs 00min	-	20hrs 00min	22hrs 00min	19hrs 45min	-	-	-	-
% of CM having been discriminated against for any reason (6)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

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**Table 37** : Type of coping strategies adopted type1, type 2 , and type 3 HH according to the level of education of the HH head

	HH with AIDS death (type 1)			HH with non AIDS death (type 2)			HH with no deaths (type 3)		
	Illiterate	Primary	Secondary/ Higher	Illiterate	Primary	Secondary/ Higher	Illiterate	Primary	Secondary/ Higher
<b>Sustainable coping strategies</b>									
% HH having reduced their savings	66.7	68.6	69.1	65.1	76.9	72.7	62.5	73.3	64.3
% HH having reduced required investments (standing as a need) (1)	10.0	7.1	4.3	15.0	15.4	9.1	5.9	14.3	16.7
% HH having reduced consumer durable expenses	19.2	0	7.7	11.8	16.7	22.7	11.8	33.3	17.5
% HH having sold non-productive assets (jewellery, other non-essential items)	7.1	0	12.5	0	0	14.3	0	0	0
% HH having increased their average daily time devoted to productive activities (2)	10.9	15.7	14.1	10.9	21.2	11.5	16.3	25.9	15.4
% HH having reduced their average daily time devoted to family and other activities (3)	12.5	19.6	18.3	28.1	21.2	26.9	16.3	25.9	16.2
% HH having adopted other sustainable coping strategies (please specify)									
<b>Partially sustainable coping strategies</b>									
% HH with members who out-migrated in quest for employment opportunities away from the place of residence	9.4	13.7	16.9	10.9	17.3	11.5	12.2	11.1	11.1
% HH having entrusted their children to distant families	12.5	21.6	15.5	10.9	17.3	11.5	6.1	7.4	10.3
% HH having a member who quit their job to take care of other HH members who are sick	3.1	3.9	0	0	0	1.3	2.0	0	0.9
% HH having adopted other partly sustainable coping strategies (please specify)									
<b>Unsustainable coping strategies</b>									
% HH having received substantive help (in cash or in-kind ) from any source (4)	79.7	60.8	73.2	64.1	61.5	64.1	40.8	40.7	30.8
% HH having borrowed money on unfavorable terms	1.6	2.0	9.9	3.1	5.8	9.0	6.1	0	16.2
% HH having increased their incomes through sales of assets (1)	21.9	15.7	11.3	10.9	17.3	10.3	16.3	14.8	7.7
% HH having reduced their basic food expenditures	28.6	33.3	24.3	34.9	19.2	18.4	8.2	14.8	12.1
% HH having withdrawn their children from school	28.1	25.5	23.9	23.4	13.5	10.3	20.4	3.7	15.4
% HH with members who could not access health centers while in need of health care services	45.3	47.1	43.7	31.2	28.8	17.9	42.9	14.8	22.2
% HH having adopted other unsustainable coping strategies (please specify)									

**NOTES.**

(1) This entry could be specified as lands/plot of land, livestock, housing, productive tools, and vehicles.

(2) Productive activities are those meant to generate income as well as those related to productive assets maintenance. This entry could be further stressed by introducing the following items: % HH having increased their incomes through waged workers, % HH having increased their incomes through self-employment, % HH with a member working more than one hour overtime in the same job, % HH with a member having found an extra-job, % HH with a member having joined the work force for the first time, % HH with a member who changed for a and better paid one.

(3) Family activities refer to: care of other family members and household chores while other personal activities include resting, sleeping, hygiene, entertainment, and social activities which can furthermore rank among social, community, political, religious and economic activities.

(4) A substantive help could be a gift or a loan accounting for at least 2-3 % of the family income per annum.

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**Table 38** : Type of coping strategies adopted by type 1, type 2, and type 3 HH according to the assets of the HH and by child gender. For urban HH, please use appropriate assets categories (housing, productive assets, urban lands, other assets for the measurement of their assets)

	HH with AIDS death (type 1)			HH with non AIDS death (type 2)			HH with no deaths (type 3)		
	No assets	House	Electric-HH appliances	No assets	House	Electric-HH appliances	No assets	House	Electric-HH appliances
<b>Sustainable coping strategies</b>									
% HH having reduced their savings	100.0	53.8	68.5	66.7	50.0	74.2	60.0	50.0	65.7
% HH having reduced required investments (standing as a need) (1)	0	0	7.5	0	20.0	10.6	0	20.0	10.9
% HH having reduced consumer durable expenses	100.0	0	8.3	0	0	20.9	0	0	19.0
% HH having sold non-productive assets (jewellery, other non-essential items)	0	0	7.7	0	0	4.8	0	0	0
% HH having increased their average daily time devoted to productive activities (2)	28.6	0	12.9	16.7	30.8	11.6	16.7	8.3	16.8
% HH having reduced their average daily time devoted to family and other activities (3)	14.3	27.8	14.0	16.7	38.5	22.7	33.3	16.7	15.6
% HH having adopted other sustainable coping strategies (please specify)									
<b>Partially sustainable coping strategies</b>									
% HH with members who out-migrated in quest for employment opportunities away from the place of residence	0	14.0	12.3	0	14.3	12.8	16.7	14.6	12.7
% HH having entrusted their children to distant families	42.9	12.1	16.4	33.3	11.8	11.6	16.7	6.7	9.2
% HH having a member who quit their job to take care of other HH members who are sick	0	0.9	1.8	0	0.8	0.6	0	1.1	1.2
% HH having adopted other partly sustainable coping strategies (please specify)									
<b>Unsustainable coping strategies</b>									
% HH having received substantive help (in cash or in-kind ) from any source (4)	100.0	83.3	70.2	66.7	69.2	62.8	66.7	33.3	33.5
% HH having borrowed money on unfavorable terms	0	0	5.3	16.7	0	7.0	0	0	12.7
% HH having increased their incomes through sales of assets (1)	0	11.1	15.2	0	15.4	12.8	0	0	12.1
% HH having reduced their basic food expenditures	50.0	11.1	27.2	20.0	46.2	21.2	0	9.1	11.6
% HH having withdrawn their children from school	42.9	28.0	25.1	16.7	11.8	15.1	16.7	14.6	13.9
% HH with members who could not access health centers while in need of health care services	57.1	55.6	42.7	16.7	23.1	23.8	66.7	33.3	24.3
% HH having adopted other unsustainable coping strategies (please specify)									

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**Table 39** : Type of coping strategies adopted by type 1, type 2, and type 3 HH according to HH income level

	HH with AIDS death (type 1)			HH with non AIDS death (type 2)			HH with no deaths (type 3)		
	Low income	Median income	High income	Low income	Median income	High income	Low income	Median income	High income
<b>Sustainable coping strategies</b>									
% HH having reduced their savings	66.7	71.4	64.9	81.1	69.4	62.2	72.6	64.3	55.8
% HH having reduced required investments (standing as a need) (1)	0	16.7	8.0	15.0	4.8	25.0	18.2	16.7	15.4
% HH having reduced consumer durable expenses	10.0	13.3	7.7	33.3	12.0	11.1	29.6	13.6	6.2
% HH having sold non-productive assets (jewellery, other non-essential items)	0	0	9.1	0	8.3	0	0	0	0
% HH having increased their average daily time devoted to productive activities (2)	9.9	20.8	8.1	18.4	10.9	11.8	15.7	13.6	18.5
% HH having reduced their average daily time devoted to family and other activities (3)	14.1	22.6	12.2	24.5	25.0	27.5	21.4	10.2	18.5
% HH having adopted other sustainable coping strategies (please specify)									
<b>Partially sustainable coping strategies</b>									
% HH with members who out-migrated in quest for employment opportunities away from the place of residence	7.0	20.8	12.2	12.2	15.2	9.8	12.9	13.6	9.2
% HH having entrusted their children to distant families	14.1	11.3	21.6	10.2	12.0	15.7	5.7	8.5	10.8
% HH having a member who quit their job to take care of other HH members who are sick	0	0	5.4	0	1.1	0	2.9	0	0
% HH having adopted other partly sustainable coping strategies (please specify)									
<b>Unsustainable coping strategies</b>									
% HH having received substantive help (in cash or in-kind ) from any source (4)	76.1	73.6	68.9	57.1	64.1	68.6	34.3	37.3	35.4
% HH having borrowed money on unfavorable terms	5.6	3.8	4.1	4.1	8.7	5.9	11.4	20.3	3.1
% HH having increased their incomes through sales of assets (1)	9.9	18.9	14.9	8.2	13.0	15.7	12.9	6.8	12.3
% HH having reduced their basic food expenditures	22.9	15.1	38.4	14.9	21.7	32.0	10.1	13.8	10.8
% HH having withdrawn their children from school	26.8	37.7	14.9	10.2	17.4	15.7	7.1	27.1	12.3
% HH with members who could not access health centers while in need of health care services	42.3	56.6	37.8	22.4	25.0	25.5	20.0	37.3	24.6
% HH having adopted other unsustainable coping strategies (please specify)									

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**Table 40** : Type of coping strategies adopted by type 1, type 2, and type 3 HH according to the help or gifts HH received from the Government (GVT), civil society (non-governmental organizations (NGOs), des religious organizations (ROs), and community (extended family or neighbors (EFN), and community-based organizations (CBOs)

	HH with AIDS death (type 1)				HH with non AIDS death (type 2)				HH with no deaths (type 3)			
	No help	CBOs EFN	NGOs RO	GOV	No help	CBOs EFN	NGOs RO	GOV	No help	CBOs EFN	NGOs RO	GOV
<b>Sustainable coping strategies</b>												
% HH having reduced their savings	82.0	57.6	47.8	77.8	70.6	72.4	80.0	77.8	65.9	59.0	83.3	61.5
% HH having reduced required investments (standing as a need) (1)	5.9	3.2	12.5	50.0	22.2	7.4	25.0	0	12.5	16.7	50.0	0
% HH having reduced consumer durable expenses	0	13.3	30.0	0	46.2	7.7	0	14.3	20.0	0	66.7	33.3
% HH having sold non-productive assets (jewellery, other non-essential items)	11.1	6.3	0	0	5.9	0	0	0	0	0	0	0
% HH having increased their average daily time devoted to productive activities (2)	5.1	15.7	10.3	13.3	13.5	14.1	7.1	22.2	19.3	7.5	20.0	11.8
% HH having reduced their average daily time devoted to family and other activities (3)	8.5	15.7	23.1	33.3	18.9	25.6	64.3	33.3	14.9	20.0	40.0	11.8
% HH having adopted other sustainable coping strategies (please specify)												
<b>Partially sustainable coping strategies</b>												
% HH with members who out-migrated in quest for employment opportunities away from the place of residence	13.6	12.0	12.8	20.0	10.8	12.4	6.3	27.8	12.3	11.3	0	23.5
% HH having entrusted their children to distant families	11.9	14.0	30.8	13.3	9.5	13.3	12.5	5.6	7.0	11.3	0	23.5
% HH having a member who quit their job to take care of other HH members who are sick	1.7	2.0	5.1	0	0	1.0	0	0	0	1.9	10.0	0
% HH having adopted other partly sustainable coping strategies (please specify)												
<b>Unsustainable coping strategies</b>												
% HH having received substantive help (in cash or in-kind ) from any source (4)	-	90.0	94.9	80.0	-	84.8	100.0	77.8	-	62.3	70.0	35.3
% HH having borrowed money on unfavorable terms	3.4	3.0	2.6	13.3	10.8	3.8	0	0	14.0	7.5	0	17.6
% HH having increased their incomes through sales of assets (1)	15.3	16.0	15.4	6.7	23.0	7.6	12.5	5.6	6.1	18.9	30.0	5.9
% HH having reduced their basic food expenditures	23.7	27.6	26.3	20.0	18.1	27.6	31.2	33.3	8.8	13.2	20.0	11.8
% HH having withdrawn their children from school	22.0	23.0	35.9	53.3	13.5	17.1	12.5	11.1	10.5	26.4	0	29.4
% HH with members who could not access health centers while in need of health care services	40.7	44.0	64.1	60.0	28.4	23.8	25.0	16.7	22.8	41.5	40.0	35.3
% HH having adopted other unsustainable coping strategies (please specify)												

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**Table 41** : Type of coping strategies adopted by type 1, type 2, and type 3 HH according to the various kinds of transfers HHs received from the Government (dp = disability pension, c/o a = child/orphan allowance, ua = unemployment allowance, opt = other public transfers)

	HH with AIDS death (type 1)				HH with non AIDS death (type 2)				HH with no deaths (type 3)			
	dp	c/oa	ua	opt	dp	c/oa	ua	opt	dp	c/oa	ua	opt
<b>Sustainable coping strategies</b>												
% HH having reduced their savings	77.8	75.0	0	75.0	77.8	80.0	0	60.0	58.3	100.0	100.0	100.0
% HH having reduced required investments (standing as a need) (1)	50.0	0	0	0	0	0	0	33.3	0	0	0	0
% HH having reduced consumer durable expenses	0	0	0	20.0	14.3	0	0	50.0	50.0	100.0	0	0
% HH having sold non-productive assets (jewellery, other non-essential items)	0	0	0	0	0	0	0	0	0	0	0	0
% HH having increased their average daily time devoted to productive activities (2)	14.3	20.0	0	18.2	26.7	11.1	0	10.0	12.5	50.0	0	0
% HH having reduced their average daily time devoted to family and other activities (3)	35.7	20.0	0	27.3	40.0	44.4	0	20.0	12.5	50.0	0	0
% HH having adopted other sustainable coping strategies (please specify)												
<b>Partially sustainable coping strategies</b>												
% HH with members who out-migrated in quest for employment opportunities away from the place of residence	21.4	0	0	27.3	27.8	11.1	0	0	25.0	0	0	0
% HH having entrusted their children to distant families	14.3	16.7	0	9.1	5.6	11.1	0	10.0	25.0	0	0	0
% HH having a member who quit their job to take care of other HH members who are sick	0	0	0	0	0	0	0	0	0	0	0	0
% HH having adopted other partly sustainable coping strategies (please specify)												
<b>Unsustainable coping strategies</b>												
% HH having received substantive help (in cash or in-kind ) from any source (4)	78.6	66.7	100.0	81.8	77.8	100.0	0	100.0	37.5	100.0	0	0
% HH having borrowed money on unfavorable terms	14.3	0	0	9.1	0	11.1	0	10.0	12.5	0	100.0	0
% HH having increased their incomes through sales of assets (1)	7.1	16.7	0	9.1	5.6	0	0	20.0	6.3	50.0	0	0
% HH having reduced their basic food expenditures	14.3	66.7	100.0	72.7	35.3	22.2	0	30.0	13.3	0	0	0
% HH having withdrawn their children from school	50.0	16.7	0	27.3	11.1	11.1	0	10.0	31.2	0	0	0
% HH with members who could not access health centers while in need of health care services	57.1	16.7	0	54.5	16.7	33.3	0	10.0	37.5	0	0	0
% HH having adopted other unsustainable coping strategies (please specify)												

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**Table 42 : Type of coping strategies adopted by type 1, type 2, and type 3 HH according to the various kinds of help HH received from the Government (l = loan, mt = money transfer, f = food, h = other help in-kind , e = employment, h = other form of help)**

	HH with AIDS death (type 1)						HH with non AIDS death (type 2)						HH with no deaths (type 3)						
	Help in cash		Help in-kind		Other help		Help in cash		Help in-kind		Other help		Help in cash		Help in-kind		Other help		
	l	mt	f	h	e	h	l	mt	f	l	mt	f	h	e	h	l	mt	f	
<b>Sustainable coping strategies</b>																			
% HH having reduced their savings	100	100	0	0	0	100	0	83.3	0	0	0	100	50.0	100	0	0	0	0	
% HH having reduced required investments (standing as a need) (1)	0	0	0	0	0	0	0	25.0	0	0	0	0	0	0	0	0	0	0	
% HH having reduced consumer durable expenses	0	20.0	0	0	0	100	0	33.3	0	0	0	0	0	100	0	0	0	0	
% HH having sold non-productive assets (jewellery, other non-essential items)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
% HH having increased their average daily time devoted to productive activities (2)	0	37.5	0	50.0	0	0	0	7.7	0	0	0	0	50.0	50.0	0	0	0	0	
% HH having reduced their average daily time devoted to family and other activities (3)	0	37.5	0	50.0	0	0	0	23.1	0	100	0	0	0	50.0	0	0	0	0	
% HH having adopted other sustainable coping strategies (please specify)																			
<b>Partially sustainable coping strategies</b>																			
% HH with members who out-migrated in quest for employment opportunities away from the place of residence	50.0	22.2	0	0	0	0	0	15.4	0	0	0	0	0	0	0	0	0	0	
% HH having entrusted their children to distant families	50.0	0	0	50.0	0	0	0	7.7	0	0	0	0	50.0	0	0	0	0	0	
% HH having a member who quit their job to take care of other HH members who are sick	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
% HH having adopted other partly sustainable coping strategies (please specify)																			
<b>Unsustainable coping strategies</b>																			
% HH having received substantive help (in cash or in-kind ) from any source (4)	100	100	0	100	0	100	0	100	0	100	0	100	100	100	0	0	0	0	
% HH having borrowed money on unfavorable terms	0	0	0	0	0	0	0	0	0	0	0	100	100	0	0	0	0	0	
% HH having increased their incomes through sales of assets (1)	0	0	0	50.0	0	0	0	7.7	0	100	0	0	0	0	0	0	0	0	
% HH having reduced their basic food expenditures	0	55.6	0	100	0	100	0	30.8	0	100	0	0	50.0	0	0	0	0	0	
% HH having withdrawn their children from school	0	33.3	0	0	0	100	0	7.7	0	100	0	0	0	0	0	0	0	0	
% HH with members who could not access health centers while in need of health care services	50.0	66.7	0	0	0	100	0	7.7	0	100	0	0	0	0	0	0	0	0	
% HH having adopted other unsustainable coping strategies (please specify)																			

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**ANNEXE B: Basic social Indicators by Ministry**

<b>HEALTH</b>						
	1985	1990	1995	2000	2005	2010
1. Life expectancy at birth		52	51	47		
2. Infant mortality rate	97	93	89	112		
3. infant mortality rate due to AIDS						
4. under 5 mortality rate	150	149	150	171		
5. under 5 mortality rate due to AIDS						
6. % infants with low birth weight (less than 2,500 grams)			14			
7. % children under 5 suffering from moderate-severe wasting (below -2 stand. Deviations for height of reference population)			8.3			
8. DPT3 immunisation coverage (proportion of one-year-old children immunised against diphtheria, pertussis, and tetanus with 3 doses)			51	62		
9. Measles immunisation coverage			53	62		
10. ORT use (percentage of all cases of diarrhoea in children under 5 treated with oral rehydration salts and/or recommended home solution)			19.8	35.6		
11. Proportion of women 15-49 who attended at least once during pregnancy by skilled (doctor, nurse, midwife) health personnel			83	88		
12. proportion of births attended by skilled (doctor, nurse, midwife) health personnel			45	63		
<b>EDUCATION</b>						
	1985	1990	1995	2000	2005	2010
1. Primary school female gross enrolment ratios (ratios of total enrolments, regardless of age, over the population of the age group that officially corresponds to primary education)	59.3	55.6	58.4			
2. Primary school male gross enrolment ratios	84.1	78.5	79.5			
3. Secondary school female gross enrolment ratios	11.8	14.3	15.5			
4. Secondary school male gross enrolment ratios	27.5	29.8	30.5			
5. Survival rates in primary schools by grade (% of a cohort of pupils enrolled in the first grade of primary education in a given school-year who are expected to reach each successive grades)	73	70	74			
6. Repetition rates in primary schools by grade (% of pupils from a cohort enrolled in a given grade of primary education in a given school-year who study in the same grade in the following school-year)	49.6	47.9	39.9			
7. Pupil-teacher ratio in primary school	37	37	41			
8. Pupil-teacher ratio in secondary school	17	18	27			
<b>SOCIAL WELFARE</b>						
	1985	1990	1995	2000	2005	2010
1. Maternal or double orphan children (as % of children less than 15 years old)		6.1	7.4	8.6	9.9	10.7
2. Maternal or double orphan children from AIDS (as % of maternal or double orphan children)		36.2	50.7	92.7	19.7	78.0
3. Children abandoned (living with neither parents) (as % of children less than 15 years old)			14.4			