Managing HIV/AIDS at the Local Level in Africa

Project outputs and achievements

ABENGOUROU, CÔTE D'IVOIRE

2006

- *Abengourou Summary*
- *Abengourou HIV/AIDS Profile*
- *Report on the Abengourou HIV/AIDS Consultation Workshop and Action Plan*

MANAGING THE HIV AND AIDS PANDEMIC AT THE LOCAL LEVEL

EXPERIENCE FROM ABENGOUROU, CÔTE D'IVOIRE

In Abengourou, work has been underway since June 2005 between BNETD and the Abengourou Commune to develop a municipal Action Plan against HIV/AIDS. An already alarming situation - assessment of the incidence and impacts of HIV/AIDS in Abengourou shows a prevalence rate of between 10.5 and 12.5% nationally, with Abengourou at 14.6% - has been aggravated by the atmosphere of crisis, political, social and economic, in Cote d'Ivoire. Partners have been obligated to find the most appropriate responses for dealing with HIV/AIDS at the local level in such a challenging environment.

Some of the challenges facing the country are the existing conflict that has delayed commencement of the activities and caused inaccessibility, lack of funds and of coordination in NGOs and CBOs, lack of decentralisation (funds do not get to the grass root levels), lack of political commitment and immigration problems. Those living in poverty do not the funds to access treatment and care. Lack of funds at the local government level means that there is no dedicated budget line to address HIV/AIDS. Movement of the population caused by political insecurity causes a disruption in habits and routines and makes project planning and implementation very difficult.

At the same time, HIV/AIDS is a sensitive subject and it is difficult to communicate with different partners on the disease and its prevention. Added to that is a shortage of condoms to support the key messages. There are difficulties dealing with people in informal settlements and for those without housing.

The activities being undertaken by the City of Abengourou, together with BNETD, are the sensitization of partners, the preparation of a city profile on HIV/AIDS, and the preparation of a participatory city consultation and action plan to address the issue. Actors have been mobilized and a system of evaluation has been put in place, and local government associations have agreed to share their experiences.

At the national level, there has been progress with the creation of a Ministry in charge of HIV/AIDS, the elaboration of the National Strategic Plan against HIV/AIDS 2002 – 2004 and the hosting of the first international conference on "Mayors and the Role of Local Government in the Fight against HIV/AIDS". Equally important is the establishment of the national AMICAALL chapter and the elaboration of a strategic plan for 2005 – 2010 with an Action Plan developed for 2005 – 2007. Partners have been mobilized for the municipal action plans.

In Abengourou, the community profile has been completed, a consultative process has been undertaken and 200 persons interviewed. A municipal action plan has been prepared and adopted.

The Abengourou Vision is to "… sensitize the commune on the HIV/AIDS pandemic, with the prevalence rate reduced to 7% by 2015, and the creation of an environment for better treatment and care of infected and affected persons…". The three priority actions to achieve this are prevention, care and treatment and local response.

For prevention, projects at the city level will be centered around training for various actors, working with those infected or affected by HIV/AIDS, promotion of the use of condoms and creation of a knowledge management and communication strategy. For care and treatment, activities will include income-generating activities, assistance to those living with HIV/AIDS and promotion of VCT

centres. Local response will include promoting support and leadership within the municipality and the elaboration of a further action plan.

The above projects will include sensitatisation of the municipal council and other actors in Abengourou; impact assessment of HIV/AIDS in Abengourou; training of local actors on appreciative inquiry and community conversation methods, and; support to AMICCAAL activities.

République de Côte d'Ivoire
REGION DE MOYEN COMOE
DEPARTEMENT D'ABENGOUROU
COMMUNE D'ABENGOUROU

MAIRIE D' ABENGOUROU
B.P. 151 ABENGOUROU

MUNICIPAL ACTION PLAN AGAINST HIV / AIDS

COMMUNAL HIV/AIDS PROFILE

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ANUMI

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BUREAU NATIONAL D'ETUDES TECHNIQUES ET DE DEVELOPPEMENT

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ABBREVIATIONS

ANADER: Agence Nationale d'Appui au Développement Rural - *National Agency for Rural Development*

ARVs: Antiretroviral drugs

CAFOP: Centre d'Animation et de Formation Pédagogique – *Center for Primary School Teachers's Training*

CAT: Centre Antituberculeux – *TB Control Center*

CBC: Communication for Behavior Change

CDC: Center for Diseases Control

VCT: Voluntary Counseling and Testing

CIDV: Center of Information and Voluntary Testing

CIE: Compagnie Ivoirienne d'Electricité – *Ivorian Power Supply Company*

CNPS: Caisse Nationale de Prévoyance Sociale - *National Provident Fund*

CNTS: Centre National de Transfusion Sanguine – *National Center for Blood Transfusion*

ANC: Antenatal Consultation

CRTS: Centre régional de Transfusion Sanguine – *Regional Blood Transfusion Center*

DDS: Direction Départementale de la Santé – *Departmental Health Directorate*

DRA: Direction Régionale de l'Agriculture – *Regional Agriculture Directorate*

DREN: Direction Régionale de l'Education Nationale – *Regional Directorate for National Education*

DRSP: Direction Régionale de la Santé Publique – *Regional Public Health Directorate*

ENSEA: École Nationale de Statistique et d'Économie Appliquée – *National School of Statistics and Applied Economics*

FHI: Family Health International

IEC: Information, Education and Communication

INHP: Institut National d'Hygiène Publique – *National Institute for Public Hygiene*

INS: Institut National de la Statistique – *National Institute for Statistics*

ARI: Acute Respiratory Infections

STI: Sexually Transmitted Infection

MLS: Ministère de Lutte contre le SIDA – *Ministry for Aids Control*

STDs: Sexually Transmitted Diseases

WHO: World Health Organization

NGOs: Non-Governmental Organizations

UNAIDS: Joint United Nations Program on HIV/AIDS

PAHIV: *HIV-affected individual*

PEC: Prise en charge - *Care*

EIP: Extended Immunization Program

PMI: Protection Maternelle et Infantile – *Maternal and Child care center*

PNLS: Programme National de Lutte contre le SIDA - *National Program on AIDS Control*

PSP: Pharmacie de la Santé Publique – *Public Health Pharmacy*

PMCT: Prevention of Mother-to-Child Transmission

PLWHA: Personne vivant avec le VIH – Person Living with HIV/AIDS

RETRO-CI: Retrovirus Côte d'Ivoire

RGPH: Recensement Général de la Population et de l'Habitat – *General Population and Housing Census*

SFPS: Santé Familiale et Prévention du SIDA – *Family Health and AIDS Prevention*

AIDS: Acquired Immunodeficiency Syndrome

SIG: Système d'Information et de Gestion – *Information and Management System*

SODECI: Société de Distribution d'Eau en Côte d'Ivoire – *Water Supply Company operating in Côte d'Ivoire*

SODEFOR: Société pour le Développement de la Forêt - *Forestry Development Company*

SSSU: Service de Santé Scolaire et Universitaire - *Unit for Health Service Provision in Schools and Universities*

TB: Tuberculosis

UNICEF: United Nations Children's Fund

USAC: Unité de Soins Ambulatoires et de Conseils – *Ambulatory Care and Counseling Unit*

HIV: Human Immunodeficiency Virus

INTRODUCTION

AIDS is a disease that affects all social strata and professional categories in public as well as private organizations. Moreover, it is common knowledge that political and social instability plays a key role in developing countries like Côte d'Ivoire where AIDS is fast expanding[1].

Over twenty (20) years after the first clinical symptom of the Acquired Immuno-deficiency Syndrome was publicized, AIDS now ranks amongst the most devastating diseases[2]**.** Since the onset of the epidemic, the AIDS virus has infected more than 60 million individuals of whom at least 20 million have lost their lives to the disease. By the end of 2004, 39.4 million individuals were living with HIV, including 25.4 million in sub-Saharan Africa[3]. The disease hits mostly the young and economically active segment of population. Moreover, in the same year 3.1 millions AIDS-related deaths were recorded, with 2.4 million in Sub-Saharan Africa[4]. Indeed Africa is seriously hit by the HIV/AIDS epidemic, which is expanding exponentially. Besides, AIDS has ceased to be a mere public health problem. It has now become a societal problem threatening countries' development, especially poor ones.

Côte d'Ivoire has not been left unscathed by this pandemic. Indeed, Côte d'Ivoire is the most affected country in West Africa: from 500 cases of AIDS notified in 1987, more than 1.2 million cases were notified in 2001. The average prevalence rate amongst the general population is estimated at 10 percent and is likely to increase as a result of the increased and "constrained" displacements of populations ensuing from the war that broke out in Côte d'Ivoire in 2002[5].

In sub-Saharan Africa HIV is transmitted essentially through sexual intercourse. It is facilitated mostly by sexually transmitted infections (STIs), whether ulcerative or not[6]**.**

In fact, STIs act as a co-factor in the transmission of the Human Immuno-Deficiency virus infection. The risk of HIV infection is 2.3 to 13.4 times higher amongst STI-infected individuals[7]**.** With 69 million cases of curable STI cases reported in 1999, sub-Saharan Africa has the highest prevalence rate: 119 cases per 1000. The causes behind the vulnerability of African populations have been identified. They are namely under-development, poverty, gender-based social inequalities and the lack of information, etc.

People's STIs and HIV/AIDS-related knowledge are varied but often quite weak: millions of youths are unaware of HIV/AIDS-related issues. Adolescents – most hit segments of the population - are unaware of or know little about HIV/AIDS to protect themselves efficiently against the HIV-infection. Thus, STIs and HIV/AIDS are not always related and the seriousness of the HIV/AIDS disease remains poorly perceived. As a result, risk behaviors are still widespread and marked by the multiplicity of sexual partners, interactions with sex workers, the non-use of condoms, poor care for STIs still considered as "taboo" or "shameful" diseases[8].

In response to the seriousness of this modern days scourge, effective control steps including the reinforcement of HIV/AIDS awareness, HIV/AIDS screening and case notification, improvement in STI care and monitoring are required. If the first step is intensively enforced, the screening of HIV/AIDS cases and STI monitoring, however, pose genuine problems for several reasons related namely to the acceptability of screening tests.

The control of sexually transmitted infections (including HIV/AIDS in Côte d'Ivoire was stepped up from 1987 onwards following the discovery of the first cases of AIDS. It translated into the establishment of a national AIDS, sexually transmitted diseases and tuberculosis control program (PNLS/MST/TU) in June 1990. Since January 2001, a Ministry for AIDS control has been set up to coordinate control activities at all levels with the establishment of sensitization units in several public and private development organizations.

All the walks of life are affected by the HIV epidemic, with its host of aftermaths – notably on the labor world – slackening economic activities and social progress. The overwhelming majority of people living

[1] OMS, Population et Développement de l'Afrique- OMS, juin et juillet, 1999 p.39
[2] La ruche G., Djeha D, Boka Y. et al (2000), La lutte contre les maladies sexuellement transmissibles en Côte d'Ivoire : quelles stratégies face au VIH/SIDA ? Cahier santé : 10 287-292.
[3] ONUSIDA/OMS, Rapport sur l'épidémie mondiale de VIH/SIDA. *Genève, 2004, 231p*
[4] ibidem
[5] ibidem
[6] GROSSKURTH H, MOSHA F,TODD Jet al., Impact of Improved Treatment of Sexually Transmitted Diseases on HIV Infection in Rural Tanzania. Randomised Controlled Trial. *Lancet 1995; 346: 530-536*
[7] Deniaud F, Melman C. (2002), De l'appréhension des maladies sexuellement transmissibles à la prévention du VIH - *La presse médicale, Mars*, N°9,31,387-392.
[8] Touré, Profil des patients atteints d'infections sexuellement transmissibles au dispensaire antivénérien de l'INSP d'Abidjan – Thès.Med.Abidjan. Abidjan, N° 3366/03,2003

with the virus across the world are aged 15-49, key period of the working life. AIDS takes its toll on economic activities by reducing productivity, increasing costs, reorienting resources and diminishing the strength of skilled workers. The epidemic affects productivity mainly due to the increase in absenteeism[9], organizational disruptions and the attrition of specialists and the disappearance of the "institutional memory". The high rate of absenteeism, morbidity and mortality result in an increased disruption in the various business lines, inducing an accelerated staff turnover and the loss of expertise[10]. To solve these problems, activity lines, and mostly the Town Council, must get more and more involved in STI/HIV/AIDS control.

Given the devastating impact of HIV/AIDS on households, communities and societies[11], national or even local control policies and strategies are to be modified and extended accordingly. If the consequences on cities and communes are considerable, neighborhoods and suburbs are ideal places to fight against AIDS.

For Town Councils already involved and who will commit themselves to this fight, health-related costs and subsidies for the funerals of their citizens (mostly the needy) are likely to increase due to the growth in the number of deaths. Thus, the fight against this epidemic concerns the neighborhoods and localities of communes, including the Commune of Abengourou.

With the support of ANUMI (African Network of Urban Management Institutions) and UN-Habitat (United Nations Center for Human Settlements), the Bureau National d'Études Techniques et de Développement (BNETD – *National Bureau of Technical Surveys and Development*) initiated a survey of STI/HIV/AIDS profile to identify the appropriate foci of intervention. This survey was conducted in two stages:

- A survey of individuals in the neighborhoods and villages of the Commune of Abengourou in Côte d'Ivoire;
- An institutional survey.

This document describes the methodology and results of the aforementioned survey on the profile, and makes recommendations to step up HIV/AIDS control actions in the Commune of Abengourou.

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[9] Eholié S., Kakou A, Aoussi E, Bissagnéné E, Odehouri K, Kadio A (2002), SIDA et traitement ARV en entreprise- *Rapport d'étude, PVVH*
[10] K.Kober, W.V. Damme, Scaling up Access to Antiretroviral Treatment in South Africa: Who Will Do the Job? *Lancet*, 2004; 364: 103-107
[11] ibidem

I. CONTEXT OF DESIGN OF THE STI/HIV/AIDS PROFILE

I.1. DESCRIPTION OF THE COMMUNE OF ABENGOUROU

I.1.1. LOCATION

The Commune of Abengourou is located in the Eastern part of Côte d'Ivoire. It is bordered on the Northern side by the Zanzan region, on the Southern side by the Agnéby and Sud-Comoé regions, on the Western side by the N'zi-Comoé region and the Commune of Niablé and Ghana on the Eastern side. It extends over 6 900 sqkm and is located in a forest area, with a little rugged landform. (See Maps of Abengourou City and the villages in the Commune)

I.1.2. ADMINISTRATIVE AND TRADITIONAL ORGANIZATION

The Commune of Abengourou is subdivided into neighborhoods and **communal** villages as follows: Adaou, Cafétou, Bonzou 1er, Agnikro, Comikro, Résidentiel, Abengourou Extension, Indénié, Dioulakro, Adonikro, Adoukoffikro, Touzoukro, Comoekro, Akoikro, Kouassi Beniekro, and Kirifi. Most of these neighborhoods and communal villages are led by the chiefs referred to as "Neighborhood chiefs" or "Village chiefs". In addition to these neighborhoods and communal villages there are **farmsteads ("*campements*")**. In each neighborhood or communal village (chieftaincy), there are civil society organizations, NGOs, AIDS control organizations whose leaders work in cooperation with the aforementioned chiefs in conducting their activities.

The department covers an area of 5.180 sqkm and constitutes the Indénié Kingdom with six (6) cantons: Amélékia, Aniassué, Bettié, Yakassé-Feyassé, Niablé and Zaranou. Nanan Boa Kouassi III rules the kingdom.

Like several other communes in the country, animism is the predominant religious practice in the Abengourou communal villages and farmsteads. Christianity and Islam are practiced in Abengourou City.

I.1.3. POPULATION MIX

According to the 1998 General Census (RGPH), in 2004 there were 80.100 inhabitants in the Commune of Abengourou. The annual growth rate is of 2.6 percent.

The Commune is comprised of Agni people, peaceful people always heeding his Majesty the King's words for the settlement of all disputes. There are however other ethnic groups of Côte d'Ivoire living in the Commune, namely Attié, Bété, Mandé, Mandingo, Baoulé, and Lobi peoples. These ethnic groups live in full symbiosis with people from the West-African sub-region: Mali, Burkina Faso, Ghana and other countries.

I.1.4. ECONOMIC SITUATION

Abengourou is the regional capital. Perennial crops such as coffee and cocoa, which account for 14.4 percent and 3.94 percent of national production, according to the Regional Agriculture Directorate (DRA), are the predominant crops in the agricultural sector.

Food crops are comprised of rain-fed and irrigated rice, plantain, corn, yam cassava and various vegetables of which tomato is the main crop.

Livestock production is essentially based on poultry, pig, cattle, sheep and goat husbandry.

The secondary sector is dominated by wood industry. There are three sawmills currently operating in Abengourou City: Holz Ivoire, NSI and SNTRA.

There is also an agrifood plant - Jean Abile Gal (JAG) plant - dedicated to coffee hulling but it is not currently operational.

I.2. SANITARY AND EDUCATIONAL BACKGROUNDS

I.2.1. THE MOYEN-COMOE REGIONAL PUBLIC HEALTH DIRECTORATE

The Regional Public Health Directorate (DRSP) comprises the sanitary districts of Abengourou and Agnibilékrou. It has three (3) Sub-dDirectorates:

- The Sub-Directorate for Administrative and Financial Matters
- The Infrastructure, Equipment and Maintenance Sub-Directorate
- The Sub-Directorate for Sanitary Matters

I.2.2. HEALTH FACILITIES

According to the Regional Public Health Directorate (DRSP), in 2005 there were 12 operational health facilities out of the 49 to be found in the Moyen-Comoé region and they were distributed as follows:

- One (1) regional hospital in Abengourou
- One (1) INHP regional antenna in Abengourou
- Two (2) urban clinics in Abengourou
- One (1) maternal-and-child care center (PMI) in Abengourou
- One (1) pupil and student health-care service in Abengourou
- One (1) urban maternity in Abengourou
- One (1) denominational health-care facility in Abengourou
- One (1) TB control center in Abengourou
- Three (3) operational students' clinics
-

Malaria is the leading affection in the region, therefore in the Commune of Abengourou, with an incidence estimated in 2004 at 154.4 per 1000. The other health priorities include: ARIs, diarrheas, anemia, AIDS, STIs and tuberculosis, reproductive health and immunization (EIP).

I.2.3. COVERAGE AND SANITARY PERFORMANCE

According to the Regional Public Health Directorate (DRSP), estimates for 2004 in terms of ratios of health workers in the Moyen-Comoé region, including Abengourou City, are as follows:

- One (1) physician per 16 200 inhabitants,
- One (1) nurse per 3 729 inhabitants
- One (1) mid-wife per 1 793 women of childbearing age.

Furthermore, the rate of health facilities use in the Moyen-Comoé area is the highest in Côte d'Ivoire, with a percentage of 35.5; the same applies to the attendance rate, which is of 41.3 percent, according to the Departmental Health Directorate (DDS) of Abengourou.

Table 1 shows the other indicators and their rates.

Table 1. 2003 Sanitary Data for Abengourou, Departmental Health Directorate

Indicators	Abengourou
Activities and productivity	
Consultants	36.6 percent
Consultations	42.7 percent
ANC 1[12]	83.2 percent
ANC 3+[13]	33.9 percent
Assisted deliveries	88.1 percent
Natimortality	3.2 percent
Infant mortality	6.94 percent

[12] Consultation pré-natale selon les tranches d'âge
[13] Consultation pré-natale selon les tranches d'âge

Child and Infant mortality	7.4 percent0
Maternal mortality	262 per 100 000
Family planning	
Protected women	8.6 percent
Vaccination coverage	
BCG[14]	104 percent
DTC/Hep. B 1[15]	99 percent
DTC/Hep. B 3+[16]	81 percent
VAR[17]	74 percent
VAA (FJ)[18]	74 percent

I.2.4. EDUCATION

In the school year 2003-2004, according to the Regional Directorate for National Education (DREN), there were 14 secondary schools operating in the Commune of Abengourou and other localities in the Moyen-Comoé region in addition to the CAFOP: 7 public schools (including two high-schools) and 7 private schools. The overall number of students in the Moyen-Comoé area, including the Commune of Abengourou, is of 20 156, including 6 321 girls, with 316 classrooms and 458 teachers. There are 58 264 students, including 26 836 girls, in primary schools.

In 2000-2001, the literacy rate was estimated at 51 percent for men and 37 percent for women. There has been a decline in literacy education activities due to the conflict situation the country has been experiencing. The number of centers decreased from 55 for 3895 attendants in 2000-2001 to 23 centers with 1186 attendants in 2003-2004.

[14] Bacille de Calmette et Guérin (Tuberculeux)
[15] Diphtérie Tétanos Coqueluche / Hépatite B1
[16] Diphtérie Tétanos Coqueluche / Hépatite B3+
[17] Vaccin anti-rubéole
[18] Vaccin anti-amare (Fièvre jaune)

II. SURVEY BESIDE INDIVIDUALS

It is a KAP (Knowledge, Attitudes, Practice) survey conducted on the populations in the Commune of Abengourou), with individual interviews, based on a questionnaire.

II.1. OBJECTIVES

Specifically, the survey was intended to investigate the following aspects:

- People's HIV/AIDS and STI-related knowledge, attitudes and practices;
- The factors of exposure to the risks of STIs and HIV;
- The organizing of medical care for patients with STIs and HIV/AIDS;
- The level of insertion and acceptance of HIV-infected individuals;
- Local statistics (epidemiology, case notification) on HIV/AIDS;
- The elements of feasibility and acceptability of the aforementioned diseases control project in communities;
- The level of responsiveness of local authorities - political, administrative, sanitary and municipal - to HIV/AIDS control activities in the Commune of Abengourou;
- The actions and activities undertaken by NGOs, local and religious associations, private sector organizations – firms and companies, informal sector vendors – and development partners' agencies involved in the HIV/AIDS scourge control in Abengourou;

The results of this survey will not only help identify the strengths and weaknesses of the Commune's response to STI/HIV/AIDS and of the HIV/AIDS control strategies implemented in the Commune of Abengourou but also to compile basic data required to assess actions that are to be conducted.

II.2. POPULATION TO BE SURVEYED

The survey covers individuals aged 15 and over of both genders, from all levels (service, function…). The Town Council has taken steps to inform people showing them the rationale of the survey so that all those who were short-listed were ultimately surveyed. The survey method used and the questionnaire are appended as **Annex 1**

II.2.1. INTERVIEWER RECRUITMENT AND TRAINING

II.2.1.1. RECRUITMENT OF INVESTIGATORS

Investigators were recruited in the light of their experience in survey conducting, in general, and especially BNETD-conducted surveys. In effect, due to its calling as research and/or survey institution, BNETD has a large base of experienced investigators with whom it usually works. Five investigators were thus recruited. The purpose was chiefly to ensure that the execution of this survey – owing to their field experience – would take advantage of their experience both in terms of quality of collected data and efficacy on the field. As a result, they were all provided the same training for the same duration (two days).

II.2.1.2. TRAINING OF INVESTIGATORS

Ensured by the technical team of the survey, this training provided the investigators the opportunity to discover the questionnaire, get familiar with it and make their first comments on the formulation of questions. The training (including the pilot survey) took place on 12-13 July 2005 and was based on two key focal points:

The presentation of the objectives, concepts and general instructions (structuring/organization of the survey, interviewer's work) of the survey on STIs/HIV/AIDS;

Review of the questionnaire and explanation of the questions and instructions thereto pertaining.

All the comments led to slight corrections to the questionnaire. Thus, the interviewer conducted the pilot survey based on this updated document. The investigators were furthermore requested not to translate the questions but rather put them as written in the questionnaire.

II.2.2. ON-THE-FIELD CONDUCT OF THE SURVEY

II.2.2.1. SENSITIZATION OF PEOPLE AND RECONNAISSANCE OF CENSUS DISTRICTS

To facilitate the ground operation and ensure a proper reception of the investigators in households, BNETD sent an information letter to the Mayor of the Commune of Abengourou. There was no problem in securing the Mayor's written authorization.

In general, the sensitization of the population was continued on the field in a friendly manner by the investigators in the household count and numbering stage. The letter of sensitization issued by the Mayor proved quite effective faced with some family heads' reluctance to release information to the investigators. All in all, the populations gave the teams deployed in the field a warm welcome.

The reconnaissance of CDs (census districts) in Abengourou was conducted shortly after the arrival of the team in the City. To that end, the team members were provided assistance by the Secretary General and the Director for Social and Cultural Affairs of the Abengourou Town Council.

II.2.2.2. HOUSEHOLD NUMBERING

With the consent of household heads, the investigators assigned a number to households and drew up the inventory of household members. This inventory focused, among other things, on the gender, the date of birth (age, if the date of birth is unknown) of each member of the household. The household numbering consisted in undertaking a thorough numbering of all the households in each CD.

II.2.2.3. COLLECTION OF DATA PROPER ON THE FIELD

The administering of the questionnaire began immediately after the households numbering and selection stage. The survey was conducted though direct interviews of the individuals concerned, using the door-to-door approach; the interviews were conducted respectfully and in observance of the respondents' intimacy. According to the sampling plan, 10 households were to be interviewed per CD, with 3 eligible individuals per household on average.

II.2.3. DATA PROCESSING AND ANALYSIS

II.2.3.1. COMPUTERIZED DATA CAPTURE

The principle of double data capturing was selected to minimize errors due to entry by self-controls. The data manager, a statistics engineer with proven know-how in computer science, trained the investigators.

After capturing the data under Excel, the files were merged and transferred to Epi Info 2002 for a set of consistency checks before the generation of the analytical Tables.

II.2.3.2. SURVEY INDICATORS

To meet the specific objectives, the survey focused on the following objectives:

- Features of the subjects covered by the survey;
- Proportion of subjects by levels of knowledgeability about HIV/AIDS;
- Proportion of subjects by knowledgeability about HIV/AIDS risk factors;
- Subjects' STIs and HIV/AIDS-related attitudes and practices;
- Proportion of subjects using condoms;
- Proportion of subjects accepting to work in the same department or office as an STI or HIV/AIDS-infected individual or to live with such an individual;
- Item of feasibility or responsiveness to a HIV/AIDS control action;
- Investigators' opinions about the existence of HIV/AIDS care facilities;
- Impacts (statistics) of STI/HIV/AIDS on the Commune as a whole;
- Strengths and weaknesses of the Commune's response to STI/HIV/AIDS.

The determination of the level of knowledge, of the categories of behaviors and practices was made possible by weighting variables as per their significance[19] (See Annex of variable weighting).

***Knowledgeability*:** On the survey form, each item in the STI/AIDS knowledgeability chapter was scored from 0 to 1 (depending on whether the answer was right or wrong).

The sum total of such scores would give a total ranging from 0 to 20.

Thus, a total ranging from:

- 0 to 9 would correspond to a low knowledgeability;
- 10 to15 would correspond to an average knowledgeability;
- 16 to 20 would correspond to a good knowledgeability.

***Behavior*:** A score was assigned to the items pertaining to the respondents' attitude as regards STI/AIDS (depending on whether the response was positive or negative). The sum total of such scores would give a total ranging from 0 to 10;

Thus, a total ranging from:

- 0 to 6 would correspond to an improper behavior;
- 7 and 10 would correspond to an adequate behavior.

***Practices*:** Items corresponding to sexual practices were scored 0 when such practices were good or from 0.5 to 1 point when they were improper.

- A sum total of scores = 0, would correspond to good practices
- A sum total of scores > 0, would correspond to improper practices

Although the weighting of the various items pertaining to knowledgeability, behavior and practice remains to be validated, it enabled the survey to determine the categories required t assess future HIV/AIDS control actions.

II.3. RESULTS AND COMMENTS ON THE INDIVIDUALS SURVEY

II.3.1. LIMITATIONS OF THE SURVEY

This survey based on interviews conducted to collect information on STI/HIV/AIDS, the respondents' sexual practices, the statistics on these STI/HIV/AIDS, and the strengths and weaknesses of the Commune's response to STI/HIV/AIDS is likely to have some limitations (sources of biases) that are worth underlining. Answers to some questions concerning sexual practices (number of sexual partners, interaction with sex workers…) were doubtful: sexuality being a sensitive topic considered as taboo in Abengourou or even in Côte d'Ivoire, and the tackling of which is often marred by lies and unspoken truths.

To limit lie-related biases we fostered an atmosphere of confidence by reassuring the respondents about the confidentiality of our interview. Although we used the systematic sample drawing to reduce biases – and like in all this type of survey – one of the most common biases could be answers modified to be in accord with society.

Therefore, we believe this survey enables us not only to obtain an indication of the knowledgeability, attitudes and practices of the individuals interviewed in neighborhoods and suburbs of Abengourou; but also an indication of the consequences of STI/HIV/AIDS, and the strengths and weaknesses of the Commune's response to these scourges. Therefore, the results cannot be inferred from the responses of the interviewed population, let alone the general population. Nonetheless, these results are basic data that can be used to design action plans for HIV/AIDS control, monitor the behavior of the populations in Abengourou City and measure the effects of the preventive actions enforced in the Commune of Abengourou.

II.3.2. SOCIAL AND DEMOGRAPHIC FEATURES OF THE SAMPLE

Table 2 presents the features of the sample subjects.

In effect, Table 2 shows a population comprised mostly of males (55.5 percent), youths (average age = 24), with a secondary school background (64.3 percent) in Abengourou City, who are often farmers/students/teachers (54 percent) living generally with a partner (45.5 percent) or are single (54.5 percent).

[19] Koffi M., Analyse situationnelle des IST/VIH/SIDA, IPS(WA), mars 2004

Several surveys confirm the male-gender predominance in cities in Côte d'Ivoire (INS, 1998). These remarks do show that people and most of the labor employed in these cities or by companies are predominantly male (2 men for 1 woman)[20].

Table 2. Distribution of subjects per social and demographic features

Features	n	Values sought	
1. Age (years)	200	Average: 24 Minimum: 15 Maximum: 59	
2. Sex	200	Female: 44,5 percent Male: 55,5 percent Sex-ratio: 2	
3. Educational level	200	Uneducated: 18,5 percent Primary school: 31,2 percent Secondary school: 64,3 percent Higher education: 4,5 percent	81,5 percent
4. Professional category	200	Farmer: 26,5 percent Housewife: 16 percent Pupil: 17,5 percent Teachers: 10 percent Other: 30 percent	
5. Matrimonial status	200	Married (or cohabitating): 45,5 percent Single: 54,5 percent	
7. Tobacco	200	Yes: 39,8 percent No: 60,2 percent	
8. Alcohol	200	Not at all: 66 From time to time: 31,5 percent Regularly: 2,5 percent	
9. Injections in neighborhood clinics	200	Yes: 38,5 percent No: 61,5 percent	

Furthermore, the youthful feature (average age = 24) has also been noted in other surveys[21] from which it emerges that the 20-29 and 30-39 age brackets account for the majority of the population with an economic activity. Such a HIV/AIDS-infected population has a negative impact on the whole economy, causing a decline in production but also an increase in social outlays through health costs.

Finally, the average knowledgeability is to be taken into account, as evidence shows that knowledgeability about AIDS increases with the level of education[22].

II.3.3. KNOWLEDGEABILITY ABOUT STI/AIDS

II.3.3.1. GENERAL KNOWLEDGEABILITY ABOUT STI/AIDS

Table 3 sums up the assessment of the subjects' general knowledgeability about STI/AIDS.

Table 3. Distribution of Subjects as per General Knowledgeability about STI/AIDS

General knowledgeability about STI/AIDS	n	Values sought
1. Has already heard of STIs	200	Yes: 86.5 percent No: 13.5 percent
2. Has already heard of AIDS	200	Yes: 97 percent No: 3 percent

[20] Aventin L. Huard P (1998), VIH/SIDA et entreprise en Afrique : une réponse socio-médicale à l'impact économique ? L'exemple de la Côte d'Ivoire- *Gestion des informations sociales - MOST. Document de travail N°19*.
[21] ibidem
[22] MICS-Côte d'Ivoire Enquête à indicateurs multiples - *ENSEA/UNICEF, p.65*, 2000.

3. AIDS does exist	200	Yes: 96.5 percent No: 4.5 percent
4. Meaning of AIDS	200	Right: 38.5 percent Wrong: 9.5 percent Does not know: 52 percent
5. Malaria facilitates AIDS-infection	200	Yes: 14 percent No: 46.5 percent Does not know: 39.5 percent
6. Having an STI facilitates HIV-infection	200	Yes: 67 percent No: 18.5 percent Does not know: 14. 5 percent
7. AIDS can trigger other diseases	200	Yes: 83.5 percent No: 6.5 percent Does not know: 10 percent
8. Knowledge of the existence of a drug to cure AIDS	200	Yes: 28 percent No: 63 percent Does not know: 9 percent
9. AIDS is curable	200	Yes: 8 percent No: 92 percent

Several lessons are to be drawn from Table 3: virtually all the respondents had already heard of STIs (86.5 percent) and AIDS (97 percent) through several channels, including medical services, mass media (Radio, Television, Printed press), friends and family.

Regarding the fact of having already heard of AIDS, the same remarks are made elsewhere, with 92.8 percent of respondents who have already of it[23]. Besides, we could notice that 96.5 percent of the individuals surveyed in Abengourou believe in the existence of AIDS, and that confirms the survey conducted at STAR AUTO[24].

However, 61.5 percent of the respondents have no idea of the meaning of "AIDS" and 14 percent thought that malaria favored AIDS. Sixty-seven (67) percent of the respondents knew of the role of STIs in HIV transmission. For 72 percent of them, there is no drugs for AIDS and for those who know of the existence of such drugs, 92 percent assert that AIDS is not curable.

Some misconceptions about the role of malaria in HIV transmission and about information on AIDS treatment are defended in Abengourou and in other surveys[25] as well. ***This shows that even if messages are disseminated through the various channels of communication, it would be advisable to check their contents and also to take into account all these biases.***

II.3.3.2. *KNOWLEDGEABILITY ABOUT HIV-AIDS TRANSMISSION*

Table 4. Subject Distribution as per Knowledgeability about AIDS Transmission

Knowledgeability about HIV-AIDS transmission	n	Values sought
1. By injection drug use	200	Yes: 77,5 percent No: 22,5 percent
2. By having unprotected sex	200	Yes: 95,5 percent No: 4,5 percent
3. Through mosquito bites	200	Yes: 32,5 No: 63,5

[23] ibidem

[24] Buhler W. Kouamé I.P (2003), Programme de lutte contre le VIH/SIDA à Starauto - *Rapport d'étude, Abidjan.*

[25] UNISA ABET Institute Daimlerchrysler KAPB Baseline Study - *UNISA ABET Institute/GTZ, www.weforum. Org/globalhealth/cases*,2001.

4. Through blood-smeared objects	200	Yes: 95 percent No: 3 percent Does not know: 2 percent
5. Through blood transfusion	200	Yes: 91,6 percent No: 4,7 percent Does not know: 3,7 percent
6. From an infected pregnant woman to her child-to-be	200	Yes: 82 percent No: 12 percent Does not know: 6 percent
7. By wearing the clothes of an infected individual	200	Yes: 21 percent No: 77 percent Does not know: 2 percent
8. During group circumcisions /excisions with contaminated material	200	Yes: 98 percent No: 2 percent
9. By marrying the wife /husband of a deceased relation	200	Yes: 86,5 percent No: 4,5 percent Does not know: 9 percent
10. During reunion celebrations (Yam festivals, Easter celebrations)	200	Yes: 55,5 percent No: 41,5 percent Does not know: 3 percent
11. In unfinished buildings	200	Yes: 56 percent No: 41,5 percent Does not know: 2,5 percent
12. In marketplaces by night.	200	Yes: 60 percent No: 40 percent

Table 4 shows a good knowledgeability about the usual ways of HIV contamination, that is injection drugs use (77.5 percent), blood transfusion (91.6 percent), unprotected sex (95.5 percent), blood-smeared objects (95 percent), pregnant mother-to-child (82 percent) and during circumcisions/excisions (98 percent). In addition to the aforementioned ways of contamination, there are other ways of transmission: levirate /sororate (86.5 percent), unfinished buildings (56 percent), reunion celebrations (55.5 percent). The MICS-Côte d'Ivoire Survey[26], already quoted, and the survey conducted by Konaté[27] noted all these ways of transmission. Therefore, it should be expected that in our survey, the knowledgeability about all these ways should have an impact on the attitudes and practices of the surveyed populations. Unfortunately, as we will see later, it is not so.

Furthermore, some biases concerning the routes of contamination are worth noting, namely: mosquito bites (32.5 percent) and the fact of wearing the clothes of an infected individual (21 percent). ***These results do show that in developing sensitization messages, these biases which do not favor positive attitudes towards AIDS-infected individuals should be taken into account.***

II.3.3.3. KNOWLEDGEABILITY ABOUT RISK BEHAVIORS

It is to be noted that the respondents knew of the usual risk behaviors as **Table 5 shows**: having several sexual partners (97 percent), having unprotected sex (94.5 percent) and interacting with sex workers (91,5 percent), hanging around drinking places (54 percent), hanging around bars, hotels and night clubs (59 percent), having sex under the influence of alcohol (88 percent).

Table 5. Subject Distribution as per Knowledgeability about Risk Behaviors

Knowledgeability of risk behaviors	n	Values sought
1. Hanging around drinking establishments (*maquis*)	200	Yes: 54 percent No: 44 percent Does not know: 2 percent
2. Hanging around bars, hotels and night clubs	200	Yes: 59 percent No: 38 percent Does not know: 3 percent
3. Having several partners	200	Yes: 97 percent No: 3 percent

[26] MICS-Côte d'Ivoire Enquête à indicateurs multiples- *ENSEA/UNICEF, p.65*, 2000.

[27] Konaté, Analyse situationnelle du Moyen-Comoé, Côte d'Ivoire, mars, 2004

4. Having unprotected sex	200	Yes: 94.5 percent No: 5.5 percent
5. Interacting with sex workers	200	Yes: 91.5 percent No: 8.5 percent
6. Having one's nails cut/beard cut by itinerant barbers	200	Yes: 96.9 percent No: 3.1 percent
7. Having sex while under the influence of alcohol	200	Yes: 88 percent No: 9 percent Does not know: 3 percent

These (outstanding!) responses underscore the gaps between theory and practices (see next chapters) adopted by the populations in the Commune of Abengourou and should appeal to the managers of STI/HIV/AIDS control organizations and ***mostly the Municipal Authority*** to identify, in addition to knowledgeability indicators, other more relevant items that can reflect people's practices. Some behavioral model surveys attempt to understand people's behavioral motivations and attitudes for a better prevention of HIV/AIDS[28].

Some people wrongly claimed that the use of syringes in neighborhood clinics did not constitute a risk behavior (38.5 percent).

As already mentioned, such attitudes must be the focus of sensitization messages to avoid people having individual "conceptions" of HIV/AIDS, as is the case elsewhere in developing countries like Côte d'Ivoire where there is a multiplicity of AIDS control organizations that are not often trained (NGOs, Associations, Committees). Moreover, it would be appropriate to initiate actions fostering know-how and awareness amongst the people in Abengourou City.

II.3.3.4. *KNOWLEDGEABILITY*

Forty-one (41) percent have a level of knowledgeability about AIDS deemed "good" unlike the already mentioned Daimler-Chrysler survey where the proportion of subjects who answered most of the questions about knowledgeability ranged between 75 percent and 85 percent[29].

Even if individually, most answers to the questions on knowledgeability are satisfactory in the Abengourou survey, it should be noted that the proportion of subjects having good knowledge of AIDS is low, with 41 percent. This low proportion may be due to the weighting used (see Annex), which has not been sufficiently tested, even if it serves as a seminal basis for future assessments of AIDS-control actions. Besides, the weights assigned and the selected knowledgeability determinants differ from the determinants used in the Daimler-Chrysler[30] survey.

II.3.4. SUBJECTS' STI/AIDS-RELATED ATTITUDES

II.3.4.1. *GENERAL ATTITUDES*

Table 6. Subject Distribution as per Attitudes

General attitudes	n	Values sought
1. Possibility of being personally HIV-infected	200	Yes: 64 percent No: 36 percent
2. Procuring condoms is embarrassing	200	Yes: 9.5 percent No: 90.5 percent
3. Notifying one's partner if one is AIDS-infected	200	Yes: 87 percent No: 13 percent
4. Continue to associate with a relation or friend if the latter is AIDS-infected	200	Yes: 89.5 percent No: 10.5 percent
5. Authorize infected individuals to work	200	Yes: 73.5 percent No: 26.5 percent

[28] Fisher J.D; Fisher W.A,Williams S.S, Malloy T.E Tests empiriques d'un modèle de comportement préventif du SIDA avec des homosexuelles et des étudiants hétérosexuels : information, motivation, aptitudes comportementales,1998.
[29] UNISA ABET Institute Daimlerchrysler KAPB Baseline Study - *UNISA ABET Institute/GTZ, www.weforum. Org/globalhealth/cases*, 2001.
[30] ibidem

Table 6 enables us to make a number of comments:

Embarrassment when procuring condoms (9.5 percent); non-compulsoriness of the notification of one's partner (13 percent) when one is AIDS-infected and discontinuation of the relationships with a next of kin or a friend when the latter is AIDS-infected.

This is a situation that is to be addressed in the fight against STI/AIDS. Concerning condoms, behavioral surveys on HIV/AIDS[31] have shown that their purchase must remain covert to ensure an effective coverage.

II.3.4.2. SUBJECTS' ATTITUDES SINCE THEY HAVE BEEN MADE AWARE OF AIDS

Since they have been informed of AIDS, the subjects have adopted responsive attitudes marked by the several elements presented in **Table 7.**

Table 7. **Distribution of Subjects since the Outbreak of AIDS**

Attitudes since AIDS has been publicized	n	Values sought
1. Condom use	200	Yes: 77.2 percent No: 22.8 percent
2. Faithfulness	200	Yes: 81.4 percent No: 18.6 percent
3. Abstinence	200	Yes: 44.1 percent No: 55.9 percent
4. Non interacting with sex workers	200	Yes: 80.3 percent No: 19.7 percent
5. Avoidance of levirate and sororate		Yes: 77.2 percent No: 22.8 percent

Since they have been informed of AIDS, the respondents have adopted responsive attitudes marked by several elements:

- Over 80 percent of subjects claimed to be faithful to their partner: these data are encouraging for the continuation and intensification of the awareness-raising drive already conducted in Abengourou.

However, they raise questions regarding, among other things, what people mean by "*faithfulness*"? Is it possible to claim faithfulness with more than one partner? In the African and Ivorian context, specifically, where polygamy is accepted, we have to admit that for subjects who have more than one partner and are constantly with them, speaking of *faithfulness might be quite understandable*. All such notions make the preventive control of AIDS difficult in African contexts.

Besides, over 70 percent of the respondents claimed to use condoms. The survey conducted at Daimler-Chrysler's showed that 48.97 percent of individuals claimed having already used condoms[32]. The use of condoms by the respondents is confirmed by the neighborhood talks held in the Commune of Abengourou where the participants said rightly about condoms: "they are means to prevent STI/HIV/AIDS and for contraception".

II.3.4.3. LEVELS OF ATTITUDES

It is noted that 85 percent of respondents adopted attitudes deemed "good". Among other lessons to be drawn from this datum is the fact that in Abengourou stigmatization and other elements of ostracism of AIDS-infected individuals are minimized (even though such practices do exist: 10.5 percent) thanks to the different actions of awareness-raising conducted by the various AIDS control organizations active in this Commune.

What's more, this shows in the claims of individuals who would be ready to continue to associate with an AIDS-infected friend or parent (89.5 percent), even if they are afraid of AIDS (54,6 percent).

II.3.5. SUBJECTS' SEXUAL PRACTICES

[31] La Ruche G., Djeha D, Boka Y. et al La lutte contre les maladies sexuellement transmissibles en Côte d'Ivoire : quelles stratégies face au VIH/SIDA ? Cahier santé : 10 287-292,2000.

[32] UNISA ABET Institute Daimlerchrysler KAPB Baseline Study-*UNISA ABET Institute/GTZ, www.weforum. Org/globalhealth/cases*, 2001.

II.3.5.1. GENERAL SEXUAL PRACTICES

Table 8 shows that the respondents in Abengourou were aged 17 on average when they had sex for the first time. Touré[33] indicated in his study a mean age of 17.3.

Table 8. Subject Distribution as per Sexual Practices

General sexual practices	n	Values sought
1. Age when the subject had sex for the 1st time	192	Average: 17 Minimum: 10 Maximum: 25
2. Regular sexual partner	192	Yes: 69.8 percent No: 30.2 percent
3. Live under the same roof	138	Yes: 47.8 percent No: 52.2 percent

The control program the Town Council will establish should build on this information to develop strategies that can enable the populations to enforce in their lives the education they are provided in terms of HIV/AIDS.

II.3.5.2. CONDOM USE

It is to be noted that in **Table 9,** 86.5 percent of the surveyed populations are already using condoms, sign that they know the use of it. These results are however to be taken with caution for they may not reflect reality. Indeed, to comply with a certain "social standard", the respondents often overestimate the use of condoms. Thus, although the use of condoms is recognized, it is most often irregular. In the already quoted Daimler-Chrysler survey, 48.97 percent of subjects claimed having already used condoms.

Table 9. Subject Distribution per Condom Use

Condom use	n	Values sought
1. Having already used condoms	200	Yes: 86.5 percent No: 13.5 percent
2. Condom used with their partner the last time they had sex	114	Yes: 41.8 percent No: 58.2 percent
3. Condoms make sex feel less pleasurable	185	Yes: 41.1 percent No: 58.9 percent

Furthermore, the previous Table shows that 41.1 percent of individuals considered that condoms made sex less pleasurable; 58.2 percent refused to use condoms the last time they had sex because that would have reduced their sexual pleasure. These data reflect the lack of reliable information on the role and importance of condoms in STI/HIV prevention.

Therefore, the interventions will seek to reduce the proportion of subjects who refuse to use condoms on the only ground of "lack or loss of pleasure". Among these interventions, we could also mention options such as reducing the price of condoms and making them readily available in the neighborhoods and villages in the Commune of Abengourou.

II.3.5.3. SEXUAL PRACTICES SINCE PEOPLE HAVE BEEN MADE AWARE OF AIDS

According to the results in **Table 10**, since they have been informed of AIDS, 80.2 percent of the populations said they have had unprotected sex and 35.1 percent have experienced condom burst during sexual intercourse against 13.63 percent in the Daimler-Chrysler[34] survey. Our data raise the issue of condom use, which should be a full-fledged part of the control structures' activities and be demonstrated. Currently,

[33] Touré, Profil des patients atteints d'infections sexuellement transmissibles au dispensaire antivénérien de l'INSP d'Abidjan - *Thès.Med.Abidjan, N° 3366/03*,2003

[34] UNISA ABET Institute Daimlerchrysler KAPB Baseline Study-*UNISA ABET Institute/GTZ, www.weforum. Org/globalhealth/cases*,2001.

many surveys underscore an inadequacy between the respondents' level of knowledge and the use of condoms: adequate knowledgeability and non-use of condoms[35].

Table 10. Subject Distribution as per Sexual Practices since the Subjects were made Aware of AIDS

Sexual Practices since the Subjects were made aware of AIDS	n	Values sought
1. Sex with sex workers	188	Yes: 3.7 percent No: 96.3 percent
2. Unprotected sex	192	Yes: 80.2 percent No: 19.8 percent
3. Condom burst during intercourse	185	Yes: 35.1 percent No: 64.9 percent

II.3.5.4. SEXUAL PRACTICES OVER THE PAST TWO YEARS

By and large, sexual practices remained much the same except for a slight reduction in the proportion of subjects having sex with casual partners as **Table 11** shows. Even if our survey shows a reduction in the average number of casual partners, the role of multiple partners in the fuelling of the AIDS epidemic is to be recognized. Some surveys have shown that 40.1 percent[36] and 25 percent[37] of subjects had several partners. Unfortunately, in our survey, 13 percent of individuals would refuse to notify their partners if they had AIDS.

Table 11. Subject Distribution as per Sexual practices in 2004-2005

Sexual practices	2004	2005
1. Sex with casual partners	Yes: 48,4 percent No: 51,6 percent	Yes: 36,5 percent No: 63,5 percent
2. Number of casual partners	Average: 5 Minimum: 1 Maximum: 10	Average: 3 Minimum: 1 Maximum: 8

This shows that in Africa "AIDS is more than a health problem; it is a social problem, an economic one, and the problem of the people who are yet a full-fledged part of the solution"[38]. Sensitization should integrate these dimensions of the issue.

II.3.5.5. LEVELS OF SEXUAL PRACTICES

It is to be noted that only 3 percent of the respondents have a "good" level of sexual practice against 97 percent, who have an "improper" practice. In Koffi's survey[39], only 0.4 percent of the respondents have a "good" level of sexual practice against 99.6 percent, who have an "improper" practice.

Despite a satisfactory overall knowledgeability (41 percent) and a level of attitudes qualified as "good" (85 percent), the level of sexual practices is far from meeting the expectations in such circumstances, especially when STI/AIDS control structures have been established for a while. It is true that changing behavior is an enduring activity for as psycho-sociologists say behaviors are contingent on individuals and their backgrounds (C=C(I, B)).

Indeed, AIDS prevention should not be "limited to the provision of services, information and condoms; these services should go along with structural and political changes that foster an environment in which people can easily reduce or control their exposure to HIV" [40].

[35] M.Larsen, S.E. Casey, M-T. Sartie et al., Changes in HIV/AIDS/ STI Knowledge, Attitudes and Practices among Commercial Sex Workers and Military Forces in Porto Loko, Sierre Leone. Disasters, 2004, 28 (3): 239-254

[36] Touré, Profil des patients atteints d'infections sexuellement transmissibles au dispensaire antivénérien de l'INSP d'Abidjan- *Thès.Med.Abidjan, N° 3366/03*,2003

[37] Darlène L.R, Marion S.A, Dedy S. et al. (1993), Changes in University Students' AIDS-related Knowledge, Attitudes and Behaviours, 1988 and 1992- *Canadian Journal of Public Health, vol 84, N°4, July-August: 275-278.*

[38] Population Council (1998), Prévention et soins du SIDA au niveau communautaire en Afrique : s'appuyant sur l'expérience tirée des initiatives locales. Résultats de quatre interventions en recherche pratique en Afrique de l'Est et en Afrique Australe- *Population Council/Position Action*, *P.35*

[39] Koffi M., Analyse situationnelle des IST/VIH-SIDA à IPS (WA), mars 2004

[40] OMS (1999), Population et Développement de l'Afrique- OMS, juin-juillet, p.39

Once again, knowledgeability does not necessarily go together with good practice, especially when the behavior plays a pivotal role

The improper behaviors identified in our survey could well be said to foster negative effects of AIDS on the Commune of Abengourou.

III. NEIGHBORHOOD DISCUSSIONS

III.1. OBJECTIVES

The specific objectives of this survey are as follows:

Assess the populations' HIV/AIDS-related knowledge, perceptions and (current, to be promoted and stimulating factors behind) practices;

Identify social and cultural factors that favor HIV/AIDS;

Identify the reasons accounting for such behaviors and perceptions;

Identify networks and channels of communication within the various communities in the Commune of Abengourou;

Identify communicational approaches based on the segmentation of the Commune of Abengourou.

III.2. FOCUS GROUP DISCUSSION (FGD)

Eight focus groups were set up. Each focus group comprised five participants at least and seven participants at most, that is a total of forty-eight. The questions in the discussion guide are focused on the participants' knowledge, attitudes and practices and the communication plan on STI/HIV/AIDS. The purpose was to assess their knowledgeability, identify subjects having risk behaviors, the aftermaths of STIs and HIV/AIDS on the Commune of Abengourou as a whole, and identify communicational approaches. The selection of this approach is motivated by the fact that focus groups generate considerable information much faster and at a lesser cost than individual interviews. As a rule, communities accept them better for they resort to group discussion, which is a natural form of communication in most communities.

Focus Group Discussions are not a series of individual interviews but rely on group dynamics and the flow of discussions to deepen the topic under consideration.

For this survey, a Focus Group Discussion guide has been developed and pre-tested before being used; the method is described in **(Annex…)**.

III.3. GROUP DYNAMICS

On the whole, the majority of the selected participants, aged 15 and over, from all walks of life and of both genders expressed themselves on nearly all the questions raised in connection with STI/HIV/AIDS and the answers to questions are to be analyzed and interpreted.

III.4. COMPUTERIZED DATA PROCESSING

For the data to be used, each transcription was studied separately for coding. This facilitates the processing and sorting of codes with the software QSR NUD*IST or EXCEL for them to be entered in the register. In this register all the answers are classified by theme, that is the participants' features, their knowledge, attitudes, practices and the communication approaches in response to STI/HIV/AIDS in the Commune of Abengourou.

III.5. RESULTS OF THE TALKS AND COMMENTS

III.5.1. LIMITATIONS OF FGDs (FOCUS GROUP DISCUSSIONS)

The participants often amicably agree on answers, hence the need for a degree of caution in assessing the results. The results yielded by these focus groups cannot be extended to society, in the broadest sense of the term: they can provide a range of standpoints and opinions but not their frequency of dissemination within society. However, it should be underlined that the likely impact of the aforementioned limitations concerning the reliability of these results is low because the subject matter of the survey and its goal had been explained to the selected participants before the trained facilitator launched the FGD.

III.5.2. FEATURES OF THE SAMPLE

The results of the survey show that:

Overall, 48 individuals took part in the Focus Group Discussions, including 23 women and 25 men;

The average age of the participants was 22, with a minimum of 15 and a maximum of 55;

The average household size is of 8 members, with the minimum and maximum ranging from 2 to 20;

Table 12. Kinship of the participants in the talks with the household head		
Kinship	Size	Percentage (percent)
Household head himself/herself	4	8
Spouse of the household head	3	6
Children of the household head	33	69
Others	8	17
Total	48	100

Over 80 percent of the participants were either household heads (8 percent) or spouses (6 percent) or sons or daughters to the household heads (69 percent);

More than half of the participants in the Focus Group Discussions attend junior high schools (54 percent), primary school children and the subjects who did not attend schools account for a quarter of the sample, that is 19 percent and 6 percent, respectively (see Table 13);

Table 13. Level of education of the participants in the conversations		
Educational level	Size	Percentage
Uneducated	3	6
Primary school	9	19
Junior school	26	54
High school	8	17
Higher education	2	4
Total	48	100

The participants' matrimonial status **(See Table 14)** shows that no participant is a divorcee (0 percent). Those who are legally or traditionally married are less numerous (10 percent). Over 90 percent of the participants are single and the sample includes no widow (0 percent).

About 54 percent of the participants in the Focus Group are unemployed, 35 percent work in the informal sector and only 10 percent have a wage-earning job **(See Table 15).**

Tableau 15. Economic Status of the Participants in the Talks		
Economic Status	Size	Percentage
Wage-earner	5	10
Informal Sector	17	35
Unemployed (pupil, unemployed, housewife, retired)	26	54

Table 14. Matrimonial Status of the Participants in Conversations		
Matrimonial status	Size	Percentage
Married or living in a couple	5	10
Single	43	90
Divorced	0	0
Widow (er)	0	0
Total	48	100
Total	48	100

The data analysis shows that the average age of the surveyed populations is inferior to 50 by half, that is 22 years. But surveys showed that people that are most affected by HIV/AIDS all over the world are aged 15-49, a key period in working life (sexually active)[41]. This means that the populations in the Commune of Abengourou remain potentially vulnerable to HIV/AIDS.

[41] OMS& ONUSIDA, Rapport sur le VIH-AIDS, 2003.

However, 10 percent of the participants being married, we can say *a priori* that they are less susceptible to the risks of catching STI/HIV/AIDS sexually. It would be so only if they were faithful or used condoms with their other partners. Even in that case they would remain vulnerable to HIV/AIDS. For, there are always risks of catching this disease through wounds by blades, needles and other means.

Singles represent 90 percent of the respondents. As compared with married individuals, they are *a priori* more exposed to STI/HIV/AIDS by sexual route. For they are single either because they are reluctant to marry or because they have several partners.

It is furthermore noticeable that the average household membership of the respondents is approximately of eight individuals. This figure is in excess of the average number of individuals per household, which is of six members, in Côte d'Ivoire[42]**. Therefore, in case of infections amongst the population in the Commune of Abengourou, several individuals would be affected as a result**.

III.5.3. KNOWLEDGEABILITY OF STI/HIV/AIDS

The participants in the various focus groups are knowledgeable about STIs, HIV/AIDS and condoms.

Concerning the participants' knowledgeability about STIs, it emerges that the various focus groups know about such diseases and most of the participants define them as "diseases caught during unprotected sexual intercourse".

Some participants mentioned a few STIs (zoster, syphilis, gonorrhea, and AIDS) and their symptoms. According to one participant, "the change from STD as initially referred to to STI now is due to AIDS". Because "AIDS is said to be part of STIs".

In terms of knowledgeability about HIV/AIDS, the participants' statements can be summed up in three points, that is:

- The definition of AIDS
- The difference between a HIV-positive individual and an AIDS-infected individual
- AIDS treatment and preventive means.

For participants AIDS is defined as the Acquired Immuno-Deficiency Syndrome. It is due to the Human Immunodeficiency Virus (HIV). They mentioned the following routes of transmission: sex, contamination by blood, accidental contamination (razors, blades…), mother-to-child transmission during pregnancy, transmission on delivery and during breastfeeding. Some participants listed sputum as another path of transmission, which some other participants dismissed. And as one participant put it "I disagree for saliva; what is in question is rather mouth-sores". Another participant seconding this position noted "Otherwise everybody would die".

If for some participants an AIDS-infected individual is recognizable by clinical signs and through the screening test, for the others "it is difficult to know by sight". For, "if an individual has not developed the disease yet, he cannot be recognized as such".

Most of the ethnic languages have a local name for AIDS:

- In Mandingo, it is referred to as "si ban banan" (disease for life)
- In Mandingo, it is called "banan djougou ba" (great and bad disease)
- In Mandingo, it is also referred to as "si dan" (life end)
- In Agni, it is called "babasro"
- In Baoulé, it is referred to as "nzissikokolo" or "babasro"
- In Bété, it is called "fâ"(women disease).

Furthermore, the mentioning of the screening test as a mean to identify an AIDS patient was disputed by one participant who claimed that "the screening test is meant for those with the virus but who are not sick yet".

As far as the difference between a HIV-positive individual and an AIDS patient is concerned, there are on the one hand those who make a distinction: for them "the HIV-positive individual has a virus in his blood but has not yet developed the disease. As for AIDS patients, they have the virus in their blood and develop the disease and opportunistic infections." In other terms, "it is the stage when the disease shows, when all the symptoms are apparent".

[42] Institut National de la Statistique, Recensement Général de la Population et de l'Habitat, Côte d'Ivoire, Abidjan, 1998.

There are on the other hand those who make no difference: to them "HIV-positive individuals and AIDS patients are just the same".

A third group of participants claim they cannot make any difference, for "This AIDS thing is not something you can recognize when someone has it".

On AIDS treatment, there are two trends:

For most participants, there is no cure to AIDS because there is no vaccine. They assert that the patient can be helped to live longer by means of an adequate treatment though these "drugs do not destroy the virus in the blood".

As for the other trend, which is less voiced, AIDS can be cured. The participants in this category refer to traditional healers or "*comian* or traditional healers" "for all the molecules that are found in tablets and other medications are found in herbs". They end up saying "solutions are to be found in the forest".

There are two noteworthy facts regarding the means of prevention of AIDS. On the one hand, most of the participants listed elements related to the two modes of transmission: sexual contamination and blood contamination. Concerning sexual transmission, one participant underscored that enforcement is not easy. On the other hand, some of the participants (a minority) made proposals regarding risk behaviors. "Close rue princesse in Dioulakro neighborhood and bars", for example.

As for participants' knowledgeability about condoms, it emerges from the discussions that for the participants condoms are a mean to prevent STI/HIV/AIDS and for contraception. In effect, they describe it either as "an object in latex used during sexual intercourse to avoid STIs and pregnancies" or as "little hats you wear on peter during the thing". Some participants furthermore mention the existence of a female condom. This being said, where can these condoms be bought?

According to the various participants they can be procured in pharmacies, hotels, "from DIALLOs' " that is Mauritanian retailers. Purchase from Mauritanian retailers is however subject to controversy. And according to one participant they will not sell condoms on "religious grounds". He added: "to them, condoms promote sexual promiscuity". Except for this case, "condoms are seemingly available everywhere".

The interpretation of these results will thus be presented focusing on two aspects, that is: STI/HIV/AIDS-related data on the one hand, and the results concerning condoms on the other hand.

In most focus groups discussions, the participants answered unequivocally that STIs are "diseases gotten during unprotected sexual intercourse".

If the acronym STI (Sexually Transmitted Infection) roughly provides an answer, it should be underlined that the tendency for participants to define STIs by their ways of transmission reflects a desire: linking the prevention of these infections with their ways of transmission. In effect, it emerges from these results that participants know these STIs better through their ways of transmission. For them, "considering the way of transmission, it is avoidable".

Likewise, on the difference between a HIV-positive individual and an AIDS patient, some participants were able to distinguish clearly both stages. Talking about such knowledgeability, one participant said "we acquired it from books, on TV and on the radio, or outside and elsewhere".

If the participants seem knowledgeable about STI/HIV/AIDS , the results were however tainted by some distortions and misconceptions. And they must be corrected in the recommendations.

It was repeatedly argued that "AIDS is communicable through sputum". The discussion on this mode qualified by health specialists as an "impossible way of transmission" reflects a lack of information amongst the participants and the dysfunction of the HIV/AIDS control committees in the Commune of Abengourou.

There are also those for whom "HIV-positive individuals and AIDS patients are just the same"; hence the misconception that screening tests are meant to recognize AIDS patients. Very often such misconceptions and biases stemming from the lack of information and training are the root causes of phenomena like stigmatization and discrimination.

The participants are all the more familiar with condoms, as they existed before the advent of AIDS. They were used as a mean for contraception, that is to avoid unwanted pregnancies.

Currently, condoms or sheaths have been assigned another use: preventing STI/AIDS. In effect, for the time being prevention is the only effective weapon since there is no vaccine against this pandemic.

In this regard, participants recognize that condoms are not the only means for prevention even with regards to the sexual transmission pattern. Abstinence and faithfulness to the sexual partner also constitute other means.

By linking prevention and way of transmission, the participants do not automatically exclude the other transmission routes, notably: blood and accidental contamination, mother-to-child transmission, transmission during pregnancy, on delivery and during breastfeeding.

Here are selected statements related to the knowledgeability about STI/HIV/AIDS collected in the sample census districts in the neighborhoods of the Commune of Abengourou:

- Man "We know for a fact that there is no STIs without sex intercourse. And if such intercourse is unprotected diseases such as AIDS and gonorrhea can occur".
- Woman "We know these are terrible diseases"
- Woman "It is known that AIDS is a serious and fatal disease".
- Man "This AIDS thing kills".
- Woman "It makes you lose weight".
- Man "It is a dangerous disease, for one thing; it is quite contagious for another thing; and thirdly it is causing much damage all over the word".
- Man "It causes diarrhea".
- Woman "It's an STD".
- Man "You can get AIDS if you go with a girl unprotected".
- Woman "If you use a blade that has already been used to shave an AIDS patient".
- Woman "By using a contaminated syringe".

III.5.4. STI/HIV/AIDS-RELATED ATTITUDES

They will be discussed under three headings:

- The behavior of the participants towards an infected individual (third party, next of kin, workmate).
- Their opinions about an infected individual who keeps on working.
- The existence of transmission factors in the Commune of Abengourou.

On the first item, we may distinguish two positions. On the one hand, there are participants who clearly express their reactions: those who claim to maintain the same behavior as towards uninfected individuals; those who argue that they would be cautious and those who say they would be supportive.

On the other hand, there are participants who indicate the policy to adopt vis-à-vis an infected individual. They are in greater number. Most of them advocate demonstration of support and affection. Others advise referral to a physician, the maintenance of relations, acceptance and proper keeping of sharp objects, and assistance.

On the second item, three cases may be identified. There are those who voice their opinions clearly. They are the larger group. Amongst them a minority is for the maintenance of the infected individual in his position. Others suggest a change in position and/or a workload reduction. A participant in Cafetou is against if the individual concerned is an AIDS patient. There are on the other hand participants, who without voicing their standpoints mention either what has already been suggested, that is "referring the patient to a physician, or providing him/her support by all means" or suggest a position change or a workload reduction, transfer to a service that is safe from "risk of injury".

Concerning the third item pertaining to the existence of places favoring transmission in the Commune of Abengourou, all the participants in the various focus groups provided positive answers. They listed bars, hotels, drinking establishments (*maquis*), unfinished houses, market places by night.

It emerges from the statements of the participants who expressed clearly what their behavior would be towards an infected individual, that they accept or would accept to associate with STI and HIV/AIDS-infected individuals, be they third parties, a next of kin or a workmate. Can the same be said for those who without voicing their standpoints mentioned the policy to be adopted towards an individual?

For sure they are fairly knowledgeable about the appropriate behavior[43] towards an infected individual and their needs.

Concerning the participants' opinion about an infected individual who keeps on working, we can assert that those who clearly voiced their views approve of their working as long as they are fit enough to do so. What's

[43] AVOAKA (M-J), Formation des pairs : guide du participant, Abidjan, Centre de Coopération Internationale en Santé et Développement, 2000.

more, this is what the International Labor Organization advocates and states, "People infected by HIV-related diseases should be able to work as long as they are medically fit to hold an available and appropriate job" [44].

Did the participants who, without expressing clearly their opinions, mentioned what it would be appropriate to do, do so because they concur with the foregoing stance?

Regarding the existence of places constituting STI/HIV/AIDS transmission factors in Abengourou City, it being mentioned by all the participants is less revealing than the types of examples they gave in support of their standpoints.

Here are selected statements related to the knowledgeability about STI/HIV/AIDS collected in the sample census districts in the neighborhoods of Abengourou Commune:

- *Woman "If someone has AIDS, well me I keep way from him".*
- *Woman "Well, me I get close to him to raise his spirits, to encourage him".*
- *Man "I will continue to stay with him".*
- *Woman "I'll take care of him".*
- *Man "I stay close to him and chat a lot with him".*
  - Man "Me, I encourage him to keep on working".
  - Man "I'll tell him to keep on, to do as if nothing had happened".
  - Woman "Most of the time from the prostitutes. These are places where there are risks of transmission".
  - Woman "Yeah, in public toilets".
  - Man "In *maquis* and night clubs".
  - Man "You can get it everywhere, even at home.

III.5.5. STI/HIV/AIDS-RELATED PRACTICES

The result-oriented activities revolve around four key items:

STI/HIV/AIDS treatment and prevention strategies;

HIV/AIDS screening test;

The impacts of STI/HIV/AIDS on the Commune of Abengourou;

The strengths and limitations of STI/HIV/AIDS control committees active in the Commune of Abengourou.

As far as STI (sexually transmitted infections) treatment is concerned, several respondents argue that "they readily get treatment" since "the health facilities in the Commune of Abengourou are manned by doctors and nurses" who ensure "consultations and make diagnoses for such ailments" to administer appropriate treatment to infected individuals. Some participants assert that sensitization campaigns and the prevention of STI/HIV/AIDS through "condom distributions" are conducted by health workers, committees and non-governmental organizations involved in STI/HIV-AIDS control but at "irregular intervals". Concerning STI/HIV/AIDS control committees, their mandates are as follows: train "peer educators, supervisory staffs", conduct sensitization drives and community mobilization. And they add, "The Town Council makes no move".

On that score, several respondents note that the activities of the said committees are "at a standstill". And only the members of those committees can account for this situation as one participant said, "it lies with the committees to explain what happened".

As regards the screening test, according to a few participants, it is "a biological test performed on human serum to detect the virus in the blood" in order to check "the prevalence of the disease". It "enables an individual to know how to behave, to be aware of their serostatus and orient their life". The result is "confidential". As such its management is the responsibility of practitioners and patients, "the physician and

[44] Bureau International Travail, Recueil de directives pratiques du B.I.T sur le VIH-SIDA et le monde du travail en Afrique, Genève-Paris, B.I.T, 2003.

the patient" according to all the respondents. While they give an accurate definition of the screening test, they underscore that practice is "difficult", even tricky. They claim "to be afraid".

On the consequences of STI/HIV/AIDS on the Commune of Abengourou, several respondents note that there are scores of consequences: deaths related to "these scourges are in greater number in families", extended work discontinuations "for a year", absenteeism and its aftermaths, decline in productivity in the various business sectors", "overwork" (double workload) in the enterprises operating in the Commune of Abengourou which spend "a lot on sick people", "sick individuals are hardly productive for "they are physically weakened" and the Commune of Abengourou is "the loser" under such circumstances for "lack of sensitization".

At the level of the Abengourou Town Council, some respondents argue that they take care of "a few isolated cases, and that's it". And for most respondents they indicate having no accurate idea of the activities conducted by the Abengourou Town Council and/or the municipal committee since it was established: "We know nothing about how this municipal HIV/AIDS control committee operates". As far as medical care is concerned, they add that the Town Council "does not often take the participants into account".

The review of STI/HIV/AIDS-related practices show that despite the existence of STI/HIV/AIDS control committees, NGOs and the presence of health workers in the Commune of Abengourou, several participants do not yet master STI/HIV/AIDS prevention techniques due to the timidity and irregularity of the activities of the aforementioned STI/HIV/AIDS control entities and agents. Now, prevention is the most effective strategy to control STI/HIV/AIDS [45] since there is not yet any cure to AIDS.

The structures existing in the Commune of Abengourou can contribute to the prevention of these affections and the pandemic of the century by providing information that are specific and understandable to all, by promoting safe sex. The screening test should come in addition. But for laboratory tests performed in the Commune of Abengourou to be reliable they must be performed by qualified staff.

In effect, if the staffs have not been properly trained, the results can induce errors[46]. This seems to account partly for several participants' "fear" to undergo the screening test. This fear can partly be due to the fact there is not yet any cure to eradicate the virus.

The assessment of the consequences of STI/HIV/AIDS on the Commune of Abengourou, enterprises and participants can be made at the following levels[47].

Increase in the frequency of absences: this is not only due to health problems but also to the fact that participants (especially women) are liable to take leaves to take care of their families and attend funerals.

Skilled workers are getting increasingly rare; wages might increase while municipal receipts are dwindling.

Costs of allowances paid by enterprises to employees: one of the weaknesses of the Town Council is the non-provision of care for infected individuals due to budget constraints. And yet, in case of demise of the family head their dependents come up against a set of problems: difficulties in catering for school fees inducing often the early quitting of school, difficulties in accessing medical care[48]. This is why the Town Council should heed more the social dimension of HIV by providing each year for a budget for AIDS control and care for infected individuals and/or the needy.

Here are selected statements about STI/HIV/AIDS-related practices collected in the sample census districts in the neighborhoods of the Commune of Abengourou:

- Woman "Me, I manage to see a doctor to provide treatment".
- Woman "Me, I go to the screening center to check if what I have is AIDS; if it is not I go see a doctor for treatment".
- Man "I had a cousin who had it. He boiled some leaves with lemon, drank it and said when he passed water the disease would be evacuated".
- Woman "To avoid STIs, you must use condoms, avoid passing water everywhere".
- Man "To avoid STIs, we must disinfect sharp objects".

[45] Fédération Internationale pour la Planification Familiale, Déclaration sur les maladies sexuellement transmissibles, le VIH-SIDA et sur la santé reproductive, Royaume–Uni,1997.

[46] ibidem

[47] ALAN WHITESIDE, L'impact économique du VIH et du SIDA en Afrique, Université du Natal, département d'économie de la santé et de recherche sur le VIH-SIDA, Afrique du Sud, 1998.

[48] FAO, L'impact du VIH-SIDA sur les institutions du développement, Harare, 6-12 juin, 1998.

- Man “To avoid catching AIDS either I have only one girl-friend and am faithful to her or if I cannot be faithful to one girl-friend, each time I have sex I use a condom”.
- Man “He who has never had sex must abstain from it”.
- Woman “We must mostly avoid using objects that have already been used by other people”.
- Woman “Talking about steps to take, we can mention faithfulness, abstinence and the use of condoms”.
- Woman “For me the screening test is a test performed to find out one’s serostatus, find out if does not carry the virus”.
- Man “Me, too, I know that the test is free, it is not charged but is a poisoned chalice”.
- Woman “I know that the test is performed at the PMI”.
- Woman “No, because if I’m told that I am HIV-positive, I will no longer be able to sleep; I will no longer be good to anything”.
- Man “Well, I’m going to do my test. If you live with a partner or a girl-friend and it so happens that it is her that you plan to marry, you are going to do your test”.
- Woman “They go from compound to compound to talk about AIDS”.
- Woman “They shoot motion pictures”.
- Woman “They visit schools to sensitize students”.
- Man “They show up at events to tell us about AIDS and distribute condoms”.
- Man “What I like most is motion pictures shown on wide screens and their going from compound to compound to tell us about AIDS”.
- Woman “What I like is their sensitization of people to the dangers of AIDS and STIs”.
- Man “The problem is that uneducated parents do not understand these issues and dislike people coming to talk sex with their children or with them in presence of their children”.
- Woman “They are given several answers for a same question from one compound to another”.
- Man “Well, anyway we can’t see anything the Town Council does for AIDS control”.

III.5.6. NETWORKS AND COMMUNICATION CHANNELS

Women heard of STI/HIV/AIDS:

- At hospital
- Outside, through participants
- Through next of kin at home
- On television

And men heard of it:

- On the street
- On television
- In books
- At school
- Through communication channels

Women identified a few communication channels:

- Going from house to house : “Some participants can walk up streets with a loud-hailer to inform the inhabitants”
- Use of the griot’s services
- Having direct talks
- Organizing debates
- Using television
- Placards in hospitals
- Using health workers (doctors, nurses, mid-wives)
- Using the local radio station

- Using neighborhood chiefs
- Establishing monitoring centers
- Organizing marches
- Sketches

Men listed the following means of communications:

- Going from neighborhoods to neighborhoods in the commune
- Frequent group discussions
- Showing motions pictures
- Drawings displaying the bad sides of AIDS
- Radios and television
- Sensitizing through tales, proverbs, plays in view of drawing a lesson, a moral.

IV. INSTITUTIONAL SURVEY

This is a survey conducted with organizations involved in AIDS control. It is a survey that was to lead to the generation of documents after interviews conducted with the various health facilities managers, leaders of NGOs and associations, and private sector officials. The aim was to collect information on organizations having established control committees and HIV-AIDS care committees.

In sum, a specific interview was conducted with a number of decision-makers and/or leaders of the city and its suburbs. Thus, interviews were conducted with a number of health workers, corporate committee leaders, religious leaders and civil society leaders on specific issues pertaining to STI/HIV/AIDS in the Commune of Abengourou.

IV.1. OBJECTIVES

The survey was specifically intended to:

- Indicate statistics on STI/HIV/AIDS (and other infections) in the commune and the Abengourou region;
- Identify notified HIV/AIDS cases;
- Identify TB cases (opportunistic disease)
- Understand the operation and organization of the various AIDS control structures (Associations, NGOs, health facilities, private sector HIV/AIDS control committees).

IV.2. RESULTS AND COMMENTS ON THE INSTITUTIONAL SURVEY

IV.2.1. IMPEDIMENTS AND LIMITS OF THE INSTITUTIONAL SURVEY

Despite the warm receptions punctuated by rare inhospitable receptions in the structures we visited, we noted a recurring impediment: difficulty in accessing documents to collect information. In addition, we were faced with the inobservance of meeting dates, which cost the research teams much in time and money.

IV.2.2. STATISTICS

With a rate of prevalence of 14.6 percent, the Abengourou region is the most hit region in the country. This applies to the capital of the Moyen-Comoé region, that is to say Abengourou City[49]. Prevalence amongst pregnant women is also the highest on record and reaches 13 percent[50]. In this target group, uneducated women are the most affected, with a rate of 19.10 percent. Women with primary and secondary school backgrounds represent 9.6 percent and 9.3 percent, respectively**.**

In 2003, in voluntary and routine screening, 91 cases of HIV/AIDS were identified out of a total of 941 pregnant women, which is a rate of prevalence of 9.67 percent.

In schools, four (4) HIV/AIDS cases were identified in 2002-2003 out of 86 tests performed, that is 4.65 percent; and in January-March 2004, 5 HIV/AIDS cases were identified out of 180 tests performed, that is a prevalence rate of 2.78 percent[51].

As far as STIs are concerned, the incidence in the region is also among the highest, with 14 per 1000 in 2003. This incidence is quite high in schools. From 5.8 percent in 2000-2001 it fell to 3.5 percent in 2001-2002 and 4.2 percent in 2002-2003.[52]

IV.2.3. CASE NOTIFICATION

The main sites for AIDS case notification in Côte d'Ivoire are regional or general hospitals or research projects on HIV/AIDS, with screening laboratories. The majority of AIDS cases are to be found in the 25-40 age brackets.

[49] Projet Rétrovirus Côte d'Ivoire / MLS/ MSP, Surveillance du VIH-SIDA et de la Syphilis en cote d'Ivoire, Rapport d'activités 2000-2001
[50] ibidem
[51] Konaté, Analyse situationnelle du Moyen-Comoé, Côte d'Ivoire, mars 2004
[52] ibidem

In the Moyen-Comoé region, case notification started in Abengourou City in 1989 and sites of notification were as follows: The CHR (*Regional Hospital* – Medical Unit and Laboratory); the CAT (*TB Control Center*); The Urban Clinic and the Dioulakro Clinic. In 1989 and 1994 there were one (1) and 114 cases notified in the region, respectively[53].

In 1995: 1602 cases; 1997: 2572 cases on aggregate, including 280 new cases with 13.3 percent of pregnant women; 1999: 4300 cases on aggregate, including 400 new cases with 12 percent of pregnant women; 2000: 4606 cases on aggregate, including 306 new cases with 12 percent of pregnant women[54]. For percentage see graph 4.

IV.2.4. **CONJUNCTION WITH MORBID FACTORS**: TUBERCULOSIS

Tuberculosis (TB) is the most common opportunistic infection in Africa and Côte d'Ivoire. There is only one TBC in the region, located in Abengourou City. Screenings are performed through bacteriological analysis by good level technicians. TB has been declared a social disease in Côte d'Ivoire and TB care is free of charge in Abengourou City and the Moyen-Comoé region as a whole. Stocks of drugs are properly monitored despite a few stock-outs. TB incidence was rated in 2003 at 1 per 1000 in the Moyen-Comoé region and mostly in Abengourou City. HIV/AIDS prevalence amongst TB-infected individuals in the region is of 40-45 percent[55].

[53] Konaté, Analyse situationnelle du Moyen-Comoé, Côte d'Ivoire, mars 2004
[54] Touré Karamoko, Rapport d'activités de la coordination régionale de lutte contre les IST/VIH-SIDA, Abengourou, 2000
[55] Centre Antituberculeux, Rapport d'activités, Abengourou, 2003

V. THE COMMUNAL RESPONSE TO HIV/AIDS

At the level of the communal response, the objectives selected for review are the objectives more or less constantly pointed out at both regional and national levels according to plans - a short-term plan (STP) has been developed by June 1987 for the establishment of the PNLS (*National AIDS Control Plan*), the first Medium Term Plan (MTP I, 1988-1993…) - until 1994: prevention of mother-to-child transmission, prevention of contaminations by sexual and blood routes, improvement in care for patients and HIV-positive individuals, and promotion of medical research on AIDS.

V.1. PREVENTION OF MOTHER-TO-CHILD TRANSMISSION

The rate of HIV-1 transmission from mother-to-child – off drug administration – ranges from 25 percent to 30 percent in sub-Saharan Africa. In Côte d'Ivoire, RETRO-CI (KZT) and DITRAME (ANRS) projects revealed the efficacy of the short ZIDOVUDINE regimen by the end of pregnancies in reducing this transmission. These interventions contributed to reduce the mother-to-child transmission of the virus by 37-50 percent[56]. PMCT has been initiated in the Moyen-Comoé region since October 2001 and is conducted in 3 facilities in Abengourou City: Cafetou Maternity, the CHR Maternity and the PMI. In 2003, on aggregate 803 women accepted to undergo the screening test. Seventy-four (74) were HIV-positive and 12 cases remained indeterminate. Of the women who delivered, only 11 infants could be tested and of those 9 were identified as HIV-positive, which is a reduction in transmission by 96.67 percent. However, this figure being low, this result should not be extrapolated.

V.2. PREVENTION OF CONTAMINATIONS BY SEX AND BLOOD

V.2.1. SOCIAL MOBILIZATION AND SENSITIZATION

In general, under its sectoral AIDS control policy the Government has started establishing and/or authorizing the establishment of AIDS control units in many business sectors through its specialized structure and other competent structures.

Consequently, Mayors, General Councilors and other city officials perceived the need to control HIV since AIDS is now more than mere public health problem. It is a genuine development problem. As a result, they made decisions to take steps to ensure and improve the population's health.

To that end, a set of activities were conducted[57]:

- Holding of a seminar in Yamoussoukro that led to the Declaration referred to as the Yamoussoukro Declaration in April 2002;

- Establishment in all the Communes and within the Departmental Regional Councils of a permanent health committee or unit with the mandate to initiate and conduct HIV/AIDS control activities.

Abengourou City is involved in this fight. The structures listed hereafter have been identified in Abengourou City and they fall into the following categories:

V.2.1.1. ASSOCIATIONS AND NGOs

Religious committees (CHRIST-ROI, SCOUT CATHOLIQUE, GEEAD (Génération des Elèves et Etudiants des Assemblées de Dieu – ***Association the Generation of Students from the Lord's Assemblies***), ACEEPCI (Association des Chrétiens des Eglises Évangéliques Protestantes de Côte d'Ivoire – *Association of Christians from Protestant and Evangelical Churches of Côte d'Ivoire*), AEEMCI (Association des Elèves et Etudiants de Côte d'Ivoire – *Association of Students of Côte d'Ivoire*), JEC (Jeunesse Catholique – *Catholic Youth*)…

Youth Associations and NGOs: AJD (Association des Jeunes du quartier Dioulakro – *Association of the Youth from Dioulakro*), GAPA (Génération des Allies pour le Progrès d'Abengourou – *Generation of Allies for Progress in Abengourou*), FRATERNITE DE DIOULAKRO (*Dioulakro Brotherhood*, AELS (Association Évangéliques de Lutte contre AIDS – *Evangelical Association Against AIDS*), REPMASCI (Réseau des Professionnels de Media engagés in AIDS control en Côte d'Ivoire – *Network of Media*

[56] UNICEF, Programme de prévention de la transmission mère-enfant du VIH en Côte d'Ivoire : analyse de la situation des formations sanitaires de 9 capitales régionales de la Côte d'Ivoire, 2000

[57] Union des villes et communes de Côte d'Ivoire, rapport d'activités, 2003

Professionals involved in AIDS Control in Côte d'Ivoire), CLUB ESPOIR (*Hope Club*), PPP (Projet des Professionnels de sexe libres et leurs Partenaires – *Free Sex Professionals' Project and their Partners*), CI (Côte d'Ivoire) FORCE PLUS, CARITAS, RETROCI, RUBAN ROUGE (*Red Ribbon*) (See Annex)

V.2.1.2. PRIVATE SECTOR

Corporate committees (CIE, ANADER, SODEFOR, CNPS, SODECI)

V.2.1.3. THE TOWN COUNCIL AND THE PUBLIC SECTOR

- Regional coordination
- Departmental coordination
- Sub-prefectoral committees
- The Municipal committee
- Committees for the villages and farmsteads in the Commune (not yet operational)
- School health clubs
- Internal AIDS control committees (DREN)

In short, the activities of the HIV/AIDS control bodies are chiefly based on prevention. Their strategies are focused on the avoidance of risk behaviors and on condom use.

However, some of these organizations provide psychosocial care, namely RUBAN ROUGE, YEBOKABE and CERAB, which is the only PLWHA known in Abengourou City and the region.

V.2.2. VOLUNTARY COUNSELING AND TESTING

HIV counseling and testing are recognized as a key activity in HIV/AIDS prevention and care.

In Abengourou, some health facilities had been identified by the RETRO-CI Project to house HIV-testing activities: the laboratory of the Regional Hospital (CHR) for patient screening, and the TB Control Center (CAT) for voluntary testing and the screening of consumptive patients. The works of rehabilitation of the premises that are to shelter VCT services at the urban clinic are in progress. This clinic center operated from July 2004 to end of March 2005.

V.3. IMPROVEMENT IN CARE FOR PATIENTS AND HIV-POSITIVE INDIVIDUALS

V.3.1. HIV/AIDS CARE

Virological and immunological monitoring is ensured only in Abidjan. The restriction of possibilities for viral load assay raises the issue of access of upcountry populations to ARVs and, notably, their follow-up. Bio-monitoring requires PLWHAs to go regularly to Abidjan, incurring additional costs for transportation, accommodation and miscellaneous expenses.

In addition to being provided several background documents, the public health workers were trained in clinical and psychosocial care across the country in 1994-1997. A burgeoning organization is noticeable in the Moyen-Comoé region, mainly in Abengourou, where about thirty physicians from health facilities in the region attended a training on care for PLWHAs from 29 September to 2 October 2003. The training of the Moyen-Comoé physicians is in line with the Ivorian health Authorities' desire to step up the disease control on the ground by decentralizing access to care for PLWHAs. To reach this target, the Ministry of State, Ministry of Health and Population made the commitment to open a referral treatment center for AIDS patients, including by means of ARVs in each health region, to start with, then in each sanitary district.

ARV therapy was introduced in Côte d'Ivoire in the early 1990s. Currently, there are only 7 accredited facilities entitled to administer ARVs and they are all based in Abidjan. To date, there are approximately 2500 individuals on ARVs in Côte d'Ivoire. According to estimates, 12.000 would need ARVs and the cost for treatment is on average CFA F 27 000 per month (MLS, 2003). The region now shelters ARV provision centers but they are in insufficient number. This is why patients from the region are often referred to USAC in Abidjan.

V.3.2. ACCESS TO DRUGS

PSP ensures pharmaceutical products are available. It is represented in all the sanitary districts in the Moyen-Comoé region. PSP distributes STI kits and Cotrimoxazole for the treatment of opportunistic infections. A PSP ARV-account is also opened with the District pharmacy

Also, PSP tangibly contributes to the avoidance of transmission by making expendable equipment and, mostly, delivery kits available. In the Moyen-Comoé region, 79.3 percent of orders placed with PSP were effectively executed in 2003

VI. PROMOTION OF MEDICAL RESEARCH ON AIDS

Like in most African countries since the outbreak of the pandemic we can notice an involvement of tradi-practitioners who proposed several "miraculous" products, more or less successfully. Ivorian scientists are also involved. Many attempts were made to find cures to AIDS. No research activity of this type has been identified in Abengourou City, let alone the Moyen-Comoé region.

VI.1. STRENGTHS AND WEAKNESSES OF THE COMMUNAL RESPONSE TO AIDS

VI.1.1. REGARDING PREVENTION

Strengths:

- Existence of several operational AIDS control committees, associations and NGOs in the city;
- Existence of corporate committees;
- Involvement of religious and traditional leaders;
- The leaders of nearly all these structures have been trained in IEC;
- Existence and operation in the City and the region of PMCT and PPP (Care Project for loose women and their partners) projects;
- At the educational level, in each school there is an AIDS control committee;
- Programs are initiated by students themselves and IEC sessions are held on Wednesdays;
- All the structures of National Education in the city have an internal committee for their staff.

Weaknesses:

- Lack of means: program implementations are often subject to the assistance of donors and other development partners;
- Lack of specific activities for truck drivers in Abengourou and the region;
- People in villages and the farmsteads in the Commune are somehow overlooked;
- Considerable actions for youths but very few for adults;
- Lack of a blood transfusion center in the city and the region;
- Noticeable lack of means for the training of peer educators in schools.

VI.1.2. REGARDING BIOLOGICAL CARE:

Strengths:

- Existence of a treatment committee geared towards administering a patient-customized treatment. This committee will manage ARVs;
- The gradual organization of medical care for PLWHAs through the training of physicians;
- The experience acquired in the implementation of PMTC projects;
- Availability of ARVs in Abengourou City.

Weaknesses:

- Limitations of the technical support center for the biomonitoring of patients on ARVs at the regional level;
- People's poverty, which limits the contribution of families and communities to care for PLWHAs;
- Lack of guides and home-based activities.

VI.1.3. REGARDING PSYCHOSOCIAL CARE:

Strengths:

- The involvement of associations and NGOs in effective psychosocial care for patients and their entourage;
- Training of health workers in counseling;
- Existence of a specific convention binding the Belgian Technical Cooperation Agency and the

Sanitary Authorities to prevent the turnover of trained staffs;

Weaknesses

- The inadequacy of material and financial resources required for better care for PLWHAs;
- Stigmatization and discrimination which require the provision of care to PLWHAs to be kept secret;
- Lack of guide and community care activity;
- Inadequacy of NGOs' financial resources;
- Few NGOs are involved in care provision, home-based monitoring and support.

VI.1.4. REGARDING STIs:

Strengths

- Inclusion of care for STIs in primary health care;
- Availability of effective drugs against STI agents on the lists of drugs distributed by PSP;
- Existence of an STI Treatment Guide;
- STI kit preparation by PSP;
- Adequate epidemiological surveillance at the communal level and across the region.

Weaknesses

- Lack of training of the newly- recruited staffs;
- Significant use of self-prescription and informal structures (tradi-practitioners pharmacists, street hawkers) for STI treatment;
- STI kits and cotrimoxazole stock outs;
- Existence of a single type of kit for all kinds of STIs.

VI.1.5. REGARDING RESEARCH AND EPIDEMIOLOGY

Strengths:

A review of the materials related to research works on HIV conducted in 1996-2000 shows a total of 180 publications made and 499 papers written. Biology, clinical studies and epidemiology are amongst the most investigated fields. This favored adequate knowledge of the infection in the Ivorian context.

RETRO-CI project has conducted several surveys on PMCT at the level of Abengourou City and its region.

There are statistics available on case notifications in all health facilities and they are centralized at the RD level, rendering investigations easier in this field.

Weaknesses:

There are no specific activities on therapeutic research at the level of the city and the region. This reflects the situation in the whole country.

VI.1.6. REGARDING FUNDING

NGOs have limited financial resources. Moreover, the lack of funding for community micro-projects and income-generating activities accounts for the lack of actions that can have an effective impact on the reduction of HIV/AIDS.

VI.1.7. UNEXPLORED AVENUES OR FIELDS TO BE FURTHER INVESTIGATED

- Social and economic impact,
- PLWHAs' rights and duties,
- Ethics and HIV,
- Direct and indirect costs of the HIV infection.

VII. FINDINGS AND RECOMMENDATIONS

VII.1. 1- KEY FINDINGS

This survey enabled us to find out that 41 percent of the population had a good level of knowledge of AIDS (key STIs, link between STIs and HIV, transmission modes, means to avoid them); a pattern of behavior deemed "appropriate" in 85 percent of the populations. Besides, all the participants had good attitudes towards infected individuals (they maintain the same behavior) and approve of their being allowed to work as long as their health status allows them to. But high-risk practices were noted in 97 percent of the respondents. Even if these findings should be further examined by other surveys to come up with specific conclusions, it was noted that in Abengourou City, the administrative center of the Moyen-Comoé region, knowledgeability about STIs/HIV/AIDS is no guarantee for appropriate attitudes, let alone health-promoting practices. These data show that if no step is taken in the Commune of Abengourou, the HIV-infection is liable to hinder its development, in the strictest sense, within a few years.

Moreover, we noted weaknesses due to the lack of boldness in the actions undertaken by the regional coordination body, departmental, communal and corporate committees and AIDS control associations and NGOs, a communication gap between the citizens and the officials - mostly the Town Council - about the operation of the various AIDS control bodies. This gave an impression that no action was taken to control STI/AIDS. The populations expressed their desire to be regularly sensitized and trained in STIs and HIV/AIDS issues at the level of the Commune of Abengourou. They all called for the extension of care to destitute populations (the needy). *Global Business Coalition on HIV/AIDS* underscores the designing of specific control strategies that can help develop prevention and care actions for both patients and their families. The consequences of STIs and HIV-AIDS on the Commune of Abengourou are so considerable that some individuals have the feeling that not much is done for them. They expressed their desire to be regularly sensitized and trained in STI and HIV-AIDS issues. They all called for the provision of care to a greater number of people by the Town Council by providing for a budget item for HIV/AIDS control in its development plan on yearly basis.

VII.2. BEHAVIORAL ANALYSIS AND COMMUNICATION PLAN

Knowledgeability and practices as regards STI/HIV/AIDS have been summed up in **Table 16**. The behavioral problem, the behavior to be promoted, obstacles and incentives have been specified.

Table 16. Behavioral Analysis of Knowledgeability and Practices as regards STI/HIV/AIDS				
Subject	Current knowledge	Knowledge to be promoted	Obstacles	Incentives
STI/ HIV /AIDS	Most of the participants know about AIDS; modes of STI/HIV/AIDS transmissions are known; The means to prevent them have been identified; The participants establish a link between STIs and AIDS; The main STIs listed are herpes, syphilis, gonococcal infection.	AIDS is transmitted through blood, sexually, from mother to child but there are also other more insidious and less known forms of transmission: contaminated objects, and the practice of levirate and sororate; STIs and AIDS can be contracted in the following places: bars, drinking establishments (*maquis*), hotels, ritual celebrations (Easter, Yam festival), unfinished buildings, marketplaces late at night; AIDS complications lead to death.	Lack of knowledge about STI/HIV/AIDS ; Denial (the refusal to acknowledge the existence of AIDS; The influence of culture and tradition; Fear; Poor information; Preconceived notions; People feel ashamed to buy condoms Mobility Desire to procreate Poverty Illiteracy Carelessness Generation gaps Megalomania Easy-money making Multiple partners Unfaithfulness in couples Stigmatization of and discrimination against PLWHAs	People give greater importance to interpersonal, inter-group interactions, TV, the radio and other communication channels to fight against STI/HIV/AIDS in the Commune of Abengourou; AIDS is considered as a dangerous disease to be avoided; Participants want to better know the means of prevention and treatments, and the consequences on the Commune of Abengourou as a whole; The participants expressed their desire to see the Town Council (Municipality) more involved in AIDS control initiatives Participants* would like the Town Council, Committees, NGOs and other STI/HIV/AIDS control organizations to distribute condoms but at a cheaper price.

The key target groups as well as the type of communication and key messages are also analyzed in **Table 17**. This outline should be examined in more detail when developing the communal strategic STI/HIV/AIDS control plan.

Table 17. Segmentation of the target public and communication approaches

Communication approaches	Issue	Target public	Activities
Advocacy	No focus on HIV/AIDS-related issues in the Commune of Abengourou	The Town Council The General Council Political leaders Opinion leaders: traditional chiefs, religious leaders Ministries Representations of development partners	Seminar Joint planning Review Special events
Social mobilization	Cursory knowledge of the factors of transmission, means of prevention and treatments for STI/HIV/AIDS	The Town Council The General Council Ministry of Health Other ministries (Industry, Trade, Communication, Social Affairs, Education, Higher Education…) International Agencies (UNDP, UN Habitat, UNFPA, W.H.O., UNICEF, ANUMI…) international and local NGOs (RETROCI, PEPFAR, Red Ribbon, Repmaci, Rose Blanche, Regard Plus, GAPA, Yeboukabe, Cerab, Cifor plus Yakassé, AEEMCI…) Corporate committees (CIE, SODECI, ANADER, SODEFOR, CNPS…) Communicators Health workers Community workers PLWHA networks Managers of hospitality complexes Teachers and pupils Community leaders (Village chiefs, *griots*) Administrative authorities	Regular meetings Workshops Training in interpersonal communication Supervision Feed back Training in community mobilization Involvement in planning, implementation and evaluation
Behavior Communication Change	Cursory knowledge and/or shallow knowledge of STI/HIV/AIDS and the scale of the HIV/AIDS phenomenon	Military Teachers Women Youths Students Individuals Migrants, truck drivers Defense and security forces Farmers Sex workers…	Research on the target public Behavioral analysis Development and use of communication tools Training Dissemination of messages and tools

VII.3. RECOMMENDATIONS

DIRECTED AT BNETD:

Organize a workshop to deliver the findings of this survey;

And conduct research on:

- The socio-economic impact of AIDS,
- PLWHAs' rights and duties,
- Ethics and HIV,
- Direct and indirect costs of the HIV infection,
- Provide technical support to the Town Council for all the activities to be conducted under this project.

DIRECTED AT THE MUNICIPAL AND OTHER LOCAL AUTHORITIES:

- Get the managers and heads of services in the Commune actively involved by sending them letters and organizing workshops;
- Reinforce the organization of structures directly involved in AIDS control in Abengourou;
- Plan an activity review day for the organizations involved in AIDS control;
- Provide financial support for STI/AIDS control activities;
- Improve the populations' information on STI/AIDS by launching a health newsletter, generating and disseminating posters and showing awareness-raising motion pictures in facilities with waiting rooms (restaurants, medical services, bars, hotels, Rue Princesse…);
- Make condoms affordable to all by cutting down prices and diversifying sale points;
- Extend STI/AIDS care to the destitute (destitution criteria to be defined);

DIRECTED AT (PRIVATE AND PUBLIC) HEALTH WORKERS IN ABENGOUROU CITY JOINTLY WITH THE TOWN COUNCIL:

- Structure STI/AIDS control focusing on the target groups identified in this survey;
- Train peer educators;
- Train health personnel in counseling;
- Improve people's know-how in terms of condom use;
- Organize awareness-raising activities (for example, by paying visit to AIDS-infected individuals) while taking into account the corresponding ethical dimensions;
- Reshuffle the medical service in view of intensifying VCT, care for AIDS patients and ensuring confidentiality;
- Establish a forum of consultation with public STI/AIDS control facilities;
- Put in place an information system liable to ensure greater confidentiality of medical details;
- Establish a supervisory and monitoring mechanism for STI/AIDS control activities;
- Plan other activities for sensitization to STI/AIDS.

DIRECTED AT DEVELOPMENT PARTNERS:

- Support STI/AIDS control initiatives in the Commune of Abengourou

REGARDING THE DEVELOPMENT OF THE COMMUNAL ACTION PLAN WHICH SHOULD TAKE INTO ACCOUNT THE FOLLOWING FINDINGS:

- The populations in Abengourou City have a good knowledgeability – up to 41 percent – but a low level in terms of practice;
- Nearly all the respondents do agree on stepping up sensitization to STI/AIDS and the implementation of an action plan for control.

REGARDING THE FOLLOWING PREVENTION AND CARE RELATED ITEMS

- Direct sensitization slogans at adults while taking into account a number of socio-cultural aspects such as sororate/levirate, the mistress phenomenon and the marriage of adolescent girls;
- Intensify the sensitization of women, defense and security forces, and young girls;
- Conduct activities aimed at reducing stigmatization and discrimination against PLWHAs;
- Devise special programs for the populations in the villages and farmsteads in the commune;
- Develop the testing practice by opening the VCT center of the clinic;
- Promote the establishment of other corporate committees;
- Initiate in the city and the region interventions directed at risk and vulnerable groups such as mobile populations along migratory roads and at border posts;
- Extend PMCT to several health facilities in view of improving physical accessibility;
- Promote the establishment of a CNTS regional antenna at the level of Abengourou City;
- Provide focused refresher courses in counseling that meet genuine needs;
- Adopt an ARV cost-reduction policy by promoting a policy of generics to make them accessible to a greater number of patients;
- Contribute to the establishment of an accredited center for the provision of ARVs in the region or build up its capacities if existant;
- Develop a guide for community care;
- Prepare a guide and kits for home-based care;
- Promote and train the members of community organizations in community and home-based care;
- Reinforce the capacities of NGOs for community and home-based care provision (health care and support) to HIV-infected and affected individuals by providing adequate financial and technical support;
- Launch assistance programs for families to enable them to provide care to their members who are ill. This could involve initiating and funding income-generating activities;
- Provide financial and technical support to NGOs and community groups in the region for greater effectiveness in their endeavors;
- Reassure the populations about the maintenance of the confidentiality of their test results.
- Plan a chronogram for psychotherapy meetings with the different social strata in the neighborhoods of the Commune of Abengourou.
- Continue the process of inauguration of STI/HIV/AIDS control committees in the neighborhoods of the Commune of Abengourou and the villages in the Commune.
- Reorganize and reactivate STI/HIV/AIDS control committees in the various neighborhoods of the Commune of Abengourou where they have already been established.
- Conduct regularly sensitization and community mobilization activities in the framework of STI/HIV/AIDS prevention.
- Provide training to the members of STI/HIV/AIDS Committees and NGOs, and health workers in designing and production techniques for printed and computerized materials for IEC/BCC and advocacy for programs/development projects.
- Ensure the availability/regular distribution of condoms in all the neighborhoods and suburbs of the

Commune of Abengourou.

- According to the participants, Mauritanian retailers do not sell condoms. As they are established in all the neighborhoods and suburbs of Abengourou, discussions should be initiated with them to get them involved in condom sale.
- Ensure regular promotion of STI/HIV/AIDS control committees with participants.
- Extend the provision by the Municipal Committee of care for AIDS patients to the largest number of individuals.
- Establish an information management system (database) pertaining on one hand to the indicators of HIV/AIDS prevention, namely sensitization, community mobilization, condom promotion, transfusion safety, injection safety, and VCT indicators and, on the other hand, care indicators such as the monitoring of patients not on ARVs, patients on ARVs, the availability of ARVs, HIV/TB-infected patients.

If most participants seem to distinguish a HIV-positive individual from an AIDS patient, they use, however, both terms indifferently when they speak. To consider a HIV-positive individual as an AIDS patient may affect the spirits of the infected individual and his kin. Therefore the appropriate use of these terms should be emphasized since there is currently no cure to AIDS while the HIV-positive individual can be given effective treatments that will make him live longer.

Supervisory and managerial staffs should be trained to explain and answer questions on the HIV-AIDS related policy of the Commune of Abengourou. They must be in a position to explain the opportunities for reasonable adjustments that can be made, according to circumstances, for HIV-infected individuals or AIDS patients and help them keep on working as long as possible.

The insertion of HIV/AIDS-infected and affected individuals should be promoted.

All in all, to perpetuate the achievements of the fight against STI/HIV/AIDS it is necessary to devise and implement an integrated plan to fight off rumors**,** level off obstacles and neutralize the other key factors of exposure to STI/HIV/AIDS, which impede the realization of the target of control of the AIDS scourge in the Commune of Abengourou.

THE FOLLOWING PRIORITY STRATEGIC INTERVENTION FOCI (PSIF) OR PRIORITY FIELDS OF ACTION (PFA) HAVE BEEN DETERMINED:

1. Awareness-raising among the youths
2. STI Care
3. Condom use
4. War on poverty
5. Care for PLWHAs
6. Awareness-raising amongst men-in-uniform and similar categories
7. Curbing the negative effects of some traditional practices
8. Awareness-raising amongst sex workers and migrants, sex workers and their partners
9. Communal STI/HIV/AIDS control capacity building
10. Reduction in the vulnerability of women to the HIV/AIDS epidemic
11. Protection of people living with HIV/AIDS and affected individuals

REFERENCES

ALAN WHITESIDE, L'impact économique du VIH et du SIDA en Afrique, Université du Natal, département d'économie de la santé et de recherche sur le VIH-SIDA, Afrique du sud, 1998.

Aventin L. Huard P (1998). VIH/SIDA et entreprise en Afrique : une réponse socio-médicale à l'impact économique ? L'exemple de la Côte d'Ivoire - *Gestion des informations sociales - MOST. Document de travail N°19*.

AVOAKA (M-J), Formation des pairs : guide du participant, Abidjan, Centre de Coopération Internationale en Santé et Développement, 2000.

BUREAU INTERNATIONAL TRAVAIL, Recueil de directives practices du B.I.T sur le VIH-SIDA et le monde du travail en Afrique, Genève- Paris, B.I.T, 2003.

Darlène L.R, Marion S.A, Dedy S. et al. (1993). Changes in University Students'AIDS-related Knowledge, Attitudes and Behaviours, 1988 and 1992 - *Canadian Journal of Public Health, vol 84, N°4, July-August: 275-278.*

Deniaud F, Melman C. (2002). De l'appréhension des maladies sexuellement transmissibles à la prévention du VIH - *La presse médicale, mars*, N°9, 31, 387-392.

Eholié S., Kakou A, Aoussi E, Bissagnéné E, Odehouri K, Kadio A (2002). SIDA et traitement ARV en entreprise - *Rapport d'étude, PVVH*.

FAO, L'impact du VIH-SIDA sur les institutions de développement, Harare, 6-12 juin,1998.

FEDERATION INTERNATIONALE POUR LA PLANIFICATION FAMILIALE, Déclaration sur les maladies sexuellement transmissibles, le VIH-SIDA et sur la santé reproductive, Royaume–Uni, 1997.

Fisher J.D; Fisher W.A,Williams S.S, Malloy T.E Tests empiriques d'un modèle de comportement préventif du SIDA avec des homosexuelles et des étudiants hétérosexuels : information, motivation, aptitudes comportementales,1998.

GROSSKURTH H, MOSHA F,TODD Jet al. Impact of Improved Treatment of Sexually Transmitted Diseases on HIV-Infection in Rural Tanzania. Randomised Controlled Trial. *Lancet 1995; 346: 530-536*

INSTITUT NATIONAL DE LA STATISTIQUE, Recensement Général de la Population et de l'Habitat, Côte d'Ivoire, Abidjan,1998.

K.Kober, W.V. Damme Scalling up Access to Antiretroviral Treatment in South Africa: Who Will Do the Job? Lancet, 2004; 364: 103-107

Koffi Marcel, Analyse situationnelle des IST/ VIH-SIDA, IPS (WA), 2004

Konaté, Analyse de la situation et de la réponse régionale face au SIDA du Moyen-Comoé, mars 2004

La Ruche G., Djeha D, Boka Y. et al, La lutte contre les maladies sexuellement transmissibles en Côte d'Ivoire : quelles stratégies face au VIH/SIDA ? Cahier santé : 10 287-292,2000.

LOHOUES-OBLE, Avant-projet de loi relatif à la santé de la reproduction en Côte d'Ivoire, Phase 1, 2003.

MICS-Côte d'Ivoire Enquête à indicateurs multiples- *ENSEA/UNICEF, p.65*, 2000.

OMS (1999). Population et Développement de l'Afrique - OMS, juin-juillet, p.39

OMS& ONUSIDA, Rapport sur le VIH/SIDA, 2003.

ONUSIDA (2002). Le point sur l'épidémie de SIDA.

ONUSIDA, Rapport sur l'épidémie mondiale de VIH-SIDA, Genève, 2002

Population Council (1998). Prévention et soins du SIDA au niveau communautaire en Afrique : s'appuyant sur l'expérience tirée des initiatives locales. Résultats de quatre interventions en recherche pratique en Afrique de l'Est et en Afrique Australe- *Population Council/Position Action*, *P.35*

Touré, Profil des patients atteints d'infections sexuellement transmissibles au dispensaire antivénérien de l'INSP d'Abidjan - *Thès.Med.Abidjan, N° 3366/03*,2003

UNICEF, Programme de prévention de la transmission mère-enfant du VIH en Cote d'Ivoire : analyse de la situation des formations sanitaires de 9 capitales régionales de la Cote d'Ivoire

UNISA ABET Institute Daimlerchrysler KAPB baseline study - *UNISA ABET Institute/GTZ, www.weforum. Org/globalhealth/cases*, 2001.

ANNEXES

ANNEX 2: QUESTIONNAIRE

	MUNICIPAL ACTION PLAN FOR HIV/AIDS CONTROL IN THE COMMUNE OF ABENGOUROU INDIVIDUAL SURVEY July 2005

IDENTIFYING Serial no._____|___|___|___|
Date of Survey |___|___|_/__|_0__|_7__|_/__|_0__|_5__|
Neighborhood_____
Census District (CD)_____|___|___|___|___|
Interviewer's name_____
SECTION I: SOCIAL AND DEMOGRAPHIC FEATURES

No.	Wording and Instructions	Category/Modalities Code	Report to
Q101 Sex	Note the respondent's gender.	MALE 1 FEMALE 2	
Q102 Age	How old are you?	!___|___| NSP…	
Q103A Educlevel	Have you attended school?	YES1 NO2	Q104
Q103B Educ.level	How far have you been to school?	PRIMARY 1 SECONDARY 2 HIGHER EDUCATION 3 KORANIC SCHOOL 4 OTHER (Specify)_____5	
Q104 Educ.level	Can you read?	READILY 1 WITH DIFFICULTY 2 NOT AT ALL3	
Q105 Occupat.	What is your main occupation?	….. … …	
Q106 Religion	What is your religion?	CATHOLIC…....1 PROTESTANT…..2 MUSLIM ...3 ANIMISTIC…...4 OTHER (Specify) _____ 5	
Q107 Ethnic gp.	What is your ethnic group/nationality?	…...…	
Q108 MatriStat.	What is your current matrimonial status?	LIVING WITH S.O.(married or cohabiting)1 SINGLE2 WIDOW(ER)3 DIVORCED4 SEPARATED5	Q109
Q109 Monog	Do you live with someone? Are you in a polygamous or monogamous situation?	Polygamy..1 Monogamy2	
Q110 NbChild.	How many children do you have?	!___|___|	
Q111 DepChild.	Beside your children, how many dependents do you have?	!___|___|	
Q112 Tobacco	Do you smoke?	Yes…..1 No …..2	
Q113 Alcohol	Do you drink alcohol?	Not at all….1 From time to time.…..2 Regularly…..…..3	
Q114 Inject	Do you go for injections in neighborhood clinics?	Yes…..1 No …..2	

SECTION 2: GENERAL KNOWLEDGE OF STI/ HIV/AIDS

No.	Wording and Instructions	Category/Modalities Code	Report to
Q201 STI	Have you ever heard of sexually transmitted diseases (infections)?	Yes…..1 No …..2	
Q202 CitSti	List STDs (STIs) you know of?	…	
Q203 Aware	Have you ever heard of AIDS?	Yes…..1 No …..2	
Q204 Medium Masmedia MedicServ Friend Family	If so, how did you get informed about AIDS?		
	Mass media	Yes …1	
		If so, on Television !___|, Radio !___| in newspapers !___|	
		No...2	
	Medical service	Yes .1	
		No..….2	
	Friends	Yes ….1	
		No…...2	
	Family	Yes ….1	
		No..….2	
	At a meeting, a seminar...	Yes ….1	
		No...2	
Q205 Sexist	For you, does AIDS really exist?	Yes ….1 No..….2 Does not know....3	
Q206 Meaning	What does AIDS mean?	Right…..… ...1 Wrong...…..2 Does not know..……3	
Q207 CmAbeng	Are you aware that the Commune of Abengourou is among the most hit communes in Côte d'Ivoire?	Yes ….1 No..….2 Does not know…3	
Q208 AIDSmala	Does malaria favor AIDS infection?	Yes ….1 No…...2 Does not know ...3	
Q209 STIHIV	Can the fact of having an STI favor HIV infection?	Yes ….1 No...2 Does not know ……..….3	
Q210 AIDSVirus	Can the AIDS virus trigger other diseases?	Yes ….1 No…..….2 Does not know ……3	
Q211 AidsVirus	If so, which diseases?	....	
Q212 Identific.	How can we tell someone is infected by the AIDS virus?	Blood test…1 Urine test ……2 Clinical examination. 3 Does not know ……4	
Q213	Can one live long (10 years) with the AIDS virus?	YES1	

Long		NO2 Does not know 3	
Q214 Organi	Can someone who looks healthy have the AIDS virus in his body?	YES1 NO2 Does not know 3	
Q215 Medication	Is there a cure to AIDS?	YES1 NO2 Does not know 3	
Q216 MedicP	If so, can we get cured from AIDS?	YES1 NO2 Does not know 3	

SECTION 3: KNOWLEDGE OF HIV/AIDS TRANSMISSION

No.	**Wording and Instructions**	**Category/Modalities Code**	**Report to**
Q301	One can get contaminated by AIDS:		
Q301A Drug	By using drug by injection	YES1 NO2 Does not know 3	
Q301B Contact	By touching an infected individual	YES1 NO2 Does not know 3	
Q301C Protect	By having unprotected sex	YES1 NO2 Does not know 3	
Q301D Mosquito	Through mosquito bites	YES1 NO2 Does not know 3	
Q301E ContObj	Through blood-smeared objects	YES1 NO2 Does not know 3	
Q301F BloodTr	Through blood transfusion	YES1 NO2 Does not know 3	
Q301G Pregnancy	From an infected pregnant woman to her future child	YES1 NO2 Does not know 3	
Q301H Smange	By sharing a meal with an individual who is ill	YES1 NO2 Does not know 3	
Q301I Stoilet	By using public toilets	YES1 NO2 Does not know 3	
Q301J SmokeCig	By sharing a cigarette with an AIDS patient	YES1 NO2 Does not know 3	
Q301K WearClo	By wearing the clothes of an infected individual	YES1 NO2 Does not know 3	
Q301L Scarif	During group circumcisions/excisions with contaminated material	YES1 NO2 Does not know 3	
Q301M Kiss	By kissing an individual who is ill	YES1 NO2 Does not know 3	
Q301N MarryWid	By marrying the wife/husband of a deceased relation (levirate, sororate)	YES1 NO2 Does not know 3	
Q301O CelReu	During reunion celebrations (Yam festival, Easter celebration, end-of-school year balls – in schools – cultural and sports events)	YES1 NO2 Does not know 3	
Q301P Wailkeep	At wail-keepings	YES1 NO2 Does not know 3	

Q301Q Unfbuild	In unfinished buildings	YES1 NO2 Does not know 3	
Q301R Mktplacen	In marketplaces by night.	YES1 NO2 Does not know 3	

SECTION 4: KNOWLEDGE ON THE FACTORS OF EXPOSURE TO HIV/AIDS-RELATED RISKS

No.	**Wording and Instructions**	**Category/Modalities Code**	**Report to**
Q401	What are the risk behaviors that can lead to HIV-infection?		
Q401A Hangdres	Hanging around drinking establishments (*maquis*)	YES1 NO2 Does not know 3	
Q401B Hangbhnclb	Hanging around bars, hotels and night-clubs	YES1 NO2 Does not know 3	
Q401C Sevpart	Having several partners	YES1 NO2 Does not know 3	
Q401D Havunsex	Having unprotected sex	YES1 NO2 Does not know 3	
Q401E Assprost	Associating with prostitutes	YES1 NO2 Does not know 3	
Q401F Usenstsyr	Using non-sterilized syringes in neighborhood clinics	YES1 NO2 Does not know 3	
Q401G Usecapr	Using somebody's care products	YES1 NO2 Does not know 3	
Q401H Havnbitba	Having one's nails cut/beard cut by itinerant barbers	YES1 NO2 Does not know 3	
Q401I sexunalco	Having sex while under the influence of alcohol	YES1 NO2 Does not know 3	

SECTION 5: GENERAL ATTITUDES AND BEHAVIOR CHANGE

No.	**Wording and Instructions**	**Category/Modalities Code**	**Report to**
Q501 Infectio	Do you think you can personally be infected by the virus?	Yes..1 No...…..…..2	
Q501A Pgener	Why ?(3 reasons at the most, whatever the answer may be)	1.. 2.. 3..	
Q502 Gener	Is it embarrassing to consult a doctor when we think we are AIDS-infected?	Yes…1 No..…..…..2	
Q503 Buy	Do you feel embarrassed to buy condoms?	Yes..…1 No…..…...2	
Q503A Wbuy	Why ?(3 reasons at the most, whatever the answer may be)	1 2 3	
Q504 Info	Should we inform our partner if we had AIDS?	Yes…..…1 No…..2	
Q504A InfoPart	Why ?(3 reasons at the most, whatever the answer may be)	1 2 3	

Q505 Askinaids	Will you keep on associating with a kin if they have AIDS?	Yes…..…1 No…….2	
Q505A Waskinaid	Why? (3 reasons at the most, whatever the answer)	1 2 3	
Q506 Places	Should the virus-infected individuals go to same places as others?	Yes…..…1 No…..2 Does not know3	
Q506A Wplaces	Why? (3 reasons at the most, whatever the answer)	1.. 2.. 3..	
Q507 Compel	Should the AIDS-infected individuals be compelled to inform other people?	Yes….1 No..2 Does not know. 3	
Q507A Wcompel	Why ?(3 reasons at the most, whatever the answer)	1 2 3	
Q508 Authorize	Should the AIDS-infected individuals be authorized to work?	Yes..1 No...2	
Q508A Wauthor	Why? (3 reasons at the most, whatever the answer)	1 2 3	
Q509 Change	Have you changed behaviors since AIDS has been publicized?	Yes..1 No...2	
Q509A	If so, what changes have you made?		
Q509A1 Conduse	Condom use	Yes..1 No…..2	
Q509 A2 Chfaith.	Faithfulness	Yes..…1 No…….2	
Q509 A3 Chabsti	Abstinence	Yes…..…1 No…….2	
Q509 A4 Chobu	Use of disposable objects for personal care	Yes…..…1 No…..2	
Q509 A5 chprost	Non-interaction with prostitutes	Yes…..1 No...2	
Q509 A6 chperiod	No sexual intercourse during my period	Yes..1 No...2	
Q509 A7 chmwhdr	Avoid marrying the wife/husband of a deceased relation	Yes..1 No...2	
Q509 A8 chother	Other, to be specified	Yes…1 No...2	
Q510	Who do you talk about AIDS with? Is it with... Read each modality and circle the provided answer	YES NO Does not know a) PARTNER/SPOUSE 1 2 3 b) MOTHER 1 2 3 c) FATHER 1 2 3 d) AUNT/UNCLE 1 2 3 e) BROTHER/SISTER 1 2 3 f) BEST FRIEND 1 2 3 g) RELIGIOUS LEADER 1 2 3	

		h) TEACHER 1 2 3 i) OTHER (Specify) 1 2 3	

SECTION 6: GENERAL PRACTICES, CONDOM USE, AND INFORMATION ON AIDS

No.	Wording and Instructions	Category/Modalities Code	Report to
Q601 ageinterc	How old were you when you first had sex?	!..... !..... !	
Q602 Regpart	Do you have a regular partner?	Yes..1 No.....…..2	
Q603 Resid	If so, does he/she live with you?	Yes…..…1 No...2	
Q604 Nbrpart	How many partners do you have? (beside your regular partner)	!..... !..... !	
Q605 Menses	Have you ever had sex during your menses?	Yes..1 No...2	
Q606 Typesex	What are your typical sexual practices?	Genito-genital.....…..1 Bucco-genital.2 Genito-anal….3 Other to be specified ...…...4	
Q607 Unsex	Have you ever had unprotected sex with a casual partner?	Yes…..…1 No……..2	
Q608 Last sex	When was the last time you had sex?	!..... !.....!	
Q608 Whichpart	Which partner did you have this intercourse with?	Regular partner…..…1 Casual partner…..…..2 Prostitute...……..3	
Q609 Conduse	Have you ever used condoms?	Yes…..…1 No……..2	
Q610 Condreg	Do you use condoms with your regular partner?	Yes…..…1 No……..2	
Q611 Pleascond	Do condoms make sex feel pleasant?	Yes…..…1 No……..2	
Q612 Pleasant	Why would someone refuse to use condoms?	1 2 3	
Q613 Conduse	Did you use a condom during your last sexual intercourse we talked about earlier?	Yes..1 No...2	
Q614 Price	How do you find the price of condoms?	Expensive…...1 Affordable…..2 Does not know3	
Q615 Salepoint	Where do you often buy them (if he/she has already used condoms)?	Pharmacy…....1 Shop/ Kiosk…....2 Other, specify…….…...3	
Q616 Frequency	How often do you use condoms with casual partners (for example, how many times in 10 intercourse)?	!..... !..... !	
Q617 Frequency	How often do you use condoms with regular partners?	Always…...…1 From time to time…...2 Never…...…3	
Q618 Right	Can the use of condom help prevent STDs (STIs) and AIDS?	Yes…..…1 No……..2	
	Since you have heard of AIDS (risk perception)		

Q619			
Q619A Sexprost	Have you ever had sex with prostitutes?	Yes…..1 No...2	
Q619B Unpsex	Have you ever had unprotected sex?	Yes…..1 No...2	
Q619C Sexcasp	Have you had sex with casual partners?	Yes..1 No...2	
Q619D Burstcond	Has the condom ever "burst" during the sexual intercourse?	Yes..1 No...2	
Q619E Sexunalco	Have you ever had sex under the influence of alcohol?	Yes…1 No...2	
Q620 Caspart	In 2004, did you have sex with other (casual) partners?	Yes..1 No...2	
Q620A regocc	If so, how many in 2004?	!..... !.....!	
Q621 Capartoc5	In 2005, (January –July) have you had sex with other (casual) partners?	Yes..1 No...2	
Q621A Reocc	If so, how many in 2005?	!..... !.....!	
Q622 Paststi	Did you have an STI in the past few years?	Yes..1 No...2	
Q622 A Nbrsti	If so, how many times?	!..... !.....!	
Q622B Qcons	How did you manage to get treatment the last time you had an STD/STI?	Hospital..1 Pharmacy…...2 Neighborhood nursery...3 Self-prescription….4 Traditional healer…...5	
Q622C Partinf	When you had this STD, did you inform your partner?	Yes..1 No…..2	
Q622D Danger	Are STDs/STIs dangerous?	Yes..1 No...2 Does not know…....3	
Q622 E Complic	What are the complications of STIs/STDs you know of (3 key complications)?	1.. 2.. 3..	

SECTION 8: VIEWPOINTS AND SUGGESTIONS FOR AIDS CONTROL ACTIVITIES IN THE COMMUNE

No.	Wording and Instructions	Category/Modalities Code	Report to
Q801 GrpAIDS	Do you think you are adequately informed and sensitized to AIDS in the Commune?	Yes…..…1 No....2	
Q801 A WWentity	If so, by whom and/or which structure?	Town Council..….1 Hospital….....2 School…..3 Mass media..4 Family /Friends…..….....5 NGOs (to be specified)7	
Q801 B Wactsens	What AIDS sensitization and control activities do these structures carry out in the Commune?	List them...…	
Q801D Satisfact	Are you satisfied with the services provided by these structures involved in AIDS control in the Commune?	Yes…..…1 No....2	
Q801E SatisfactP	Why? (3 reasons at the most, whatever the answer)	1.. 2.. 3..	
Q802 Commpri	Must AIDS control be a priority for your commune?	Yes…..…1 No....2	
Q802A Plpcomm	Why? (3 reasons at the most, whatever the answer)	1… 2…. 3…..	
Q803	What are the means for AIDS control the communal authorities should put in place?		
Q803A Sensmean	Sensitization unit	Yes…..…1 No....2	
Q803B Distmean	Facilitate condom distribution	Yes…..…1 No....2	
Q803C Testmean	Facilitate AIDS screening	Yes…..…1 No....2	
Q803D Treatmean	Provide treatment to sick people	Yes...1 No....2	
Q804 Favor	What is to be done to promote voluntary testing? (3 reasons, maximum)	1 2…..... 3…..	
Q805 Untest	Have you already had a screening test?	Yes...1 No…..…..2	
Q805A Testyear	If so, in which year?	!..... !..... !..... !..... !	
Q805B Untest	If no, are you ready to do a screening test?	Yes...1 No....2 Does not know 3	
Q806A Wuntest	Why? (3 reasons, maximum)	1 2 3	
Q807 Suggest	What do you suggest for the establishment of a HIV/AIDS control plan in your commune?	1 2 3	

ANNEX 3

MODE OF SELECTION OF THE PARTICIPANTS IN THE SURVEY

Focus Group Discussions were held in each Census District identified for the household survey, namely in the following four Census Districts: Cafetou, Comikro, Dioulakro 1 and Dioulakro Sud[58]. In each Census District at least two Focus Group Discussions were held (one with women and another one with men).

Two teams of two individuals each conducted the Focus Group Discussions. Each team was to conduct four Focus Group Discussions.

The participants in the different focus groups were selected through the sampling technique referred to as "functional sampling" or "convenient sampling". Thus, target individuals of both sexes (men and

[58] District de recensement : unité renfermant en moyenne 200 ménages, un quartier peut se décomposer en district de recensement selon sa taille

women) were selected: fifteen years and over. They were deemed as the most qualified to provide the desired information on STI/HIV/AIDS through note-taking.

RECORDING OF FOCUS GROUPS DISCUSSIONS: NOTE-TAKING

For data recording, note-taking was selected because it was deemed as the simplest working method for the observer. It enables him/her to collect all possible details on body language, which the other methods (tapes, video recording) do not allow from the outset. The latter might influence participants.

INTRODUCTION

Good morning Ladies/Gentlemen – Introduce yourself (The Team)

In the framework of HIV/AIDS control, the BNETD (Bureau National d'Etudes Techniques et de Développement) launches, jointly with ANUMI and UN-Habitat, a survey aimed at conducting community interviews to understand people's perception of AIDS in the Commune of Abengourou. To that end, we will talk about AIDS and sexually transmitted infections. I reassure you that the survey will be confidential and anonymous.

We can start if you have no objection.

ANNEX 4

SURVEY SHEET

Focus Group No.: ….....….....

Neighborhood/Census district:...

Facilitator:Rapporteur.....

Started at .Ended at:……..…

IDENTIFICATION AND DETAILS ABOUT THE PARTICIPANTS

Participants	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Age	**!... !...!**	**!... !...!**	**!... !...!**	**!... !...!**	**!... !...!**	**!... !...!**	**!... !...!**	**!... !...!**	**!... !...!**	**!... !...!**
Kinship with the HH (Household head) 01. HH 02. Spouse 03. Daughter 04. Step-daughter 05. Mother 06. Sister 07. Sister-in-law 08. Niece 09. Grand-daughter 10. Other parent 11. Unrelated	**!... !...!**	**!... !...!**	**!... !...!**	**!... !...!**	**!... !...!**	**!... !...!**	**!... !...!**	**!... !...!**	**!... !...!**	**!... !...!**
Education level **(Last class attended)**	**!... !...!**	**!... !...!**	**!... !...!**	**!... !...!**	**!... !...!**	**!... !...!**	**!... !...!**	**!... !...!**	**!... !...!**	**!... !...!**

Matrimonial status 01. Married 02. Single 03. Divorced 04. Widow	!... !...!	!... !...!	!... !...!	!... !...!	!... !...!	!... !...!	!... !...!	!... !...!	!... !...!	!... !...!
Participant's occupation 01. Public wage earner 02. Private wage earner 03. Petty trade 04. Service 05. Craft industry 06. Pupil 07. Unemployed 08. Retired 09. Housewife	!... !...!	!... !...!	!... !...!	!... !...!	!... !...!	!... !...!	!... !...!	!... !...!	!... !...!	!... !...!
Household membership	!... !...!	!... !...!	!... !...!	!... !...!	!... !...!	!... !...!	!... !...!	!... !...!	!... !...!	!... !...!

ANNEX 5

INSTRUCTIONS FOR FILLING THE IDENTIFICATION SECTION

Kinship with the HH		**Educational level**
01. HH (Household head)		00. Uneducated
02. Spouse		01. Grade 1
03. Daughter/son		02. Grade 2
04. Step-daughter/step-son		03. Grade 3
05. Mother/father		04. Grade 4
06. Sister/brother		05. Grade 5
07. Sister-in-law/Brother-in-law		06. Grade 6
08. Niece/Nephew		07. First form
09. Grand-daughter/grandson		08. Second form
10. Other relation		09. Third form
11. Unrelated		10. Forth form
		11. Fifth form
		12. Lower sixth form
		13. Upper sixth form
		14. Higher education
Matrimonial status		**Participant's occupation**
01. Married (legally, customarily) or unmarried cohabitation)		01. Public wage earner (civil servant)
02. Single		02. Private wage earner (company, private enterprise)
03. Divorced		03. Petty trade: market seller, street hawker...
04. Widow		04. Service: transportation, Xerox-copying, catering....)
		05. Arts & crafts: basket maker, sculptor, painter.....
		06. Pupil
		07. Unemployed
		08. Retired
		09. Housewife.

ANNEX 6

GUIDE FOR DISCUSSION ABOUT HIV/AIDS IN THE COMMUNE OF ABENGOUROU

1. KNOWLEDGEABILITY ABOUT STI/AIDS

a. What do you know about sexually transmitted infections (STIs)?
b. What do you know about HIV/AIDS?
c. How do you think one can get AIDS?
d. Is there a local name for AIDS?
e. What does it mean?
f. How can we tell someone has AIDS?
g. What difference do you make between a HIV-positive individual and an AIDS patient?
h. In your views how can AIDS be cured? Specify.
i. How can AIDS be avoided?
j. What do you know about condoms?
k. Where can you procure condoms?

2. STI/AIDS RELATED ATTITUDES

a. How would you behave towards an allegedly HIV/AIDS-infected individual?
b. What would you do if a member of your family had HIV/AIDS?
c. What would you do if one of your kin or workmates had HIV/AIDS?
d. What do you think of infected people who keep on working?
e. What are places that are liable to facilitate transmission?

3. PRACTICES REGARDING STI/HIV/AIDS

a. What do you use as treatments for STIs (Sexually transmitted infections)?
b. What steps do you take to prevent STIs?
c. What steps do you take to prevent HIV/AIDS?
d. What steps should be taken to avoid being infected by the AIDS virus?
e. What do you know of the screening test?
f. Would you accept to do or repeat your screening test? Why?
g. How do STI/AIDS control committees operate in your commune (in terms of activities)?
h. In what are you satisfied with these committees?
i. What problems do they come across?
j. In what are you satisfied with the Town Council as regards HIV/AIDS control?

4. COMMUNICATION PLAN

a. As regards STI/AIDS control what do you expect from the Municipality?
b. What AIDS control means could the Town Council put in place?
c. In your views, how can your knowledgeability and your community's knowledgeability of AIDS be improved (suggestions)?
d. Group dynamics (comments following the focus group).

ANNEX 7

WEIGHTING OF VARIABLES PERTAINING TO KNOWLEDGEABILITY, BEHAVIOR AND PRACTICE (KOFFI Marcel, 2004)

SECTION 2, SECTION 3, SECTION 4: KNOWLEDGEABILITY ABOUT STI/AIDS:

(The serial numbers are the same as the serial numbers in the questionnaire)

Q 201 Have you ever heard of STIs ?(maximum = 0.5 score)

- Yes 0.5 score ——
- No 0 score ——

Q202 List STDs STIs you know of? (maximum = 1score)
- Gonococcal infection 0,25 score
- Syphilis 0,25score
- AIDS 0,25 score
- Chancroid 0,25 score

Q203. Have you ever heard of AIDS? (maximum=0.5score)
- Yes 0,5 score
- No 0 score

Q205. Does AIDS really exist? (maximum=1score)
- Yes 1 score
- No 0 score

Q206 Definition of AIDS ? (maximum=1score)
- Right 1 score
- Wrong 0 score
- Does not know 0 score

Q207 Abengourou is among the most hit communes in Côte d'Ivoire by AIDS ? maximum=0,5score)
- Yes 0,5 score
- No 0 score
- Does not know 0 score

Q208 Does malaria favor HIV infection? (maximum=0,5score)
- Correct 0 score
- Incorrect 0,5 score
- Does not know 0 score

Q209 Can the fact of having an STI favor HIV infection? (maximum=1 score)
- Yes 1 score
- No 0 score
- Does not know 0 score

Q210 Can the AIDS virus trigger other diseases? (maximum=1 score)
- Yes 1 score
- No 0 score
- Does not know 0 score

Q212 How can we tell someone is HIV infected (maximum=1 score)
- Blood test 1score
- Urine test 0score
- Clinical examination 0score
- Does not know 0score

Q213 Can one live long (10 years) with the AIDS virus? (maximum=0,5 score)
- yes 0,5score
- No 0 score
- Does not know 0 score

Q214 Can someone who looks healthy have the AIDS virus in his body? (maximum=0,5 score)
- yes 0,5score
- No 0 score
- Does not know 0 score

Q215 Is there a cure to AIDS? (maximum=0,5 score)
- yes 0,5score
- No 0 score
- Does not know 0 score

Q301 The contamination by the AIDS virus is communicable through: (maximum=5,5score)
- Drug I.V. 0,5 score
- Unprotected sex 0,5 score
- Contaminated objects 0,5 score
- Mother-to-child transmission 0,5 score
- Blood transfusion 0,5 score
- Circumcision/excision 0,5score
- By marrying the wife/husband of a deceased relation 0,5score
- During reunion celebrations (Yam festival, Easter celebration, end-of-school year balls – in schools – cultural and sports events) 0,5score
- At wail-keepings 0,5score
- In unfinished buildings 0,5score
- In marketplaces by night 0,5score

Q401 Risk behaviors that can cause HIV contamination (maximum=5 score)
- Having several partners 1score
- Unprotected sex 0,5 score
- Syringes in clinics 0,5score
- Hanging around drinking establishments 0,5score
- Hanging around bars, hotels and night-clubs 0,5score
- Care products 0,5 score

Itinerant barbers 0,5 score
Having sex while under the influence of alcohol 0,5score
Associating with prostitutes 0,5 score

KNOWLEDGEABILITY EVALUATION: (TOTAL = 20 SCORES)

Total > 15 score	Good level
Total comprised between 15 and 10 score	Average level
Total<10 score	Low level

SECTION 5: STI/HIV/AIDS RELATED ATTITUDES

Q501. Do you think you can be personnally infected by the virus? (maximum = 1 score)
Yes 1 score
No 0 score
Q502 Is it embarrassing to consult a doctor when we think we are AIDS-infected? (maximum = 1 score)
Yes 1 score
No 0 score
Q504 Should we inform our partner if we had AIDS? (maximum = 0,5 score)
Yes 0,5score
No 0 score
Q505 Will you keep on associating with a kin if they have AIDS? (maximum = 0,5 score)
Yes 0,5score
No 0 score
Q506 Should the virus-infected individuals go to the same places as others? (maximum = 0,5 score)
Yes 0,5score
No 0 score
Does not know 0 score
Q507 Should the AIDS-infected individuals be compelled to inform other people? (maximum = 0,5 score)
Yes 0,5score
No 0 score
Does not know 0 score
Q508 Should the AIDS-infected individuals be authorized to work? (maximum = 0,5 score)
Yes 0,5score
No 0 score
Q509 Have you changed behaviors since AIDS was publicized? (maximum = 1 score)
Yes 1 score
No 0 score
Q509A1 Condom use (maximum = 0,5 score)
Yes 0,5 score
No 0 score
Q509A2 Faifulthness (maximum = 0,5 score)
Yes 0,5 score
No 0 score
Q509A3 Abstinence (maximum = 0,5 score)
Yes 0,5 score
No 0 score
Q509A4 Use of disposable objects for body care (maximum = 0,5 score)
Yes 0,5 score
No 0 score
Q509A5 No association with prostitutes (maximum = 0,5 score)
Yes 0,5 score
No 0 score
Q509A6 No sexual intercourse during my period (maximum = 0,5 score)
Yes 0,5 score
No 0 score
Q509A7Avoid levirate/sororate(maximum = 0,5 score)
Yes 0,5 score
No 0 score
Q510 Who have you talked about AIDS with? Is it with (maximum = 1 score)
Partner/spouse 0,25 score
Mother 0,25 score
Father 0,25 score
Aunt/Uncle 0,25 score

ASSESSMENT OF STI/HIV/AIDS RELATED ATTITUDE (Total = 10)

Total > 6 score	Good attitude
Total equal 5 or 6 score	Accescoreable attitude
Total<5 score	Inadequate attitude

SECTION 6 AND SECTION 8: SEXUAL PRACTICES

Q601 How old were you when you first had sex? (maximum = 0,5)
<18 0,5 score
= 18 0 score
Q604 How many partners do you have? (beside your regular partner)? (maximum = 1)
0 partner 0 score
= 1 partner 1 score
Q605 Have you ever had sex during your menses? (maximum = 1 score)
Yes 1 score
No 0 score
Q606 What your typical sexual practices? (maximum = 1)
Genito-genital 0 score
Bucco-genital .....0,5 score

Genito-anal 0,5 score
Q607 Have you ever had unprotected sex with a casual partner? (maximum = 1 score)
Yes 1 score
No 0 score
Q608A Which partner did you have this intercourse with? (maximum = 1 score)
Regular partner 0 score
Casual partner 1 score
Q609 Have you ever used condoms? (maximum = 1 score)
Yes 0 score
No 1score
Q610 Do you use condoms with your regular partner? (maximum = 1 score)
Yes 0 score
No 1 score
Q611 Do condoms make sex feel less pleasant? (maximum = 0,5 score)
Yes 0,5 score
No 0 score
Q613 Did you use a condom during your last sexual intercourse we talked about earlier? (maximum = 0,5 score)
Yes 0 score
No 0,5 score
Q617 How often do you use condoms with regular partners? (maximum = 1 score)
Always 0 score
From time to time ..... 0 score

Never 1 score
Q618 Can the use of condom help prevent STDs (STIs) AIDS? (maximum = 0,5 score)
Yes 0 score
No 0,5 score
Q619 A - Have you ever had sex with prostitutes? (maximum = 0,5 score)
Yes 0,5 score
No 0 score
Q619B Have you ever had unprotected sex? (maximum = 0,5 score)
Yes 0,5 score
No 0 score
Q619C Have you ever had sex with casual sexual partners? (maximum = 0,5 score)
Yes 0,5 score
No 0 score
Q619 D Has the condom ever "burst" during the sexual intercourse? (maximum = 1 score)
Yes 1 score
No 0 score
Q619E Have you ever had sex under the influence of alcohol? (maximum = 0,5 score)
Yes 0,5 score
No 0 score
Q620 In 2004 did you have sex with other (casual) partners? (maximum= 1 score)
Yes 1 score
No 0 score
Q620A If so, how many in 2004 ? (maximum = 1 score)
1 partner 0,5 score
> 1 partner 1 score
Q621 In 2005 (January –July) have you had sex other (casual) partners? (maximum = 1 score)
Yes 1 score
No 0 score
Q621A If so, how many in 2005? (maximum = 1 score)
1 partner 0,5 score
> 1 partner 1 score
Q622B How did you manage to get treatment the last time you had an STD/STI? (maximum = 1 score)
Hospital 0 score
Pharmacy, Neighborhood nursery, Self-prescriscoreion, Traditional healer 1 score
Q805 Have you ever had screening test ?)(maximum = 1 score)

Yes 0 score
No 1 score

Q806 Are you ready to do your screening test again?) (maximum = 1 score)

Yes 0 score
No 1 score

ASSESSMENT OF SEXUAL PRACTICES (Total= 20 scores)

Good sexual practices 0 score
Acceptable practices (but presence of risks) 01-07 score
Inappropriate practices (considerable risk) 08-14 score
Bad practices
Dangerous practices (major risk) 15- 20

République de Côte d'Ivoire
REGION DE MOYEN COMOE
DEPARTEMENT D'ABENGOUROU
COMMUNE D'ABENGOUROU

MUNICIPAL ACTION PLAN AGAINST HIV / AIDS

CONSULTATIVE PROCESS AND STRATEGIES

March 2006

BUREAU NATIONAL D'ETUDES TECHNIQUES ET DE DEVELOPPEMENT

ACRONYMS

IGA : Income Generating Activities
AJI :
ANADER : *Agence Nationale d'Appui au Développement Rural* (National Agency for Rural Development)
ANUMI : *Réseau Africain des Institutions de Gestion Urbaine* (African Network of Urban Management Institutions)
ARV : AntiRetroVirals
BNETD : *Bureau National d'Etudes Techniques et de Développement* (National Bureau of Technical Surveys and Development)
CAT : *Centre Antituberculeux* (TB Control Center)
BCC : Behavior Change Communication
VCT : Voluntary Counseling and Testing center
CIDV : Center of Information and Voluntary Testing
CRTS : *Centre Régional de Transfusion Sanguine* (Regional Blood Transfusion Center)
DAUDL : *Département Aménagement Urbain et Développement Local* (Department of Urban planning and Local Development)
DREN : *Direction Régionale de l'Education Nationale* (Regional Directorate for National Education)
FRAT-MAT : Fraternité Matin
GAPA : *Génération des Alliés Pour le Progrès d'Abengourou* (Allies Generation for Progress in Abengourou)
IEC : Information, Education and Communication
STI : Sexually Transmitted Infections
STD : Sexually Transmitted Diseases
OVC : Orphan and Vulnerable Children
NGO : Non Governmental Organization
PAVIH : HIV-affected individual
PEC : Care
EPI : Expanded Immunization Program
PMCT : Prevention of Mother-to-Child Transmission
PLWHA : Person Living With HIV/AIDS
RETRO-CI : Rétrovirus Côte d'Ivoire
AIDS : Acquired Immuno – Deficiency Syndrome
HIV : Human Immunodeficiency Virus
VIPP : Visualization Integrated to Participatory Processes

TABLE OF CONTENTS

INTRODUCTION

The HIV/AIDS pandemic has been raging in Sub-Saharan Africa for some time, especially in Côte d'Ivoire where the prevalence rate ranks among the highest.
The city of Abengourou, in the East of the country, appears as the most severely affected locality with a 14.6 % prevalence rate.
It is in this context that the relevant authorities have been working continuously to promote the contribution of all partners whose intervention could foster a critical reduction of the plague.

In the context of UN-HABITAT actions to better grasp the impact of HIV/AIDS pandemic at the local level and build municipal capacity to manage it, the *Bureau National d'Etudes Techniques et de Développement*/BNETD (National Bureau of Technical Surveys and Development), in partnership with the *Réseau Africain des Institutions de Gestion Urbaine /ANUMI* (African Network of Urban Management Institutions), conducted a pilot project in Abengourou Commune in order to develop a municipal HIV/AIDS control plan.
The methodological approach adopted by BNETD for this mission builds on three (3) critical phases:

- The diagnosis phase

This phase comprises two stages:

- A situational analysis conducted by BNETD helped establish an external diagnosis.
- An Open day enabled local populations to voice their problems directly, thus giving rise to an internal diagnosis.

The results of both stages made it possible to establish a summary diagnosis called strategic diagnosis.

- The planning phase

It is conducted as a workshop and involves the following stages:

- Validation of the summary diagnosis (internal and external);
- Formulation of a shared vision for HIV/AIDS control;
- Presentation and validation of the strategic foci of the intervention;
- Presentation and validation of intervention programs;
- Formulation of specific goals for each program;
- Definition of actions for each specific goal;
- Development of a performance timeframe over ten years.

- Programming phase

It is conducted as a workshop and comprises two main stages:

- Selection of the project actions for each strategic focus;
- Development of the draft project sheets.

PART ONE
OPEN DAY

1.1 - METHODOLOGY

The approach used to carry this Open day is the Visualization Integrated to Participatory Processes (VIPP).

It combines brainstorming used to generate ideas and the meta-plan for continuous card-based visualization with some simple rules: one idea per card, respect of others' points of view and consensus on the ideas to be retained. This approach alternates plenary sessions and group work.

The supervision of the small groups was ensured by a team of four (4) BNETD experts, with one of them acting as senior moderator.

1.2 - Roll-out of the Open day

The Open day was held in Abengourou on August 10, 2005.

It involved four (4) stages:

- The opening ceremony,
- The constitution of work groups,
- Work in committees,
- The summary of the results.

1.2.1 – Opening ceremony

The opening ceremony was held in the conference room of the Abengourou City Hall.

It gathered about 80 people, including:

- The Secretary General of the Prefecture representing the Prefect of the Moyen Comoé region;
- The first Deputy Mayor of Abengourou commune;
- The Director of the Department of Urban planning and Local Development (DAUDL), representing the BNETD General Manager;
- Administrative service officers seconded in the commune;
- The representatives of various socio-professional categories of the commune.

The ceremony was marked by various speeches that stressed the interest of developing a municipal HIV/AIDS Plan to guide the action of the City Council. These speeches also hailed the contribution of BNETD and the effective participation of various socio-professional categories of the commune.

I.2.2 - Constitution of the work groups

After the opening ceremony and the authorities' departure, all the participants moved to the Catholic Mission for the actual launch of the Open day proceedings. Three groups were formed:

- Women,
- Men,
- Youth.

Each group chose a chairman and a rapporteur.

1.2.3 –Workshop proceedings

The three groups had to reflect upon the six (6) following questions:

Question n° 1

The city of Abengourou is the most affected by the HIV/AIDS pandemics, how can you explain this situation?

Question n° 2

a- Which social categories are most affected by the pandemics in Abengourou?
b- Why?

Question n° 3

What are the socio-economic impacts of HIV/AIDS on individuals, households and business sectors in Abengourou?

Question n° 4

a- What actions have already been taken against HIV/AIDS in the commune?
b- What are the outcomes of these actions?

Question n° 5

What priority actions should be undertaken to fight HIV/AIDS?

Question n° 6

What do you expect from the commune in terms of HIV/AIDS control?

1.2.4 – Summary of the outcomes of group work

Question n° 1

The city of Abengourou is the most affected by HIV/AIDS pandemics, how can you explain this situation?

- ✓ Abengourou, a peaceful city
- ✓ Abengourou, a transit city
- ✓ Abengourou, a frontier city (melting pot)
- ✓ Abengourou, an attractive city (agricultural development)
- ✓ Inadequacy of student accommodation facilities
- ✓ General increased poverty
- ✓ Negative influence of mass media on the youth

Question n° 2

a- Which social categories are most affected by the pandemics in Abengourou?

- ✓ Uniformed services
- ✓ Teachers
- ✓ Women
- ✓ Youth
- ✓ Farm workers
- ✓ Sex workers
- ✓ Truck drivers

b- Why?

Youth:

- ✓ Sexually active
- ✓ Mimicry
- ✓ Poverty
- ✓ Naivety
- ✓ Let to themselves when they come to town
- ✓ Early sex

Women:

- ✓ Economic dependence
- ✓ Biological vulnerability
- ✓ Sexual vulnerability
- ✓ Customs: levirate, polygamy, excision, sororate, shaving
- ✓ Childbearing desire
- ✓ Illiteracy

- ✓ Unfaithfulness
- ✓ Wish to show off
- ✓ Poverty

Uniformed service:

- ✓ Professional mobility
- ✓ Dominant position
- ✓ Easy money-making
- ✓ Carelessness
- ✓ Far from family
- ✓ Uniform impressing young girls

Teachers:

- ✓ Dominant position
- ✓ Sexual harassment
- ✓ Carelessness

Sex workers:

- ✓ Poverty
- ✓ Easy money-making
- ✓ Wish to show off
- ✓ Carelessness

Question n° 3

What are the socio-economic impacts of HIV/AIDS on individuals, households and business sectors in Abengourou?

Individuals:

- ✓ Isolation
- ✓ Poverty
- ✓ Numerous deaths
- ✓ Numerous orphans

Households:

- ✓ Increased poverty
- ✓ Excess of expenses
- ✓ Orphans
- ✓ Youth delinquency
- ✓ Disruption of the family unit
- ✓ Powerlessness of the individual
- ✓ Incapacity to educate and take care of the children

Business sectors:

- ✓ Reduction in labor
- ✓ Absenteeism
- ✓ Abandonment of position
- ✓ Decreased performance
- ✓ Increased workload at the medical level

Question n° 4

a- What actions have already been taken against HIV/AIDS in the commune?

- ✓ Access to ARVs
- ✓ Decreased prevalence rate
- ✓ Quizzes: "génies en herbe"("reach for the top") and "génies santé SIDA"
- ✓ Establishment of a VCT
- ✓ Creation of a monitoring center
- ✓ Development of automated condom dispensers
- ✓ Creation of condom sale points

- ✓ Condom distribution
- ✓ Establishment of a C.D.I.S
- ✓ Conducting training workshops
- ✓ Establishment of village committees
- ✓ Organization of awareness-raising days
- ✓ Development of AIDS control committees
- ✓ Community moralization
- ✓ Organization of quizzes in educational institutions
- ✓ Care for infected and affected families
- ✓ Care for OVCs
- ✓ Strengthening of health club actions
- ✓ Wide dissemination of HIV/AIDS information

b- What are the outcomes of these actions?

- ✓ Awareness
- ✓ Decrease in the prevalence rate from 14.4 % to 10.8 %
- ✓ High involvement of donors in AIDS control in Abengourou

Question n° 5

What priority actions should be undertaken to fight HIV/AIDS?

- ✓ Door-to-door outreach activities by neighborhood committees
- ✓ Fighting stigma and discrimination
- ✓ Holding awareness raising days
- ✓ Promoting condom use
- ✓ Promoting antiretrovirals (ARVs)
- ✓ Strengthening NGO activities
- ✓ Developing accredited centers
- ✓ Voluntary testing
- ✓ Medical and psychosocial care

Question n° 6

What do you expect from the commune in terms of HIV/AIDS control?

- ✓ Technical and financial support to HIV/AIDS control facilities
- ✓ Establishment of a local radio
- ✓ Establish awareness raising units in all neighborhood
- ✓ Training in community approach methods
- ✓ Economic empowerment (IGA)
- ✓ Improved access to ARVs
- ✓ Psychosocial care of affected people
- ✓ Reactivating existing facilities

1.3 –PARTICIPATION ANALYSIS

On the whole, 40 participants from Abengourou commune took part in the Open day on August 10, 2005.

The analysis of the constitution of the various groups highlights the following:

- ❑ **MEN**
- ✓ Overall participants: 06
- ✓ Various social professional categories represented:
  - Teachers: 02
  - Administrators: 04
- ❑ **WOMEN**
- ✓ Overall participants: 09

- ✓ Various social professional categories represented:
  - Women traders: 04
  - Students: 02
  - Administrators: 02
  - Teachers: 01
- **YOUTH**
- ✓ Overall participants: 15
- ✓ Various social professional categories represented:
  - Students: 03
  - Administrators: 03
  - Teachers: 03
  - Photo reporter: 01
  - Computer specialist: 01
  - Nurse: 01
  - Security agent: 02
  - Physician: 01

The analysis of participation highlights the following weaknesses:

- ✓ The medical sector is not adequately represented
- ✓ The youth group comprised several individuals who could have reinforced men's group

Part Two

PLANNING WORKSHOP

INTRODUCTION
The planning workshop was held as a follow-up to the Open day held on August 10-13, 2005. All the participants in the Open day were retained to participate in the planning workshop.

2.1 - METHODOLOGY

The workshop proceedings were as follows:

1. Validation of the summary diagnosis (internal and external);
2. Formulation of the HIV/AIDS shared vision;
3. Presentation of the strategic foci of the intervention;
4. Identification of intervention programs.

These first four (4) stages were developed in plenary sessions. As to the last three (3) stages, they were conducted in small work groups dealing with the:

1. Formulation of specific goals based on programs
2. Definition of actions for each specific goal
3. Development of actions timeframe over 10 years

The supervision of the small groups was ensured by a team of four (4) BNETD experts, with one of them acting as senior moderator.

2.2- OUTCOMES

2.2.1- Summary Diagnosis (internal and external):

The BNETD supervision team crosschecked the external diagnosis (developed by BNETD) and the internal diagnosis resulting from the Open day.
Following this crosschecking, the following summary was made:

2.2.1.1 Stocktaking

1.1. Target populations and justification

1.1.1 Uniformed services

- Posted far from family
- Mobility
- Easy money-making
- Sexually active
- Dominant position
- Uniform impressing young girls

1.1.2 Women

- Childbearing desire
- Ritual events (Yam festival, Easter ("*paquinou*"),…)
- Use of contaminated objects
- Mother-to-child transmission
- Poverty
- Customs and traditions (levirate, sororate, shaving rite, excision,…)
- Wail-keeping
- Unfaithfulness of couples
- Vulnerability (economic, sexual, biological)
- Illiteracy
- Blood transfusion

1.1.3 15-30 Youth

- Condom breaking during sexual intercourse
- Poverty
- Daring and provoking clothes
- Megalomania (wish to show off)
- Let to themselves in urban setting
- Sexual activity
- Early sex
- Sex under the influence of alcohol and substance
- Injection in private nursing facilities
- Hanging around drinking establishments
- Hanging around bars and hotels
- Mimicry
- Naivety
- Generation gap
- Interaction with prostitutes

1.1.4 *Teachers*

- Dominant position
- Carelessness
- Sexual harassment
- Continuous contact
- Multiple partners
- Sexually active
- Shaving beard by itinerant barbers

1.1.5 *Truck drivers*

- Sexually active
- Mobility
- Multiple partners
- Casual sex

1.1.6 *Sex workers*

- Poverty
- Easy money-making
- Carelessness
- Unprotected sex
- Loose morals: sex in unfinished houses, especially in markets
- Alcohol
- Drug/substance
- Smoking
- Hanging around bars, hotels, drinking establishments
- Wish to show off
- Multiple partners

1.2 Socio-economic impacts

1.2.1 *Individuals*

- Isolation
- Poverty
- Stigma

1.2.2 *Households*

- OVCs
- Youth delinquency
- Poor access to care, education
- Disruption of households
- Stigma
- General increased poverty

1.2.3 Business sectors

- Labor shortage
- Absenteeism
- Position abandonment
- Decreased performance
- Overload of health professionals
- Reduced labor
- Decreased performance in the economic sector
- Disruption of family unit

NB: **Cross-cutting impacts**

- Stigma
- Numerous deaths
- Disruption of households

2.2.1.2 Analysis of local/communal response

2.1 STIs/HIV/AIDS prevention

2.1.1 Potentialities (strengths-opportunities)

- Existence of NGOs
- Establishment of VCTs
- Creation of monitoring centers
- School committees
- Wide dissemination of AIDS
- Village committees
- Dispensing machines
- Facilities to support GE (pilot project)

2.1.2 Constraints (Threats-weaknesses)

- Denial (rejection)
- Communal villages somehow disregarded
- No specific activities for truck drivers
- Non-operational VCTs
- Significant use of auto-medication and informal structures (*Comian*,…)
- Institutional non-viability
- High migration

2.1.3 Recommendations

- Financial support
- Reactivation of existing facilities
- Establishment of awareness raising units in neighborhoods
- Availability of condoms to the public
- Reduction in condom price
- Awareness of adults about tradition
- Reopening of VCTs
- The Municipality must provide technical and financial support to activities
- Training in BCC/IEC
- Increased awareness raising for target populations
- Conduct activities to reduce PLWHA stigma and discrimination

2.2 STIs/HIV/AIDS care

2.2.1 Potentialities (Strengths and opportunities)

- Existence of a therapy committee
- Gradual organization of PLWHA medical care
- Experience gained from PMCT project implementation
- Availability of ARVs

- Involvement of NGOs and associations
- Training of medical staff in counseling

2.2.2 Constraints

- Poverty of populations
- Lack of home-based activities and guidance
- Inadequate financial resources of NGOs
- Few NGO are involved in home-based care, follow-up and accompanying

2.2.3 Recommendations

- Develop assistance programs
- Adopt a policy of ARV cost reduction
- The municipality must provide care to PLWHAs
- Study on AIDS socio-economic impact
- Study on PLWHAs' rights and duties
- Study on HIV direct and indirect costs

2.2.2 – Abengourou's vision of HIV/AIDS control

Vision is the mental representation of what a community or a person must do or become. Far from being a sterile picture, this vision builds upon a clear awareness of the intrinsic capacities and opportunities offered by environment. This exercise enables the representatives of Abengourou population to develop the following vision:

"Abengourou, a commune sufficiently aware of HIV/AIDS pandemics, with a prevalence reduced to 7 % and an environment conducive to improved care of infected and/or affected people."
In brief, the commune of Abengourou wants to build upon the unity of its children and on its openness to the world to generate the wealth that will eventually lead to social welfare.

2.2.3 – Intervention strategic foci
The strategic foci are the main pillars on which the City Council will build its action for the 10 coming years, that is 2005-2007.
These strategic foci arise from the strategic diagnosis and build upon the potentialities and weaknesses of the territory. Thus, three (3) strategic foci have been identified:

- Prevention;
- Care;
- Local response.

2.2.4 - Intervention programs arise from the strategic foci. They help structure the municipal plan in coherent fields within the strategic foci of the commune action. Thus, the workshop identified **11 intervention programs**.

2.2.5- Specific Goals
Specific goals provide a clearer content of each strategic focus. They deal with the changes required in a given activity sector to reach the desired development. The specific goal appears as the result reached.
The specific goals are gathered per activity field to form the intervention programs. On the whole, **17 specific goals** were determined by the workshop.

2.2.6- Actions
Actions are the concrete activities to be undertaken to achieve the specific goals. For a given specific goal, there must be clearly defined actions.
On the whole, **40 actions** were determined to achieve the 17 specific goals identified.

Thus, Abengourou's MUNICIPAL HIV/AIDS CONTROL PLAN is broken down in **3 strategic actions**, **11 development programs, 17 specific goals** and **40 actions** for the 10 coming years (2004 – 2014).

2.2.7 – Reference Table of strategic foci, programs, specific goals and actions

STRATEGIC FOCUS N° 1**: PREVENTION**

1.1 AWARENESS RAISING

1.1.1 **Information is well-perceived**

1.1.1.1 Use appropriate communication networks

1.1.1.2 Mobilize adequate communication channels

1.1.1.3 Ensure outreach activities

1.1.1.4 Disseminate messages in local languages

1.1.2 Stigma and discrimination are mitigated

1.1.2.1 Educate people to accept PLWHAs

1.1.2.2 Ensure better protection of PLWHAs

1.2 TESTING

1.2.1 **The biological test of the target population is known**

1.2.1.1 Establish and equip several VCTs

1.2.1.2 Obtain the informed consent of individuals through a well-conducted counseling

1.3 CONDOMS

1.3.1 **Condoms are accessible**

1.3.1.1 Establish several sales points

1.3.1.2 Popularize condoms

1.3.1.3 Subsidize condoms for vulnerable populations

1.3.2 Condom use is improved

1.3.2.1 Monitor and evaluate the stocks of deposited condoms

1.3.2.2 Promote condom use skills

1.4 CAPACITY BUILDING

1.4.1 Material means are ensured

1.4.1.1 **Acquire materials** (teaching aids, mobile equipment)

1.4.2 The actors master HIV/AIDS control tools

1.4.2.1 Prepare training modules

STRATEGIC FOCUS N° 2**: CARE**

2.1 VCTs

2.1.1 VCT capacities are strengthened

2.1.1.1 Reinforce VCT staff

2.1.1.2 Build capacities for VCT staff

2.1.1.3 Equip VCTs with materials and supplies

2.1.1.4 Develop new VCTs

1.1.2 VCTs are more visited

1.1.2.1 Educate people to accept PLWHAs

2.2 ARVs

2.2.1 ARVs are accessible

2.2.1.1 Equip health facilities in ARVs

2.2.1.2 Facilitate PLWHA access to ARVs

2.2.1.3 Inform the population of ARV availability

2.2.1.4 Train ARV prescriptors

2.3 IGAs

2.3.1 IGAs are developed

2.3.1.1 Foster the development of micro-projects

2.3.1.2 Develop a support fund

2.3.1.3 Train PLWHAs in micro-project management

2.3.2 IGAs are monitored and evaluated

2.3.2.1 Establish a monitoring and evaluation committee

2.4 PSYCHO-SOCIAL SUPPORT

2.4.1 Financial support is available

2.4.1.1 Mobilize resources for psycho-social support

2.4.2 **Infected and affected people are provided support**

2.4.2.1 Develop a support committee

2.5.1 STIs are properly managed

2.5.1.1 Subsidize KITS

2.5.1.2 Train the staff in syndromic management

STRATEGIC FOCUS N° 3**: LOCAL RESPONSE**

3.1 LEADERSHIP

3.1.1 Local leadership is asserted

3.1.1.1 Coordinate HIV/AIDS activities on the communal territory

3.1.1.2 Search and facilitate partnerships for effective management of the fight

3.1.1.3 Initiate project and program monitoring and evaluation actions

1.1.2 PLAN IMPLEMENTATION

1.1.2.1 Educate people to accept PLWHAs

3.2.1.1 Develop appropriate means for plan management (plan management technical unit, communal/municipal committee, monitoring & evaluation…)

3.2.1.2 Leverage internal and external resources

3.2.1.3 Ensure mobilization around the plan (communication, advocacy)

3.2.1.4 Build capacities (local partners' structures and action)

3.2.1.5 Develop a monitoring and evaluation mechanism for plan implementation

2.2.8 – Actions timeframe (2005-2014)
The timeframe is a critical tool of the MUNICIPAL HIV/AIDS CONTROL PLAN. It informs about the duration and performance period of the actions and identifies the implementation agencies.

Strategic focus: PREVENTION

	Timeline 2005-2014	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	
		1	2	3	4	5	6	7	8	9	10	11	Responsible
1.1	**AWARENESS RAISING**												
1.1.1	**Information is well-perceived**												
1.1.1.1	Use appropriate communication networks												CREC
1.1.1.2	Mobilize adequate communication channels												Munic
1.1.1.3	Ensure outreach activities												Munic
1.1.1.4	Disseminate messages in local languages												CAEP;Munic
1.1.2	**Stigma and discrimination are mitigated**												
1.1.2.1	Educate people to accept PLWHAs												CREC/CASFPF/CACPJS
1.1.2.2	Ensure better protection to PLWHAs												
1.2	**TESTING**												CAEP
1.2.1	**The biological test of the target population is known**												CREC
1.2.1.1	Establish and equip several VCTs												CAEP
1.2.1.2	Obtain the informed consent of individuals through a well-conducted counseling												CASFPF
1.3	**CONDOMS**												
1.3.1	**Condoms are accessible**												
1.3.1.1	Develop several sales points												CASFPF/CACPJS/CAEP
1.3.1.2	Popularize condoms												CREC/CASFPF
1.3.1.3	Subsidize condoms for vulnerable populations												CAEP
1.3.2	**Condom use is improved**												

1.3.2.1	Monitor and evaluate the stocks of deposited condoms												CASFPF
1.3.2.2	Promote condom use skills												CASFPF/CACPJS
1.4	**CAPACITY BUILDING**												
1.4.1	**Material means are acquired**												
1.4.1.1	**Acquire materials** (teaching aids, mobile equipment)												CAEP
1.4.2	**The actors master HIV/AIDS control tools**												
1.4.2.1	Prepare training modules												CASFPF/CREC/CACPJS

Strategic focus: CARE

TIMELINE 2005-2014		2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	
		1	2	3	4	5	6	7	8	9	10	11	Responsible
2.1	**VCT**												
2.1.1	**VCT capacities are strengthened**												
2.1.1.1	Reinforce VCT staff												CASFPF
2.1.1.2	Build capacities for VCT staff												Munic
2.1.1.3	Equip VCTs with material and supplies												Munic
2.1.1.4	Establish new VCTs												CAEP;Munic
1.1.2	**VCTs are more visited**												
1.1.2.1	Educate people to accept PLWHAs												CREC/CASFPF/CACPJS
2.2	**ARVs**												
2.2.1	**ARVs are accessible**												CAEP
2.2.1.1	Equip health facilities in ARVs												CREC
2.2.1.2	Facilitate PLWHAs' access to ARVs												CASFPF/CAEP
2.2.1.3	Inform the population of ARV availability												CREC/CACPJS/CASFPF

2.2.1.4	Train ARV prescriptors												CAEP
2.3	**IGAs**												
2.3.1	**IGAs are developed**												
2.3.1.1	Foster the development of micro-projects												CASFPF/CACPJS/CREC
2.3.1.2	Establish a support fund												CAEP
2.3.1.3	Train PLWHAs in micro-project management												CAEP/CASFPF
2.3.2	**IGAs are monitored and evaluated**												
2.3.2.1	Establish a monitoring and evaluation committee												CAEP
2.4	**PSYCHO-SOCIAL SUPPORT**												
2.4.1	**Financial support is available**												
2.4.1.1	Mobilize resources for psycho-social support												CAEP
2.4.2	**Infected and affected people are provided support**												
2.4.2.1	Develop a support committee												CASFPF
2.5.1	**STIs are properly managed**												
2.5.1.1	Subsidize KITS												CAEP
2.5.1.2	Train the staff in syndromic management												CASFPF/CAEP

Strategic focus: LOCAL RESPONSE

	TIMELINE 2005-2014	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Responsible
		1	2	3	4	5	6	7	8	9	10	11	Responsible
3.1	**LEADERSHIP**												
3.1.1	**Local leadership is asserted**												

3.1.1.1	Coordinate HIV/AIDS activities on the communal territory												Munic
3.1.1.2	Seek and facilitate partnerships for effective management of the fight												Munic
3.1.1.3	Initiate project and program monitoring and evaluation actions												CAEP;Munic
1.1.2	**PLAN IMPLEMENTATION**												
1.1.2.1	Educate people to accept PLWHAs												
3.2.1.1	Develop appropriate means for plan management (plan management technical unit, communal/municipal committee, monitoring & evaluation…)												Munic
3.2.1.2	Leverage internal and external resources												CAEP
3.2.1.3	Ensure mobilization around the plan (communication, advocacy)												CREC
3.2.1.4	Build capacities (local partners' structures and action)												Munic
3.2.1.5	Develop a monitoring and evaluation mechanism for plan implementation												Munic

Part three

PROGRAMMING WORKSHOP

INTRODUCTION

Programming is the ultimate phase of the Municipal Plan development workshop. It involves two stages:

- Action selection;
- Project sheet development

The output of this stage is the action program, which actually is an inventory of all the actions significant enough to require being implemented under a project with the drafting of a proposal for funding purposes.

After the presentation of the drafting method, this document will provide an outline of each project through project sheets in order to briefly grasp the challenges and goals targeted as well as the strategies and means to be implemented.

3.1 METHODOLOGY

The programming phase was conducted following the VIPP (Visualization integrated to participatory processes) under the supervision of a senior moderator.

The main resources of this phase were:

- The list of all actions visualized on boards;
- All the participants in the workshop.

At this stage, the presence of the City Council officers is required to ensure necessary arbitration.

3.1.1- Selecting projects-actions

The projects-actions were selected based upon specific goals in a plenary. Thus, were retained as projects-actions, complex specific goals requiring substantial investment.

3.1.2- Developing project sheets

For each project-action selected, a project sheet was developed. The project sheets were developed in workgroups.

The project sheet actually is a brief introduction sheet of each project that takes into account the following parameters:

- *Specific goals*: These are direct improvements generated by the project
- *Description of present status*: The point is to list all the prevailing challenges and dissatisfactions underlying the development of the project
- *Project-related constraints*: They are factors or elements likely to undermine the success of the project
- *Beneficiary populations*: The categories of people who will benefit by the project.
- *Past or current actions*: Past and/or current project-related actions are recorded
- *Implementation strategies*: They concern the set of organization and collaboration techniques and approaches used to implement the project
- *Proposed activities*: The activities required to carry-out the project must be indicated
- *Implementation period*: It indicates the time required to reach the set goals
- *Project owner*: The institution ensuring the ownership of the project.
- *Main contractor*: It concerns the institution being serviced by the project owner to ensure the design and monitoring of the project.
- *Partners*: The actors involved in various ways in the implementation of the project, financially, materially or in the form of expertise.
- *Estimated cost*: The cost of the implementation of the project must be evaluated.
- *Desired local input*: Local actors' input for the implementation of the project must be identified. This input may be material or in-kind.
- *Environmental impact analysis*: It concerns the environment-friendliness of the project. Will the project cause damage to the environment or not?
- *Identified funding sources*: Potential funding sources must be identified.

- *Recurrent costs*: It has to be specified whether once completed the project will maintenance and operating costs.

3.2 PRESENTATION OF PROJECT SHEETS PER STRATEGIC FOCUS

At the end of the planning, 9 specific goals were retained as projects-actions and broken down per strategic focus as follows:

Prevention: 04
Care: 03
Local response: 02

3.2.1- Strategic focus 1: Prevention

The four (4) selected projects at the strategic focus level are:

1. Development of training modules for actors;
2. Fostering social rehabilitation conditions for HIV infected and/or affected people;
3. Condom popularization policy;
4. Development of a communication strategy.

3.2.2 - Strategic focus 2: Care

The 3 projects selected at this level are:

1. Development of income generating activities;
2. Support to infected/affected people;
3. Promotion of voluntary testing centers for a better care of populations.

3.2.3 - Strategic field 3: Local response

The 2 projects selected at this level are:

1. Assertion of local leadership in HIV/AIDS control
2. Development of a plan implementation strategy.

3.3 - SUMMARY TABLE OF PROJECT COSTS

The nine (9) identified projects cost a total US $ 1 194 000 (CFA F 597 000 000) for $ US 133 000 (CFA F 66 333 000) on average per project. The costs can be broken down as follows:

PROJECT No	PROJECT TITLE	ESTIMATED COST (en US $)
1	Development of training modules for actors	**24 000**
2	Fostering social rehabilitation conditions for HIV/AIDS infected and/or affected people	**100 000**
3	Condom popularization policy	**90 000**
4	Development of a communication strategy	**20 000**
5	Development of income generating activities	**200 000**
6	Support to infected/affected people	**400 000**
7	Promotion of voluntary testing centers for better care of populations	**180 000**
8	Process of local leadership assertion in HIV/AIDS control	**80 000**
9	Development of a plan implementation strategy	**100 000**
	TOTAL PROJECTS (in $ US)	**1 194 000**

3.4 - PRESENTATION OF PROJECT SHEETS

MUNICIPAL HIV/AIDS PLAN IN ABENGOUROU COMMUNE THREE YEAR PROGRAM - 2005-2007	
Action code:	Project No: 01
STRATEGIC FOCUS**: PREVENTION**	
PROJECT TITLE**: DEVELOPMENT OF TRAINING MODULES FOR ACTORS**	
1. Goals	- Capacity-building for actors - Channel actors HIV/AIDS actions - Master communication tools
2. Description of present status	- Irregular refreshment training of the actors - Inadequate background of HIV/AIDS control officers
3. Project-related constraints	- Unavailability of appropriate funding
4. Beneficiary populations	STI/HIV/AIDS control actors
5. Implementation strategies	- Design modules content - Develop modules - Train actors
6. Past or current actions	Training workshop in BCC/IEC skills
7. Proposed activities	- Seminars - Training workshops
8. Implementation period	1 year
9. Project owner	Commune
10. Main contractor	- Consulting firms - NGOs - Consultants
11. Partners	- NGOs - Associations
12. Estimated cost (× thousand) $ US	24
13. Local input	- Commune 50 % - NGOs 10 % - Development partners 40 %
14. Funding sources	- Commune - PLWHAs - NGOs - Economic operators - Others

MUNICIPAL HIV/AIDS PLAN IN ABENGOUROU COMMUNE THREE YEAR PROGRAM - 2005-2007	
Action code:	Project No: 02
STRATEGIC FOCUS: **PREVENTION**	
PROJECT TITLE**: FOSTERING CONDITIONS FOR PLWHA SOCIAL INSERTION**	
1. Goals	- Prevent PLWHA stigma - Prevent PLWHA possible rejection - Facilitate PLWHA acceptation
2. Description of present status	- Marginalization of PLWHAs - Shocking approaches - Discrimination - Family disruption
3. Project-related constraints	- Misconceptions - Prejudices - Rejection
4. Beneficiary populations	PLWHAs (HIV infected/affected people)
5. Implementation strategies	- Refer PLWHA to appropriate centers (monitoring, counseling and social support centers) - Sensitize people to a greater acceptation of PLWHA - Increase social mobilization in response to AIDS - Implement awareness raising activities in private and public sectors
6. Past or current actions	- Population outreach to reduce discrimination
7. Proposed activities	- Sensitize close / remote circles of PLWHAs - Sensitize company managers - Hold lecture forums
8. Implementation period	3 years
9. Project owner	Commune
10. Main contractor	- Consulting firms - Consultants
11. Partners	- NGOs - Monitoring centers - Social workers - Sociologists, Psychologists - Economic operators
12. Estimated cost (× thousand) $ US	100
13. Local imput	- Commune 50 % - Beneficiaries 15 % - Partners 35 %
14. Funding sources	- Commune - Beneficiaries - Partners - Others

MUNICIPAL HIV/AIDS PLAN IN ABENGOUROU COMMUNE THREE YEAR PROGRAM - 2005-2007	
Action code:	Project No: 03
STRATEGIC FOCUS: **PREVENTION**	
PROJECT TITLE**: POLICY OF CONDOM POPULARIZATION**	
1. Goals	- Make condoms accessible and available - Minimize prejudices - Reduce STI/HIV/AIDS sexual transmission
2. Description of present status	- Insufficient promotion - Lack of communication - Expensive condoms - Limited sale points
3. Project-related constraints	- The burden of tradition - Childbearing desire - Carelessness
4. Beneficiary populations	Target populations (youth, women, men, adults, sex workers, truckers, migrants …)
5. Implementation strategies	- Establish several sale points - Establish HIV/AIDS control committees in the neighborhood, in rural areas and in the commune suburbs - Promote condom use and access
6. Past or current actions	- Condom distribution through regional AIDS coordination in 2000
7. Proposed activities	- Supply sale points and HIV/AIDS committees with condoms - Ensure monitoring & evaluation of committee actions and sale points managers - Train the committees to condom use skills - Establishment of revolving - Hold education campaigns on condom use - Improve condom use - Strengthen the mechanism of condom distribution
8. Implementation period	3 years
9. Project owner	Commune
10. Main contractor	- NGOs - HIV/AIDS control structures
11. Partners	- NGO - Monitoring centers - Social workers, sociologists, psychologists, economic operators
12. Estimated cost (× thousand) $ US	90
13. Local input	- Commune 70 % - Farming cooperatives 5 % - NGOs 5 % - Economic operators 5 % - Development partners 15 %
14. Funding sources	- Commune - Beneficiaries - NGOs - Economic operators - Development partners - Others

MUNICIPAL HIV/AIDS PLAN IN ABENGOUROU COMMUNE THREE YEAR PROGRAM - 2005-2007	
Action code:	Project No: 04
STRATEGIC FOCUS: **PREVENTION**	
PROJECT TITLE**: DEVELOPMENT OF A COMMUNICATION STRATEGY**	
1. Goals	- Change individual behaviors - Reach maximum people - Disseminate information
2. Description of present status	- Hardly noticeable behavior change - Inadequate communication means and media - Unmatched communication means and techniques
3. Project-related constraints	- Inaccessibility of some areas - Burden of traditions
4. Beneficiary populations	Populations from the commune
5. Implementation strategies	- Mass actions - Outreach activities - Partnerships with NGOs, traditional leaders
6. Past or current actions	- Population outreach for behavior change
7. Proposed activities	- Conference - Slide/film presentation - Luncheon debates - Messages in local languages - Lecture forums
8. Implementation period	3 years
9. Project owner	The commune
10. Main contractor	- Consulting firms, - Consultants
11. Partners	- NGOs - Monitoring centers - Social workers - Communication specialists - Economic operators
12. Estimated cost (× thousand) $ US	20
13. Local input	- Commune 50 % - Beneficiaries 15 % - Partners 35 %
14. Funding sources	- Commune - Beneficiaries - Partners - Others

MUNICIPAL HIV/AIDS PLAN IN ABENGOUROU COMMUNE THREE YEAR PROGRAM - 2005-2007	
Action code:	Project No: 05
STRATEGIC FOCUS: **CARE**	
PROJECT TITLE**: DEVELOPMENT OF INCOME GENERATING ACTIVITIES**	
1. Goals	- Empower infected and affected people (e.g. OVCs: Orphans and vulnerable children) - Ensure project monitoring and evaluation - Mitigate HIV/AIDS social impact - Promote and support HIV/AIDS community response
2. Description of present status	- Infected and affected people dependent on relatives, friends and others - Infected and affected people left to themselves - Lack of initiatives in the field
3. Project-related constraints	- Lack of technical support - Lack of motivation - Funding discontinuation
4. Beneficiary populations	Deprived and poor infected and/or affected people
5. Implementation strategies	- Feasibility study - Market study - Search of markets - Training of beneficiaries - Resource mapping - Search for partners
6. Past or current actions	n/a
7. Proposed activities	- Develop an organization - Ensure funding - Ensure monitoring & evaluation
8. Implementation period	3 years
9. Project owner	Commune
10. Main contractor	- Consulting firms - NGOs
11. Partners	- Consulting firms - Follow-up committee
12. estimated cost (× thousand) $ US	200
13. Local input	- Commune 50 % - Population 10 % - Development partners 40 %
14. Funding sources	- Commune - Beneficiaries - Development partners - Others

MUNICIPAL HIV/AIDS PLAN IN ABENGOUROU COMMUNE THREE YEAR PROGRAM - 2005-2007	
Action code:	Project No: 06
STRATEGIC FOCUS: **CARE**	
PROJECT TITLE**: SUPPORT TO INFECTED AND AFFECTED PEOPLE**	
1.Goals	- Foster support to infected and affected people - Mitigate HIV/AIDS social impact - Mitigate HIV/AIDS impact on the health of people living with HIV
2. Description of present status	- Infected and affected people comparatively supported - Poor support
3. Project-related constraints	- Lack of financial and material means - Infected and affected people unidentified
4. Beneficiary populations	Infected and/or affected people
5. Implementation strategies	- Provide means - Establish voluntary counseling and testing centers - Establish social action units - Establish support committees in neighborhood
6. Past or current actions	n/a
7. Proposed activities	- Subsidize anti-retroviral - Provide means - Establish voluntary counseling and testing centers - Establish social action units - Ensure annual availability of patient medication - Develop a legal framework supportive to the protection of people living with HIV
8. Implementation period	3 years
9. Project owner	Commune
10. Main contractor	- Laboratories - Consulting firms - NGOs
11. Partners	- Social workers - Staff of the voluntary counseling and testing center - Social action units
12. Estimated cost (× thousand) $ US	400
13. Local input	- Commune 90 % - Population 10 %
14. Funding sources	- Commune - Beneficiary

MUNICIPAL HIV/AIDS PLAN IN ABENGOUROU COMMUNE THREE YEAR PROGRAM - 2005-2007	
Action code:	Project No: 07
STRATEGIC FOCUS: **CARE**	
PROJECT TITLE**: PROMOTION OF VOLUNTARY COUNSELING AND TESTING CENTERS FOR IMPROVED CARE OF POPULATIONS**	
1. Goals	- Promote more visits to voluntary counseling and testing centers
2. Description of present status	- A non-operational voluntary counseling and testing center due to shortage of reagents and performing materials
3. Project-related constraints	- Comparatively expensive and available anti-retrovirals - Few visits - Lack of staff training - Expensive anti-retrovirals
4. Beneficiary populations	General population/target populations
5. Implementation strategies	- Provide reagents to the voluntary counseling and testing center - Provide performing materials to the voluntary counseling and testing center - Promote the voluntary counseling and testing center - Provide subsidized anti-retrovirals to the voluntary counseling and testing center
6. Past or current actions	Detected cases from July 2004 to end of March 2005
7. Proposed activities	- Fund reagent purchase - Develop a self-funding system - Train the staff - Promote voluntary counseling and testing centers - Subsidize the purchase of anti-retrovirals
8. Implementation period	3 years
9. Project owner	Commune
10. Main contractor	Reference laboratories and other structures
11. Partners	- The population from the commune - The staff of the voluntary counseling and testing center - Development partner
12. Estimated cost (× thousand) $ US	180
13. Local input	- Commune 75% - Population 5% - Development partners 20 %
14. Funding sources	- Commune - Beneficiaries - Development partners - Others

MUNICIPAL HIV/AIDS PLAN IN ABENGOUROU COMMUNE THREE YEAR PROGRAM - 2005-2007	
Action code:	Project No: 08
STRATEGIC FOCUS: **LOCAL RESPONSE**	
PROJECT TITLE**: PROCESS OF COMMUNAL LEADERSHIP ASSERTION IN HIV/AIDS CONTROL**	
1. Goals	- Facilitate Municipal counselors' involvement in HIV/AIDS control - Reinforce the institutional framework - Improve plan management and monitoring
2. Description of present status	- Poor involvement of Municipal counselors in HIV/AIDS control in Abengourou commune - No knowledge status of the various AIDS activities conducted on the communal territory
3. Project-related constraints	- Lack of budget item - Lack of outreach radio for mobilization - Lack of motivation of Municipal counselors for AIDS control
4. Beneficiary populations	Municipal counselors and other agents of the City Council
5. Implementation strategies	- Coordinate and monitor all HIV/AIDS activities on the communal territory
6. Past or current actions	- Contribution of the municipality to the development of a counseling and monitoring center - Awareness raising (example, GAPA: *Génération des Alliés pour le Progrès d'Abengourou*/Generation of Allies for Abengourou Progress)
7. Proposed activities	- Establish a communal committee to supervise HIV/AIDS control actions - Hold periodic meetings with the City Council and other AIDS control structures - Ensure the inventory of projects and programs - Seek and facilitate partnerships for an effective management of AIDS control
8. Implementation period	Continuous
9. Project owner	Commune
10. Main contractor	- Consulting firms - NGOs and - Consultants
11. Partners	- City Council services - AIDS control structures - Companies established in the commune - Development partners
12. Estimated cost (× thousand) $ US	80
13. Local input	- Commune 75 % - Beneficiaries 5 % - External partners 20 %
14. Funding sources	- Commune - Input/contribution of beneficiaries - Development partners - Others

MUNICIPAL HIV/AIDS PLAN IN ABENGOUROU COMMUNE THREE YEAR PROGRAM - 2005-2007	
Action code:	Project No: 09
STRATEGIC FOCUS: **LOCAL RESPONSE**	
PROJECT TITLE: **PLAN IMPLEMENTATION**	
1. Goals	- Master inter- and multisectoral collaboration - Strengthen external coordination - Reduce substantially HIV/AIDS prevalence rate - Fight AIDS
2. Description of present status	- Lack of focus on AIDS issues - High HIV/AIDS infection rate in Abengourou commune
3. Project-related constraints	- Inadequate human and financial resources - Lack of local radio for mobilization on the plan
4. Beneficiary populations	Vulnerable populations (women, 10-35 year-old youths, sex workers …)
5. Implementation strategies	- Ensure inter- and multisectoral collaboration - Develop appropriate tools - Develop a strategy for mobilization on the plan (communication and advocacy)
6. Past or current actions	- Establishment of several HIV/AIDS control structures
7. Proposed activities	- Creation of a plan management technical unit - Monitor and evaluate the projects - Manage knowledge (record-keeping, restitution…) - Develop a communal AIDS database on AIDS - Build the capacities of HIV/AIDS control structures - Mobilize internal and external resources - Disseminate lessons learned from the plan - Promote experience sharing with other cities members of ANUMI…
8. Implementation period	3 years
9. Project owner	Commune
10. Main contractor	- Consulting firms - Consultants - NGOs
11. Partners	- Local AIDS structure - Communal population - International agencies
12. Estimated cost (× thousand) $ US	100
13. Local input	- Commune 50 % - Beneficiaries 5 % - Private sector and others 45 %
14. Funding sources	- Commune - Beneficiaries - Development partners - Others to seek

MUNICIPAL HIV/AIDS PLAN IN ABENGOUROU COMMUNE

PLANNING AND PROGRAMMING WORKSHOPS
Abengourou, August 10-13, 2005

PARTICIPANTS

N°	Last and first names	Qualification	Service	Function	Contact (+225)
1.	Abibata Doumbia	Municipal counselor	City hall	Trader	07-50-03-07
2.	Abokon Armand	Physician	Health Department Directorate (DD)	Department Director	35-91-35-17
3.	Adou Kouamé Noël		City hall	Administrative director	05-67-36-20
4.	Aka Adjéi	"Cane bearer" of the King	Farmer	"Cane bearer" of the King	05-71-75-99
5.	Aka Aka Kouassi Jules	Commercial	Art et Décor	Commercial	07-10-71-48
6.	Akoua Aké Y.	DESS- ASAD Student	BNETD	Initial trainee	05-34-43-20
7.	Amara Koulibaly	Guard	City Council		
8.	Amiah Quonhan Khan Jonas	Primary school teacher in Abg 2	EPP Château 2	Primary school teacher in Abg 2	05-83-60-66
9.	Appessika Kouamé	Ph. D Urban planner	BNETD	Head of sector	22-48-35-31
10.	Appia Yah Solange	Socio-cultural agent	*City Council*	*Socio-cultural agent*	08-37-73-69
11.	Assémien Rosine			Student	
12.	Assia Koffi Alphonse	Registered nurse	Abengourou PMI (Maternal and child care)	Secretary general of A.E.L.S NGO	
13.	Atsin Apo Denise	Social worker	Social Center	Social worker	35-91-30-38 07-68-15-49
14.	Attahi Koffi	Urban planner	BNETD	Department Director	05-77-42-47
15.	Behibro Fidele	Public works engineer	BNETD	Head of section	22-48-34-00
16.	Boa Sapim		City Council	City Council agent	05-92-65-92
17. 8	Daidain Emma Rachel	Corporate Communication BTS	City Council	Initial trainee	07-48-43-15
18.	Dembélé Bakary	Chairman of Ruban Rouge	Ruban Rouge	Student	35-90-34-85

19.	Ebrottié Kouadio Sylvestre	Counselor, deputy Officer of project IVC/03/P02	Youth Monitoring and Counseling Center	Counselor, deputy project officer	05-69-94-74
20.	Elogne Kabran	Municipal counselor	City Council	Teacher	07-40-91-03
21.	Hamidou Traoré	Permanent Educator	City Council	Head of socio-cultural and human development service	07-80-72-63
22.	Heba Monique	Tailor			07-37-44-43
23.	Kanga Amien Jean-Bedel	Bachelor of Arts	CNDI	Teacher	07-64-23-99
24.	Kobenan Kra Richard	Photographer	SNGO-photo	Reporter	05-77-81-12
25.	Koné Abdoulaye	Chairman of AJD	Office of Esq. TRAORE	Process server Clark	08-23-07-37
26.	Koné Koumfimbaï	Teacher	Collège Moderne Abengourou	Chairman NGO Regard	05-86-83-55
27.	Koné Moussa	Education counselor, education sciences	DREN	Regional counselor - DREN Abengourou	35-91-32-72 05-79-18-39
28. 1	Koné Yekini	Process server Clerk	Office of Mr Trazié	Chairman of AJD	08-23-07-37
29.	Kouadio Ahou Solange	Secretary	FENACCI	Trader	06-00-94-75
30.	Kouadio N'da Auguste	Primary school teacher	I.E.P Abengourou 2	Chairman of A.E.K 7A	05-90-35-29
31.	Kouakou Konan Edouard	GAPA		Commercial director	07-64-20-72
32.	Kouakou Kouadio Amos		Prefecture	Secretary General	
33.	Kouamé Amoakon		City Council	1rst Deputy Major	
34.	Kouamé Ehouman	City Council officer	Environment	Chairman of GAPA	35-91-39-56
35.	Kouity Tietoun Emile	AIDS project coordinator	ANADER	Head of service	07-43-57-31 35-91-39-44
36.	Ky Djeneba	Community counselor	Maternité Cafétou	CERAB manager	05-06-12-61
37.	Lago gouali David	Economist/Anthropologist-Health Sociologist	Consultant -BNETD	Health economist, Anthropologist-sociologist, Consultant	05-82-41-97
38.	Mathieu Koffi Amoatrin	Teacher	CND Indénié	Deputy Director of studies	35-90-34-02 07-44-31-91

39.	Méa Ano Vincent	Municipal counselor		*I.D.E.S*	07-31-74-18
40.	Mme Brou épse Tanoh Kuha Marguerite	3rd Deputy Mayor	City Council	3rd Deputy Major	05-63-47-41
41.	Mme Seka Marie Thérèse Eléonore	VCT counselor	ANADER	Social worker	07-89-51-25
42.	N'da Jean Baptiste	Socio-cultural agent	City Council	Chairman of commune youth	05-23-80-77
43.	N'goran Aya Rose	Municipal counselor	City Council	Trader	
44.	N'goran N'dri Adrien	Painter Artist	A.J.I	Chairman of Board of Directors	35-91-34-69 35-91-49-53
45.	N'gouandi Ahou Céline	Chairwoman of CAFI	CAFI	Trader	07-98-92-48
46.	N'guessan Koffi Bernard	Commercial	IVES	Commercial Director	35-91-18-83
47.	N'guessan Kouassi Hippolyte	Orientation counselor, psychologist	C.E.C	Head of C.E.C project IVC/03/P02	05-92-30-96
48.	N'zebo Rosalie	Hostess	City Council	Student	08-41-41-52
49.	Ohovo Marcel	Physician	Urban health center	Senior physician	35-91-32-08
50.	Ouattara Djakalia	Security Agent	E.I.S.B	Security guard	BP168 Abengourou
51.	Ouattara Djakalia	Security Agent	EISB	Security guard	BP 168 Abg
52.	Ouattara G. Salifou	Communicator	Le Front	Journalist	05-76-28-57
53.	Ouattara Kaliffa	Certified professor	Lycée Moderne Abengourou	Teacher	08-03-85-76
54.	Ouattara Kipeto Horo	Refrigeration Technician - Trade Council	Techno froid	Refrigeration technician	05-06-61-73
55.	Pholie Kraidy Bernard	Commissioner of police	2nd Arrondissement	Head of service	35-91-46-68
56.	Saba Kodjovi Ismaël	Application software trainer	Jamad informatique	Secretary general of Ruban Rouge-CI Abengourou	
57.	Sangaré Ami	Member of Regard Plus	Regard Plus NGO		
58.	Sika Lazare	Manager of a house-block	City Council	Secretary general of City Council	07-99-25-05
59.	Souaré Mahamoudou	Registered	Dioulakro urban health center	Nurse	05-61-55-00
60.	Souri Koné	Municipal counselor	City Council	Head of service of communication public center	05-69-35-96

61.	Tanoh Erick	Member of Ruban rouge	Ruban rouge	Student	05-69-35-96
62.	Tia Touré Ousmane	Teacher	Lycée Moderne d'Abengourou	Municipal counselor	06-15-03-18
63.	Touré Karamoko	Physician	CAT	Senior physician	35-91-32-01
64.	Traoré Adama	Traditional Moslem student		Student	05-53-69-46
65.	Traoré Moussa	REPMASCI journalist	FRAT-MAT	Chairman	07-67-66-24
66.	Tuo Gérard	Organization expert	BNETD	Head of section	05.39.07.37

ABENGOUROU COMMUNE
STATUTORY COMMISSIONS

N°	NAME	ACRONYMS
1	Economic Affairs and Planning Commission (*Commission des Affaires Economiques et de la Planification*)	CAEP
3	Commission of Social, Family and Women Affairs (*Commission des Affaires Sociales, de la Famille et de la Promotion de la Femme*)	CASFPF
4	Culture, Youth and Sports Commission (*Commission des Affaires Cultures, de la Promotion des Jeunes et des Sports*)	CACPJS
2	Land Property and Environment Commission (*Commission des Affaires Domaniales et de l'Environnement*)	CADE
5	External Affairs and Communication Commission (Commission des Relations Extérieures et de la Communication)	CREC