

# Cote d'Ivoire

Cote d'Ivoire (population 17.33 million) is a country in Western Africa that covers an area of 322,460 square kilometres. Its boundaries border the North Atlantic Ocean between Liberia, Guinea, Mali, Burkina Faso and Ghana. The capital city of Cote d'Ivoire is Yamoussoukro

According to the United Nations human development index (HDI), Cote d'Ivoire is ranked 163/177 countries worldwide (0.399)<sup>1</sup> and 31/45 African countries for which an index is available. This places Cote d'Ivoire in the group of countries with low human development.



## PALLIATIVE CARE SERVICE PROVISION

### Current services

There are no established palliative care services in Cote d'Ivoire. The HIV/AIDS epidemic has brought to the fore the need for a comprehensive and sustainable health package for terminally ill patients at community level. Although some health professionals in Cote d'Ivoire are familiar with the use of morphine for cancer and neurological pain there has yet to be a coordinated and structured plan to incorporate managed pain control into the public health system. Joseph Essombo explains the current situation:

There are already health professionals who use drugs as morphine for pain management with cancer patients, with patients suffering from neurological diseases, with patients who suffer from rheumatology problems, but it is really not yet well structured and implemented and especially it is not yet working with the community's involvement.<sup>2</sup>

### Reimbursement and funding for services

No data available.

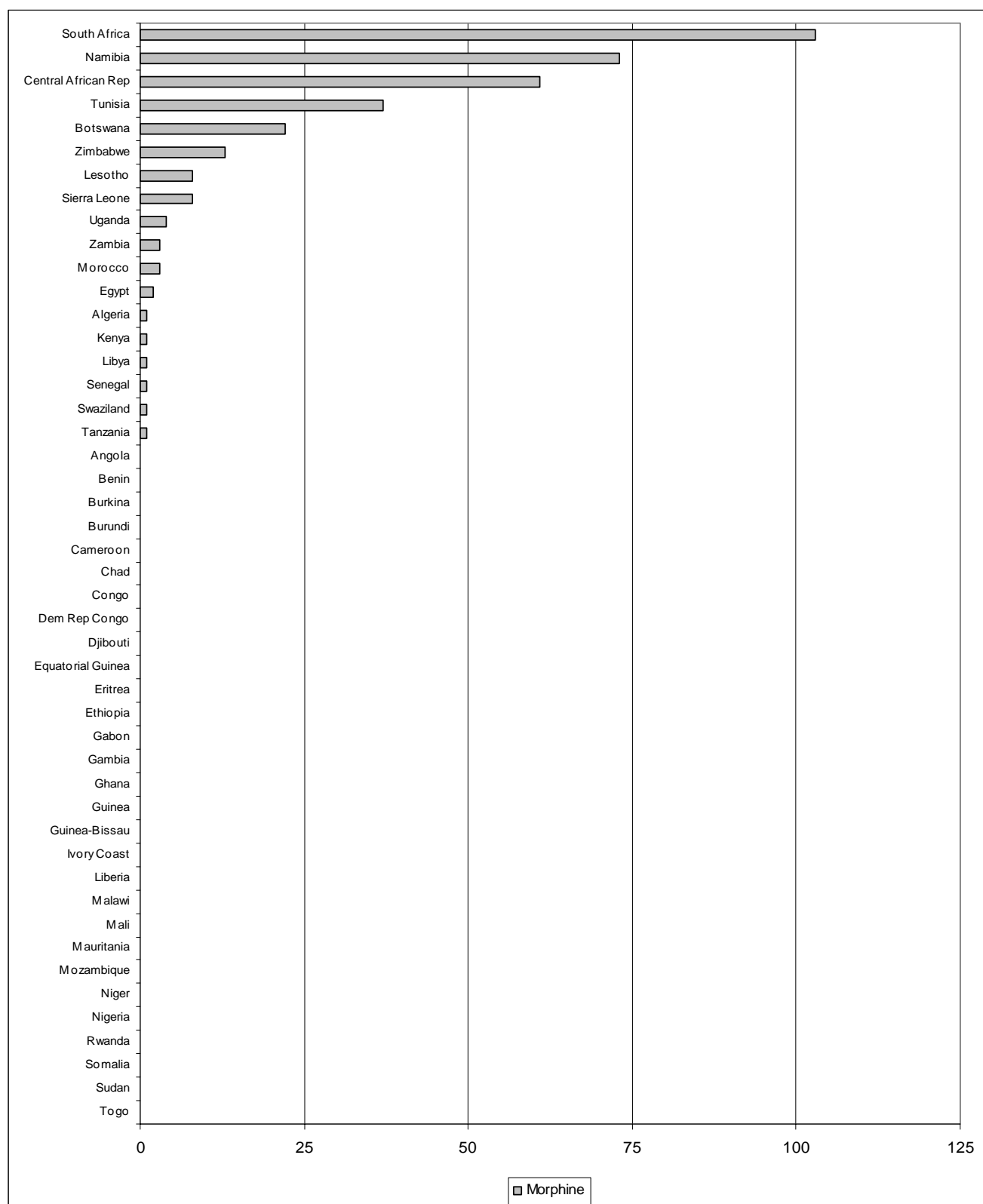
### Opioid availability and consumption

The International Narcotics Control Board<sup>3</sup> has published no data concerning Cote d'Ivoire

For the years 2000-2002, the average defined daily dose consumption of morphine for statistical purposes (S-DDD)<sup>4</sup> in Cote d'Ivoire was 0. This compares with other African countries as follows: Swaziland 1; Egypt 2; Uganda 4; Zimbabwe 13; Namibia 73; South Africa 103. Twenty nine countries reported no morphine consumption during 2000-2002 (Table 1).

While it is reported that limited supplies of opioids are available in the main cities, they are not accessible to rural communities in Cote d'Ivoire.<sup>5</sup>

**Table 1 Average daily consumption of defined daily doses (for statistical purposes) of morphine per million inhabitants, 2000-2002: countries of Africa**



Source: International Narcotics Control Board *Narcotic Drugs: Estimated World Requirements for 2004. Statistics for 2002*. New York: United Nations, 2004.

## **National and professional organisations**

### **President's Emergency Plan for AIDS Relief (PEPFAR)**

During his state of the Union address in 2003, President Bush announced his PEPFAR initiative; this groundbreaking intervention encompasses HIV/AIDS activities in more than 75 countries and focuses on 15 countries worldwide – of which Cote d'Ivoire is one of 12 in Africa – to develop integrated care and treatment programmes (Table 3). Over the next 5 years, PEPFAR is donating a total of US \$15billion, of which 15% is earmarked funding for palliative care. This has dramatically changed the palliative care landscape in Africa, as bids for new initiatives are attracting the funding for implementation. Four main areas are targeted:

- prevention of HIV transmission
- treatment of AIDS and associated conditions
- palliative care for HIV infected individuals
- care for AIDS orphans and other vulnerable children

### **Centres for Disease Control (CDC)**

The US funded Centres for Disease Control provide technical support to the Ministry of Health to develop a strategy to combat the HIV/AIDS epidemic. It also acts as the conduit for funds from the President's Emergency Plan For AIDS Relief (PEPFAR) to several government departments involved in the prevention and treatment of AIDS.

### **African Palliative Care Association (APCA)**

This international association was formed after a meeting of Hospice and Palliative Care trainers in Cape Town that led to the Cape Town Declaration. The first APCA steering committee meeting was held in Uganda from 19-20 February 2003. Steering committee members were drawn from: Kenya (Zipporah-Merdin Ali), South Africa (Kath Defilippi), Tanzania (Jacobson) Uganda (Anne Merriman) and Zimbabwe (Sambulo Mkwanzani).<sup>6</sup> In summary, APCA aims to:

- promote study, knowledge, training and research in palliative care
- foster networks and links at all levels of palliative care
- address ethical issues
- establish an international communication network
- sponsor publications
- disseminate achievements
- promote access to resources

Objectives include:

- promotion of standards
- advocating for palliative care at governmental level
- securing the availability of drugs
- encouraging the development of national associations within Africa
- promotion of training programmes
- devising standard guidelines
- advocacy

**Table 3 Countries of Africa involved in PEPFAR, the Diana, Princess of Wales Memorial Fund and WHO projects**

<b>PEPFAR</b>	<b>DIANA FUND</b>	<b>WHO</b>
Botswana,		Botswana
Cote d' Ivoire,		
Ethiopia,	Ethiopia	Ethiopia
Kenya,	Kenya	
	Malawi	
Mozambique,		
Namibia,		
Nigeria,		
Rwanda,	Rwanda	
South Africa,	South Africa	
Tanzania,	Tanzania	Tanzania
Uganda	Uganda	Uganda
	Zimbabwe	Zimbabwe
Zambia	Zambia	

### **Palliative care coverage**

No data available

### **Education and training**

No palliative care training has been implemented in Cote d'Ivoire. A comprehensive approach has been identified for future implementation, that would include training of health professionals and community based organisations. This training would best be delivered in combination with the lobbying of government to ensure that structures are in place to provide sustainable and effective palliative care at all levels throughout the country<sup>7</sup>.

### **Palliative care workforce capacity**

No data available

## **HISTORY AND DEVELOPMENT OF PALLIATIVE CARE**

### **Narrative history of palliative care**

The inaugural conference of the African Palliative Care Association in June 2004 was crucial for the 2 health professionals who attended from Cote d'Ivoire to plan a strategy for palliative care development in their country. The experiences of other practitioners on the continent provided guidance for the creation of programmes that will target people living with cancer, HIV/AIDS and other conditions. Joseph Essombo summarises the value of the conference for Cote d'Ivoire:

I think that this is the beginning of the reflection and to participate to this conference is highly important for us. It gives us the opportunity to reconsider the question of palliative care as a central question for the management and care of persons living with AIDS, but also for those ones suffering of other chronic diseases with pain as central point. It comforts us in our vision and we think that we can bring all the support that the health ministry will need. I

think of mobilizing human resources ... in Africa and that we met here, of relating to experiences that have worked out well and that we heard about here, to really help the health ministry of Côte d'Ivoire to set up a palliative care program and to integrate it not only for patients living with AIDS but also for all patients suffering and who have a problem of pain management.<sup>8</sup>

### **Hospice success stories**

No data available

### **Life/oral histories**

Dr Joseph Essombo – *coordinator, Centres for Disease Control Project Retroci, Abidjan*: interviewed by David Clark, 4 June 2004. Length of interview (West Africa group): 40 minutes.



Joseph Essombo, a physician interested in HIV/AIDS and public health, describes the dual role played by Centres for Disease Control (CDC) in Cote d'Ivoire with regards to HIV/AIDS. Technical support is provided to the Ministry of Health to establish a strategy to combat the epidemic. Secondly, funds from the President's Emergency Plan For AIDS Relief (PEPFAR) are channelled through CDC to several government departments involved in the prevention and treatment of AIDS. He suggests that palliative care is only now being considered as a way to tackle the AIDS problem. Although health

professionals in Cote d'Ivoire are familiar with the use of morphine for cancer and neurological pain there has yet to be a coordinated and structured plan to incorporate managed pain control into the health system. He reflects on the value of the inaugural African Palliative Care Association conference as an opportunity to learn from palliative care practitioners and organizations all over the continent. This gives him the confidence to advocate for palliative care development in Cote d'Ivoire. He prioritises supporting and advising the Ministry of Health in order to implement palliative care not only for those with AIDS, but for all patients requiring pain management.

Prof Beugre Kouassi – *neurologist, University of Abidjan-Cocody/Ministry of Health*: interviewed by David Clark, 4 June 2004. Length of interview (Wet Africa group): 40 minutes.



Beugre Kouassi, a neurologist, has a particular interest in the neurological manifestations of AIDS. He informs that 10% of the population of Cote d'Ivoire is HIV positive. For several years his government has attempted to mobilize resources to combat the effects of the epidemic. He identifies a gap in the holistic care and treatment of such patients. He highlights the value of palliative care as providing more than merely symptom control and pain management. While opioids are available in the main cities, pain relieving drugs are harder to source in rural parts of the country and consequently accessibility is

compromised. He shares his vision for palliative care being integrated into a complete health care package for all people living with AIDS, within 3 years. This will require

training health professionals and community organisations in palliative care, and the lobbying of government to ensure that structures are in place to provide sustainable and effective palliative care at all levels throughout the country.

## **PUBLIC HEALTH CONTEXT**

### **Population**

Cote d'Ivoire's population of around 17.33 million is made up of the following ethnic groups: Akan 42.1%, Voltaiques or Gur 17.6%, Northern Mandes 16.5%, Krous 11%, Southern Mandes 10%, other 2.8% (includes 130,000 Lebanese and 14,000 French) (1998).

Religious groups include: Christian 20-30%, Muslim 35-40%, indigenous 25-40% (2001) - *note*: the majority of foreigners (migratory workers) are Muslim (70%) and Christian (20%)<sup>9</sup>

### **Epidemiology**

In Cote d'Ivoire, the WHO World Health Report (2004) indicates an adult mortality<sup>10</sup> rate per 1000 population of 577 for males and 502 for females. Life expectancy for males is 43.1; for females 48.0. Healthy life expectancy is 37.6 for males; 41.3 for females.<sup>11</sup>

HIV/AIDS is a huge burden for sub-Saharan Africa. Throughout the region in 2003, an estimated 23-27 million people were thought to be living with the disease which also caused up to 2.5 million deaths. This represents a huge loss and impacts significantly on health systems and social and family structures.

Cote d'Ivoire is one of the worst HIV/AIDS affected countries in Western Africa. Estimates suggest that in Cote d'Ivoire, between 370,000 and 750,000 people were living with HIV/AIDS at the end of 2003. In the same year, up to 72,000 adults and children are thought to have died from the disease (Table 2).

**Table 2 Country HIV and AIDS estimates, end 2003**

Adult (15-49) HIV prevalence rate	7.0% (range: 4.9%-10.0%)
Adults (15-49) living with HIV	530 000 (range: 370 000-750 000)
Adults and children (0-49) living with HIV	570 000 (range: 390 000-820 000)
Women (15-49) living with HIV	300 000 (range: 210 000-420 000)
AIDS deaths (adults and children) in 2003	47 000 (range: 30 000-72 000)

*Source: 2004 Report on the global AIDS epidemic*

## **UNAIDS reports:**

The political and military instability in the recent history of Côte d'Ivoire has had major social and health impacts on the population. HIV prevalence in Côte d'Ivoire, already high before the conflict that began in 2002, is likely to increase as a result of the massive displacement of local populations, both within and across the country's borders. Overall, the functioning of health services has been severely affected by the crisis, resulting in limited access to health care and medication, particularly in the conflict zone. 2003 was principally marked by an upheaval in AIDS control activities following the political crisis. Although measures were taken to reduce the humanitarian consequences at the start of the conflict, HIV/AIDS-related aspects were not immediately integrated within priority-rated measures to deal with the effects of the crisis. An emergency team was therefore set up on the initiative of the UNAIDS Office in Côte d'Ivoire in order to address the lack of actions and organization, and to coordinate the immediate response to HIV/AIDS. Under the chair of the Ministry for AIDS Control, this team brought together, in addition to government representatives, the UN Theme Group on HIV/AIDS, development partners, national and international NGOs, and organizations and associations for AIDS control.<sup>12</sup>

## **Health Care System**

In 2001, the total per capita expenditure on health care was Intl \$127 (6.2% of GDP).<sup>13</sup> Among the countries of Africa, this figure falls within a spending range of Intl \$652 in South Africa (8.6% of GDP) and Intl \$12 in the Democratic Republic of Congo (3.5% of GDP). At 2.0% the smallest spending as a percentage of GDP is in Equatorial Guinea (Tables 3 and 4).

The WHO overall health system performance score places Cote d'Ivoire 137/191 countries. This composite measure of overall health system attainment<sup>14</sup> is based on a country's goals relating to health, responsiveness, and fairness in financing. The measure varies widely across countries and is highly correlated with general levels of human development as captured in the human development index.

**Tables 3 and 4 Total health expenditure (Intl \$) per capita and as a percentage of GDP: countries of Africa, 2001**

<b>Table 3</b> Health expenditure (Intl \$) per capita: Africa		<b>Table 4</b> Health expenditure (Intl \$) as a percentage of GDP: Africa	
Country	Per capita	Country	%GPD
South Africa	652	South Africa	8.6
Tunisia	463	Kenya	7.8
Botswana	381	Malawi	7.8
Namibia	342	Namibia	7.0
Libya	239	Djibouti	7.0
Morocco	199	Botswana	6.6
Gabon	197	Tunisia	6.4
Algeria	169	Gambia	6.4
Swaziland	167	Zimbabwe	6.2
Egypt	153	Côte d'Ivoire	6.2
Zimbabwe	142	Mozambique	5.9
Côte d'Ivoire	127	Uganda	5.9
Liberia	127	Guinea-Bissau	5.9
Kenya	114	Zambia	5.7
Equatorial Guinea	106	Eritrea	5.7
Lesotho	101	Lesotho	5.5
Djibouti	90	Rwanda	5.5
Gambia	78	Morocco	5.1
Angola	70	Senegal	4.8
Senegal	63	Ghana	4.7
Guinea	61	Sudan	4.5
Ghana	60	Central African Republic	4.5
Central African Republic	58	Utd Rep of Tanzania	4.4
Uganda	57	Angola	4.4
Zambia	52	Benin	4.4
Mozambique	47	Mali	4.3
Mauritania	45	Sierra Leone	4.3
Togo	45	Liberia	4.3
Rwanda	44	Algeria	4.1
Cameroon	42	Egypt	3.9
Sudan	39	Niger	3.7
Malawi	39	Ethiopia	3.6
Benin	39	Mauritania	3.6
Guinea-Bissau	37	Burundi	3.6
Eritrea	36	Gabon	3.6
Nigeria	31	Guinea	3.5
Mali	30	Dem Rep of the Congo	3.5
Burkina Faso	27	Nigeria	3.4
Sierra Leone	26	Cameroon	3.3
Utd Rep of Tanzania	26	Swaziland	3.3
Congo	22	Burkina Faso	3.0
Niger	22	Libya	2.9
Burundi	19	Togo	2.8
Chad	17	Chad	2.6
Ethiopia	14	Somalia	2.6
Dem Rep of the Congo	12	Congo	2.1
Somalia		Equatorial Guinea	2.0

Source WHO World Health Report 2004

## **Political economy**

France made its initial contact with Cote d'Ivoire in 1637, when missionaries landed at Assinie near the Gold Coast (now Ghana) border; Cote d'Ivoire officially became a French colony in 1893. From 1904 to 1958, Cote d'Ivoire was a constituent unit of the Federation of French West Africa. It was a colony and an overseas territory under the Third Republic. Until the period following World War II, governmental affairs in French West Africa were administered from Paris. In 1946, French citizenship was granted to all African "subjects," the right to organize politically was recognized, and various forms of forced labour were abolished. In December 1958, as a result of a referendum, Cote d'Ivoire became an autonomous republic within the French community and then gained independence on August 7<sup>th</sup> 1960. In a region whose political systems have otherwise been noted for a lack of stability (for example, those countries undergoing repeated military coups), Cote d'Ivoire showed remarkable political stability after its independence from France in 1960. Cote d'Ivoire evolved from a single-party state, beginning in 1990, and opposition parties, independent newspapers, and independent trades unions were all made legal.<sup>15</sup>

Although there has been an element of political and military instability in the recent history of the country, Cote d'Ivoire remains one of Africa's most diversified economies. Its location geographically and economically at the hub of Francophone West Africa leaves it ideally placed to capitalize on the economic development of the region.<sup>16</sup> Close ties to France since independence in 1960, the development of cocoa production for export, and foreign investment has made Cote d'Ivoire one of the most prosperous of the tropical African states. Cote d'Ivoire is among the world's largest producers and exporters of coffee, cocoa beans, and palm oil. Consequently, the economy is highly sensitive to fluctuations in international prices for these products and to weather conditions. The economy is still heavily dependent on agriculture and related activities, which engage roughly 68% of the population. The Ivorian economy began a comeback in 1994, due to the 50% devaluation of the CFA franc and improved prices for cocoa and coffee, growth in non-traditional primary exports such as pineapples and rubber, limited trade and banking liberalization, offshore oil and gas discoveries, and generous external finance and debt rescheduling by multilateral lenders and France. The rising world prices for cocoa will help both the current account and the government balances.<sup>17</sup>

GDP per capita is Intl \$2045. This falls within the range of \$8,272 (Libya) and \$346 (Democratic Republic of the Congo) in the countries of Africa (Table 5).

**Table 5 GDP per capita (Intl \$): countries of Africa, 2001**

Country	GDP per capita (Intl \$)
Libya	8272
South Africa	7538
Tunisia	7183
Botswana	5747
Gabon	5514
Equatorial Guinea	5239
Swaziland	5029
Namibia	4918
Algeria	4104
Egypt	3901
Morocco	3887
Liberia	2965
Zimbabwe	2271
Côte d'Ivoire	2045
Congo	1936
Lesotho	1844
Guinea	1752
Togo	1608
Angola	1578
Kenya	1452
Senegal	1323
Central African Republic	1289
Djibouti	1288
Ghana	1272
Cameroon	1269
Mauritania	1257
Gambia	1214
Sudan	1112
Uganda	964
Nigeria	915
Zambia	906
Benin	888
Burkina Faso	886
Mozambique	805
Rwanda	799
Mali	700
Chad	656
Guinea-Bissau	630
Eritrea	629
Sierra Leone	606
Niger	604
Utd Rep of Tanzania	599
Burundi	529
Malawi	501
Ethiopia	382
Dem Rep of the Congo	346
Somalia	

Source WHO

## **ETHICAL ISSUES**

### **FURTHER READING**

Akribi HAD, Desgrees Du Lou A, Msellati P, Dossou R. Issues surrounding reproductive choice for women living with HIV in Abidjan, Cote d'Ivoire. *Reproductive Health Matters* 1999;7(13): 20.

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Zellner S L. Condom use and the accuracy of AIDS knowledge in Cote d'Ivoire. *International Family Planning Perspective* 2003; 29(1): 41-47.

## **REFERENCES**

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<sup>1</sup> Report of the United Nations Development Programme 2004 (HDI 2002). Launched by the United Nations in 1990, the Human Development Index measures a country's achievements in three aspects of human development: longevity, knowledge, and a decent standard of living. It was created to re-emphasize that people and their lives should be the ultimate criteria for assessing the development of a country, not economic growth. Current values range from 0.956 (Norway, 1/177 countries) to 0.273 (Sierra Leone, 177/177 countries). Countries fall into one of three groups: countries 1-55=high development; 56-141=medium development; 142-177=low development. See: [http://hdr.undp.org/statistics/data/indic/indic\\_8\\_1\\_1.html](http://hdr.undp.org/statistics/data/indic/indic_8_1_1.html)

<sup>2</sup> IOELC interview: Joseph Essombo – 4 June 2004.

<sup>3</sup> International Narcotics Control Board (2004) *Narcotic Drugs: estimated world requirements for 2004. Statistics for 2002*. New York: United Nations, 2004.

<sup>4</sup> 'The term *defined daily doses for statistical purposes* (S-DDD) replaces the term *defined daily doses* previously used by the Board. The S-DDDs are technical units of measurement for the purposes of statistical analysis and are not recommended prescription doses. Certain narcotic drugs may be used in certain countries for different treatments or in accordance with different medical practices, and therefore a different daily dose could be more appropriate.' International Narcotics Control Board. *Narcotic Drugs: estimated world requirements for 2004. Statistics for 2002*.

<sup>5</sup> IOELC interview: Beugre Kouassi – 4 June 2004.

<sup>6</sup> Africa gets its own hospice and palliative care association! *HPCA* 2003;5(2): 4.

<sup>7</sup> IOELC interview: Beugre Kouassi – 4 June 2004.

<sup>8</sup> IOELC interview: Joseph Essombo – 4 June 2004.

<sup>9</sup> See: <http://www.cia.gov/cia/publications/factbook/geos/iv.html>

<sup>10</sup> This refers to adult mortality risk, which is defined as the probability of dying between 15 and 59 years.

<sup>11</sup> See: WHO statistics for Cote d'Ivoire at: <http://www.who.int/countries/civ/en/>

<sup>12</sup> <http://www.unaids.org/en/geographical+area/by+country/côte+d'ivoire+.asp>

<sup>13</sup> Total health expenditure per capita is the per capita amount of the sum of Public Health Expenditure (PHE) and Private Expenditure on Health (PvtHE). The international dollar is a common currency unit that takes into account differences in the relative purchasing power of various currencies. Figures expressed in international dollars are calculated using purchasing power parities (PPP), which are rates of currency conversion constructed to account for differences in price level between countries.

<http://www3.who.int/whosis/country/compare.cfm?country=s&indicator=strPcTotEOHinIntD2000&language=english>

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<sup>14</sup> Tandon, A., Murray, C. L. J., Lauer, J. A., and Evans, D. B., Measuring overall health system performance for 191 Countries. GPE Discussion Paper Series: No 30; WHO

<sup>15</sup> U.S. Dept. of State, Office of Francophone West African Affairs, Bureau of African Affairs, 2003. *Background Notes on Countries of the World 2003*. Washington, DC: U.S. Dept. of State, Office of Francophone West African Affairs, Bureau of African Affairs.

<sup>16</sup> World of Information Business Intelligence Report., 2001. Cote d'Ivoire: Economy, Politics and Government. *Business Intelligence Report*, vol. 1(1): 1-42.

<sup>17</sup> <http://www.cia.gov/cia/publications/factbook/geos/iv.html>