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NGOs and the Reconstruction of the Public Health System in the North of Côte d'Ivoire: strategies of repositioning and collaboration

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Résumé

L’éclatement du conflit militaropolitique de 2002 en Côte d’Ivoire entraine le départ des agents de l’administration publique du septentrion du pays sous contrôle de la rébellion, dont ceux du secteur de la santé. La précarité qui s’en suit motive l’intervention des organisations humanitaires internationales. Leurs actions, orientées prioritairement vers le domaine de la santé, ont nécessité l’implication d’acteurs locaux. C’est dans ce contexte qu’elles ont suscité la création d’ONG de la santé d’une part, et, d’autre part, mobilisé les associations préexistantes, constituant ainsi une société civile locale dynamique qui a assuré la sous-traitance de leurs différents projets à impact rapide. Au terme de la crise, le processus de normalisation et de reconstruction nationale qui a conduit à leur retrait du théâtre des opérations, conformément au processus de transition humanitaire mis en selle sous l’égide du gouvernement, va modifier le schéma opérationnel de ces ONG relais en vue d’une adaptation au nouveau climat. Cette étude qui s’appuie sur une recherche documentaire et des enquêtes qualitatives auprès des acteurs associatifs et du secteur public met en relief les stratégies de résilience des ONG locales dans l’optique de se repositionner et s’engager dans un processus de collaboration qui fait d’elles, un maillon indispensable du système de santé au nord de la Côte d’Ivoire.

Mots-clés : Côte d’Ivoire, ONG, système de santé publique, reconstruction

Summary

The outbreak of the military-political conflict in Côte d’Ivoire in 2002 led to the departure of government officials, including those in the health sector, from the northern part of the country, which was under rebel control. The resulting insecurity prompted the intervention of international humanitarian organisations. Their actions, oriented primarily towards the health field, required the involvement of local actors. It is in this context that they brought about the creation of health NGOs on the one hand, and on the other hand, mobilised pre-existing associations, thereby building up a dynamic local civil society that subcontracted their different quick impact projects. At the end of the crisis, the process of normalisation and national reconstruction that led to their withdrawal from the theatre of operations, in accordance with the humanitarian transition process enacted under the aegis of the government, modified the operational schemes of these relay NGOs with a view to adapting to the new climate. This study, which is based on a literature review and qualitative surveys of community actors and the public sector, highlights the resilience strategies of local NGOs in order to reposition themselves and engage in a collaborative process in order to make themselves an indispensable link in the health system in northern Côte d’Ivoire.

Keywords: Côte d’Ivoire, NGO, public health system, reconstruction

NGOs and the Reconstruction of the Public Health System in the North of Côte d'Ivoire: strategies of repositioning and collaboration

Introduction

In September 2002, war broke out in Côte d'Ivoire, splitting the country in two, with the north occupied by the rebels and the south under governmental control. The presence of the rebels led to the departure of all entities representing the State in this part of the country and the consequent deterioration of infrastructures, including health infrastructures. According to UNICEF, the war brought about "*an humanitarian crisis with the displacement of nearly a million people, the pillage and/or destruction of basic infrastructures (schools, health centres, social structures, courts, police and gendarmerie units), and the implosion of the security sector"*[1]..

The departure of public sector practitioners, combined with the deterioration of health infrastructures, and the suspension of pharmaceutical and medical equipment supplies to the area, plunged the region into a sanitary crisis which would be curbed by humanitarian intervention. Indeed, in the face of this risk, international humanitarian organisations descended on the region, leading to the creation of local NGOs with a view to taking over from public sector actors. After the Ouagadougou Agreement of 2007, between the government and the rebels, which encouraged the gradual redeployment of the administration, a collaboration began between these NGOs and the health providers who were being redeployed in the region.

Since 2011, Côte d'Ivoire has been emerging from a decade of war and setting the course for national reconstruction. International humanitarian actors have progressively withdrawn from the theatre of operations, in the context of a process of humanitarian transition set in motion by the government.

"The transfer of activities from international actors towards national and local entities is officially planned. It is a question of progressively delegating coordination responsibilities to

[1] **Unicef, «Vulnérabilités, Violences et Violations graves des droits de l'enfant» [electronic version], p.6 www.unicef.org/french/.../Rapport_UNICEF_SC_Violations_Nov2011_FINAL.pdf, Consulted on August 28th 2017**

different ministries [...], of setting up national programmes and of encouraging civil society to get organised and to take over"[2].

Indeed, since 2011, the narrative on emergence, a goal set for 2020, has been at odds with the narrative of humanitarian aid. The construction of numerous infrastructures and the gradual change in the country's image represent green lights for all indicators. Economic growth is offered as a proof of the credibility of the government's actions and of regained stability. In these conditions, the conspicuous presence of international humanitarian organisations represents a tangible contradiction to the declarations of normalisation announced in the press. This process of normalisation therefore implies their retreat, with a view to an humanitarian transition. By humanitarian transition, read the handover of social services, which international humanitarian actors had been in charge of, to the national party. For the French Red Cross Foundation, beyond this generic definition, the concept of humanitarian transition contains a broader and more complex reality.

"The relatively recent concept of humanitarian transition raises a number of questions. It appears as a necessary step between a humanitarian paradigm that is running out of steam, and a new aid system that is better connected to concepts of human development, sustainable development and social change"[3].

"It can be observed in different stages in aid-recipient countries and on different continents and can be explained by the growing will of developing countries, who have been made vulnerable by one-off or recurring crises, to take control and decide on actions concerning their populations"[4].

It was therefore in the context of the process of normalisation that the State expressed its will to break with the model of emergency humanitarian aid which had set up shop in Côte d'Ivoire. But this image of a country that has recovered enough to do without international humanitarian assistance was at odds with the lived reality of the population, many of whom had not fully recovered from the throes of the crisis and had reaped no benefits from economic growth. The emergence narrative is no longer convincing enough to obscure the difficult problems which the country is facing, including that of health infrastructures, and access to care in areas formerly occupied by the rebels, especially in the northern region where health structures, which were in decline before the war, further deteriorated during the crisis.

In spite of the rehabilitation efforts undertaken by the government and its partners in development, enormous challenges remain in the health sector. The slow reconstruction of infrastructures, the reluctance of healthcare providers to operate in the region, the resurgence

[2] **Francis A. & Virginie T., « La transition humanitaire en Côte d'Ivoire, éléments de cadrage», in : Thomas Fouquet & virginie Troit (éd.), *Transition Humanitaire en Côte d'Ivoire*, Paris, Karthala, 2017, pp. 9-24, pp. 11-12**

[3] **J-F. Mattei & V. Troit, « La transition humanitaire », *médecine/sciences* 32, n°2, 2016, pp. 211 - 215, pp. 214 - 215**

[4] **F. Akindes & V. Troit, *op. cit.*, p. 13**

of old health problems, the spread of infectious diseases, namely HIV, etc., confer a strategic role on NGOs who provide considerable support to the public health sector, with often more effort than elsewhere. These majoritarily local NGOs continue to support governmental action although they have themselves been subjected to the effects of the withdrawal of international organisations for whom they had been subcontracting rapid impact projects. The retreat of these “tutor” organisations, who funded their activities, and the reconstruction of the public health system, forced them to reposition themselves and to adopt new intervention strategies in order to avoid lapses in their procedures and to establish themselves as essential links in the system under reconstruction.

By NGO we mean an organisation whose funding is mainly ensured by private donations and which is devoted to humanitarian aid in one or several of its forms (medical or technical assistance in non-industrialised countries, aid in the case of disaster or war, etc). It is generally not-for-profit, apolitical, and created and run by volunteers. In Côte d’Ivoire, the association community is regulated by the law n°60-315 of September 21st 1960. If the association refers to a bigger entity whose objective is not solely humanitarian, NGOs specify as such. But alongside these NGOs are faith-based associations which, by way of certain structures, actively participate in the management of health issues in the region. As recipients of humanitarian sponsors given their implication in this field, they have been taken into account in the context of this study. This is why the term “NGO” here refers to civil society, religious, secular, public interest and humanitarian organisations whose not-for-profit activities are mainly or regularly focused on the sector of health.

This study sheds light on one of the sectors at the heart of humanitarian transition. It is a question of seeing how NGOs working in the health sector in the north of Côte d’Ivoire have repositioned themselves in light of the process of reconstruction of the public system, to the point of representing an essential link in the current health system. What is their margin for manoeuvre in this new context? And what are the impacts of their actions?

As well as shedding light on the role of civil society in this zone affected by the war, this article will enable us to answer the question of the reconfiguration of actors caused by humanitarian emergency.

Methodology

The study was carried out in the north of Côte d’Ivoire, mainly in the two regions of Poro (regional capital Korhogo) and Bagoué (regional capital Boundiali). The chosen methodology for data collection relied on two (2) main sources of information: a literature review, and the collection of qualitative and observational data. The qualitative approach of this research involved the use of semi-structured interviews and focus-group discussions, direct observation and documentary analysis.

Documentary research was carried out in Abidjan and in the two regions under study. In Abidjan, the research focused on libraries and documentation centres, the Department of Information, Planning and Evaluation of the Ministry of Health (DIPE), and the NGO Service at the Ministry of Health.

The documents collected included statistical documents from the health sector, study reports, projects and programmes of action and collaboration procedures between the State and civil society. The statistics enabled an understanding of the situation in the north in relation to other regions in the country, regarding infrastructures, equipment, the ratio of care providers/population, etc. The NGO Service documentation provided information about the approvals procedure for NGOs, their terms and conditions, and which NGOs were recognised by the Ministry and the collaboration system.

In the areas of study, our documentary collection focused on the NGOs under review, the Regional Health Department and the Health Districts which represented the Ministry of Health at the regional and departmental levels. The information collected provided more information about the volume of NGO activities and the functioning of the local public health system.

Overall, the documentary research was carried out without difficulty. At the NGO and associative level, there were only a few understandable reticences on behalf of certain directors, who argued that certain documents were confidential and/or the exclusive property of the sponsors who funded them. In the public sector, it was once again statistical data that was put at our disposal. Although these sources were valuable for our research, it is important to specify that they remain official documents which are remarkably superficial on the subject, and at times out of date. For this reason, interviews represented an important means of collecting information.

Interviews were conducted using a semi-structured method adapted to *in-depth studies*[5]. To properly understand the current situation, we needed a sociohistorical approach, which favours the use of semi-structured interviews. Indeed, this kind of interview enables the informer to go back over lived situations whilst being guided by what the interviewer understood so that they may provide further precisions[6]. This process enables the researcher "*to focus on the actors' experiences by reconstructing a context which gives them shape and meaning"* [7].

The use of the semi-structured interview enabled us to check and test the relationships between different variables, namely the circumstances of the creation of the NGOs which were active in the field at the time of the study, their domain and volume of activity, their relationship with the public health sector, their repositioning strategies in reaction to the new context, the

[5] **R. Ghiglione, B. Matalon, *les Enquêtes sociologiques. Théories et pratique*, Paris, Armand Colin, 1998.**
[6] **J. Guibert, G. Jumel, *La sociohistoire*, Paris, Armand Colin, 2002 p. 36**
[7] **J. Revel (Dir.), *Jeux d'échelles. La micro-analyse à l'expérience*, Paris, Gallimard/Seuil, 1996, p. 13**

profiles of directors and volunteers, sources of funding based on their efficiency, the relationships between associations and the difficulties encountered.

The interviews were structured with the help of a thematic thread which had been developed beforehand during the exploratory phase of research, carried out between September and October 2017. They were conducted in two phases. The first was carried out between mid-November 2017 and the beginning of March 2018, with a number of regular trips between Abidjan and the field of study. Most of the interviews took place during this period. The only problem was that certain key informants could not be reached and the need to question certain actors required a further trip to the field of study. This second phase of complementary interviews took place in June 2018.

These interviews enabled us to collect information on issues relative to the dimensions of the problem under study. In Abidjan, the interviews concerned officials from the Ministry of Health in charge of relationships with NGOs. The aim was to understand their perceptions of NGO action and to understand the mechanisms of the relationships between them, and of ministerial regulation.

In the field, the bulk of interviewees was made up of heads of NGOs, of international humanitarian organisations, of UN organisations and of public health sector actors, who had been identified during the exploratory phase. The criteria for inclusion in the study for NGOs and associations were:

- to be an NGO or association working in the health sector
- to be recognised by the Ministry of Health and/or by the Ministry of the Interior
- to have led several projects in the health sector in the north of Côte d’Ivoire
- to have active ongoing activities
- to be recognised by the Regional Health Department as an NGO involved in health activities.

Inactive NGOs whose former activities had not had a significant impact on the region were not selected for the study.

Results

The Ivorian crisis as a factor in the boom of health NGOs in the north of Côte d’Ivoire

The humanitarian emergency linked to the war favoured the emergence of a number of civil society organisations, as explained by A. Floridi and S. Verdecchia.

"Following the outbreak of the crisis, from October 2002 to September 2003, in less than a year, 521 Civil Society Organisations were declared, whilst from 1952 to the 19th of September 2002 there were only 595 declared Civil Society Organisations. The majority of these organisations were born and operated in the humanitarian field"[8].

The growth of the associative network is therefore relatively recent. It was boosted by the crisis which engendered a proactive awareness within a civil society which had long tagged behind governmental action, in a country where the good health of the economy post-independence, qualified as the "Ivorian economic miracle", and the fears of reprisals during the single-party phase were not conducive to the constitution of a dense civil society. The culture of associations, which was less developed to begin with in Côte d'Ivoire during the colonial period, did not favour the growth of solid NGOs after independence either. The majority of NGOs working in the health sector emerged as a result of the outbreak of the AIDS epidemic in Côte d'Ivoire[9]. Indeed, before the war in 2002, it was the AIDS epidemic which had represented the catalyst for the creation of a number of health associations, as illustrated by the following table.

Table n°1: the distribution of associations and non-governmental structures in the fight against AIDS in 1996, by year of creation.

Year of creation	Quantity	Percentage
Before 1985	13	17
After 1985	42	55
Indeterminate date	22	28
Total	**77**	**100**

Source : A. D. Blibolo, « Les organisations non gouvernementales face au SIDA en Côte d'Ivoire redynamisation ou changement d'orientation ? », Paper presented at the conference *ONG et développement du Nord aux Suds*, Bordeaux, 28-30 November 1997 (preparatory document), p. 27.

The table suggests a boom in humanitarian service in the health sector after 1985, the date when the first AIDS cases were confirmed in Côte d'Ivoire.

[8] **M. Floridi and S. Verdecocha, *Étude de faisabilité du programme d'appui à la société civile en Côte d'Ivoire*. Mapping report, July 2010. European Union, ECO3, [Online] www.eeas.europa.eu/delegations/cote.../annexes mapping tome2 fr.pdf, p. 10.**

[9] **T. A. ZRAN, *L'histoire du VIH/sida en Afrique subsaharienne : le cas de la Côte d'Ivoire de 1985 à aujourd'hui*, unique doctoral thesis in Contemporary History, Université Félix Houphouët-Boigny, Abidjan-Cocody, 2014, 674 p**

Nearly all of these burgeoning associations were headquartered in Abidjan, the hub of the fight against the epidemic. The interior of the country did not seem to be fertile ground for these associations. This reality can be seen in the northern part of the country which is our area of study, where the majority of NGOs in the health sector developed in the context of the war. Nonetheless, we observed the presence of associations whose presence in the north predated the crisis. Generally speaking, the ecosystem of civil society implicated in health activities was the result of three movements, to whit:

- Associations and NGOs whose presence in the region predated the crisis
- Associations created in the context of war
- Associations which set up in the region as a result of the crisis

The first are made up on the one hand of religious associations, called upon in the context of the apostolic movement to lead the social work of the Church or by Christian communities, and on the other hand, of national NGOs whose strong operational capacities permitted the extension of their activities throughout the entire country or in vulnerable areas.

The religious associations include *Animation Rurale de Napié* (ARN), from the name of a small commune fifteen kilometres south of Korhogo, *CARITAS* and the *Don ORIONE* Centre in Korhogo. They arrived respectively in 1989, 1993 and 1994. The two first ones are linked to the Catholic church in their respective communes (Napié and Korhogo), whereas the presence of the third one in Korhogo can be explained by the desire to respond to the difficult health problem that was raging in the region. The testimony of Sister C. Giovanna clarifies the motives for the opening of the *Don ORIONE* Centre in Korhogo:

"I have been here since 1994, when the centre opened. And the centre is a welcome centre for handicapped people. It's a centre that was opened to care for the after-effects of polio, and then gradually thanks to the vaccination against polio, we hardly have any polio left in the centre, but since it's a centre for handicapped people, we opened the doors to other kinds of handicaps".

Alongside these religious associations working in the region, there are civil society organisations that were created years before those aforementioned. This group is made up of the *Association Ivoirienne pour le Bien-Être Familial* (AIBEF), the NGO *Notre Terre Nourricière* (NTN), and the Local Committees of the Red Cross of Korhogo and Boundiali. AIBEF is a national NGO that was created in 1979. It particularly targets women and children with its family planning and reproductive health programmes. As a state-approved structure, it opened regional branches, including the one in Korhogo in 1986, as the head of the branch explained.

"The very first branch was in Boundiali in 1984. Korhogo followed in 1986 because the northern zone was favourable to the policies of family planning, since at the time the authorities were not so in favour of family planning. So the leaders of the north, who recognised the merits

of family planning, allowed the opening of the first branches in Boundiali and then in Korhogo. Korhogo being the region, it swallowed up Boundiali."[10].

The youngest in this group of associations is *Notre Terre Nourricière*, created with a view to encouraging agricultural development in the region.

"It was created on April 16th 2002. We began with the fact that we are mainly agricultural technicians. And we got together because we felt something coming, to be honest. |...] So ANADER[11] having left after September 19th (the beginning of the war in Côte d'Ivoire), the field was left vague. So we, at the same time, started to manage the farmers. I'm not saying that we took the place of ANADER, but we were doing the same thing. So we started to manage the farmers. But since they say a healthy mind in a healthy body. At the same time as working with the farmer, he is someone who works with strength. But if he's not healthy, what do you do? And we saw that there were starting to be illnesses because we were much more rural than urban at this point. Often people said "I have malaria, fatigue, etc". We thought that if there was no follow-up in healthcare anymore that we should start with that. That's how it started. But at the same time we understood that was wasn't malaria, but there was diarrhea and other things. So we started with water sanitation. That's how we started"[12].

This was the state of associations involved in health in the north before the crisis. It clearly shows a blatant deficit of mobilisation by civil society which contrasts with the crisis situation at the origin of the second emergence movement of NGOs in the north.

The associations created in reaction to the military-political crisis are the most numerous. The majority of NGOs intervening in the health sector emerged during the decade-long Ivorian crisis. Indeed, interviews and direct observation showed that the majority of NGOs in this area are focused on the health sector. This is important, since it indicates that this sector represented a major challenge to avoid an humanitarian disaster in this part of the country where the presence of the rebels had led to the retreat of public health sector personnel back to area under governmental control.

The rebels' inability to take up the relay led to an urgent need for humanitarian aid. It was in this context that humanitarian organisations and international NGOs intervened. These included Médecins Sans Frontières, the ICRC, Care, Elizabeth Glaser Pédiatrc AIDS Foundation (EGPAF), Health Alliance International, Save the Children, Action Contre la Faim, Médecins du Monde, etc., whose action programmes required local relays for implementation. These organisations therefore brought about the creation of local NGOs, positioned as sub-contractors. "The international organisations that came brought about the creation of a number of NGOs", confirmed a head of the Regional Health Department of Poro – Tchologo - Bagoué.

[10] **Interview with Fanhoman TOURE, Regional coordinator at AIBEF, on 17/02/2018 in Korhogo**
[11] **Agence Nationale d'Appui pour le Développement Rural (National Support Agency for Rural Development)**
[12] **Interview with Anzoumana OUATTARA, official in the health sector, on 23/02/2017 in Boundiali**

The arrival of international humanitarian organisations with attractive turnkey projects therefore boosted the associative movement in the region. The fact that most projects focused on the health sector considerably affected the configuration of NGOs. As an actor present in the region since the beginning of the war explained, "there was a lot of money in the crisis. Which is to say that NGOs got funding". It was in this same context that new branches of NGOs operating in other parts of the country were opened, with some NGOs relocating to this area which had become favourable to humanitarian activities linked to health.

This third wave was made up of two NGOs which are amongst the most active in the field. These were the NGO *Initiative Développement Environnement Afrique Libre* (IDEAL Inter) and *Santé et Action Sociale* (SAS).

The first was operating in Danané[13], one of the border regions with Liberia and Guinea, where the violence of the Ivorian conflict peaked. Because of the overwhelming insecurity, the promoters of the NGO decided to move the headquarters and activities to Korhogo in 2003, where the rebels' hold on the region had brought about a relative calm.

"We were born in 2000. Officially we got our paperwork (accreditation) in 2000. IDEAL was born in the west of Côte d'Ivoire, in Danané to be precise. We were born out of the Liberian crisis because everyone who worked for IDEAL had already worked for other international NGOs. So because they had to leave, we had to get a structure set up to take over certain activities [...]. The west of the country was very violent during the crisis, very hard. We were lucky to be able to move Burkinabe populations and help them to get home. It was when we were in Korhogo with friends, with the calm that was there, that we thought, why didn't we set up here? So that's what we did, we came here"[14]

Yet the calm alone did not explain their setting up in the area. Indeed, as the regional capital and the second biggest city under rebel occupation, Korhogo had been a destination for international humanitarian workers who were ready to finance local structures. It was therefore an area which offered good survival prospects for certain NGOs which were struggling in other inaccessible areas at the time. As for the NGO *SAS*, created in Bouaké on May 15th 1995, and part of the leading national associations engaged in the fight against AIDS in Côte d'Ivoire, it opened a branch in Korhogo to expand its activities in the fight against AIDS in this region that had been deserted by the public sector practitioners.

Overall, it is the convergence of these three movements that made up the associative landscape in the health sector in our area of study. Nonetheless, to grasp the importance of NGO and association action, it is worth noting the state of the public health sector. This will

[13] **A town located in the far west of Côte d'Ivoire.**

[14] **Interview with Aboubacar OUATTARA, President of the Board of Directors of the NGO IDEAL Inter, on 02/03/2018 in Korhogo**

enable us to understand the development of the NGOs' positioning in this sector. Indeed, there are no longer as many NGO and association activities as during the crisis period. With the redeployment of the administration and the reconstruction of health infrastructures, the public health sector has been gradually reasserting itself, though enormous challenges still remain. This is why, to understand the weight of NGOs in this new configuration, it is worth taking a look at the public sector.

A public health system under permanent reconstruction in the north of Côte d'Ivoire

From the outbreak of war to the Ouagadougou Agreement in 2007, the health system in this part of the country survived on life support from international and national humanitarian aid. Because of this, a number of infrastructures were abandoned, pillaged or deteriorated. For this reason, in spite of the rehabilitation of health centres and the building of new infrastructures in the context of the Presidential Emergency Programme (PPU) and the National Development Programme (PND), the scars of the war have prevented the health system from operating at full capacity, confining it to the status of a sector under permanent reconstruction. Before examining the particular difficulties facing this sector in the north of the country, it is worth painting a picture of the infrastructures in the two regions under study.

Table n°2: Health infrastructures in the Poro and Bagoué regions

Health districts	CHR*	HG*	ESPC*	Private/religious	Total public
Korhogo	1	0	78	36	**79**
Boundiali	0	1	13	8	**14**
Tingrela	0	1	11	1	**12**
Région	**1**	**2**	**102**	**45**	**105**

Source : Regional Department of Health and Public Hygiene, Poro - Tchologo - Bagoué
*__CHR__ : Regional Hospital Centre *__HG__ : General Hospital *__ESPC__ : Primary Health Care Centre

These infrastructures cater to a total population of around 1 143 220 inhabitants, distributed as follows: 834 861 in Korhogo, 278 710 in Boundiali and 129 649 in Tingréla.

According to the statistics, that is 1 143 220 inhabitants for one Regional Hospital Centre, to which must be added the 260 519 inhabitants of the Health District of Ouangolo and the 252 928 inhabitants of Ferkessédougou which are also part of this health region. Indeed, Poro – Tchologo - Bagoué is the biggest health region in the country. Therefore, in spite of the

efforts made by the government and its partners in development in the aftermath of the crisis, these infrastructures remain insufficient.

This problem is compounded by their dysfunctioning, namely, the deterioration of the technical facilities, the regular closure of certain services for maintenance, the dearth of certain specialised services, the lack of means to move and evacuate patients (ambulances), etc.

As for human resources, there is a glaring discrepancy between the official statistics communicated by the Regional Health Department and those provided by the heads of health centres. For example, according to the Regional Department's statistics, the general hospital in Boundiali has 14 doctors, whilst its director declares that he only has five. Upon closer analysis, it became clear that the Regional Department's statistics were obsolete because out of date. In the absence of regular updating of the data, this information does not reflect the reality. Indeed, even though a lack of health personnel is a problem throughout Côte d'Ivoire, the particularity of this region is that it has, as well as this insufficiency, the highest rates of mobility amongst health personnel in the country.

"We are in the region with the highest personnel mobility in the country. There are regularly transfer requests towards the south and west of the country. People do not want to stay in Korhogo", declared an official of the Health District of Korhogo.

The distance of the area from the capital[15], the instability and insecurity[16], the lack of opportunities to carry out parallel activities (private clinics, plantations, commerce, etc) to supplement their incomes, lead a number of health providers to request transfers away from the area. Nearly all the doctors and a number of health workers in this region live alone, having left their families in the south, especially in Abidjan. This situation contributes to the fragility of this system under reconstruction. Solutions are being sought constantly. In constant search of its bearings in an urban area, the public health sector often resorts to the services of NGOs to support it and sustain its action in communities where it is struggling to make headway.

This is why, in spite of the process of national reconstruction which required the progressive withdrawal of international humanitarian organisations, local NGOs will not abdicate or disappear. On the contrary, they will develop strategies with a view to repositioning themselves according to the prerogatives of the public sector, but also according to its weaknesses. This adaptation of local structures is very edifying, because it provides information regarding the reconfiguration of actors that emerged as a response to the emergency situation and the

[15] **Located more than 700 kms from Abidjan, it takes almost 6 hours of driving to get to Korhogo and a bit longer to get to µBoundiali and Tingréla, the last Ivorian town before the Malian border. The deterioration of road infrastructures has added to access difficulties.**

[16] **Since 2014, Korhogo has been the site of a dozen mutinies by ex-rebels, integrated into the national army, claiming war premiums. These mutinies led to disruptions and violence amongst civil populations. To these disturbances must be added the circulation of small arms and light weapons which contribute to the phenomenon of highway robberies, breaking and entering, assaults with weapons, etc.**

affirmation of awareness of the importance of civil society in the process of national development. It is a question of understanding the strategies of resilience and repositioning of these actors in the context of reconstruction and their contribution to the management of the shortcomings of the public health system.

The repositioning of NGOs in response to the reconstruction of the public health sector: an indicator of the dynamism of local civil society

At the end of the humanitarian emergency in Côte d'Ivoire, which coincided with the retreat of international organisations, one of the recurring questions was the fate of local NGOs which emerged in the context of the emergency. There was a real and understandable concern about their capacity to adapt to the new situation. Being itself aware of this situation, local civil society proceeded to build resilience strategies, one of the most important of which was their repositioning according to the needs which remained in spite of the reconstruction that was underway. This is why the label of "NGO" was no longer sufficient to describe the reality of their action in the field. This label conceals a multitude of activities in different domains of health. Indeed, this generic label cannot describe the polymorphic nature of their activities. These associations are not distinguished solely by their organisational and operational logics, and even less by their legal status. Their specificity comes from their identity, their domain of activity and their interaction with the institutional environment. In response to the return of the State system, they reframed their activities to make their influence in the region sustainable. It was no longer a question for them of running after projects to subcontract, but rather of repositioning themselves in order to adapt to this new environment. We will therefore examine the main health activities which favoured this repositioning.

<u>The fight against HIV/AIDS: a common denominator for NGOs and a symbol of their adaptation to the new climate</u>

This is the hub of activity for nearly all of the associations. At the Regional Department of Health and Public Hygiene, it was unhesitatingly declared that it was the context of emergence of NGOs in the region that led to this situation.

"The reason that there are a lot of organisations focused on AIDS is that during the crisis, in the region here, most of the funded activities were centred on HIV. And the international organisations that came brought about the creation of several NGOs and it must be said that it's in the HIV/AIDS domain that there is the most funding"[17].

For NGOs, the focus on AIDS by international organisations can be explained by the risk of an explosion of the epidemic in the region as a result of the crisis. For the head of the SAS centre, this was also what led the NGO, which worked exclusively in the field of psychosocial

[17] **Interview with Henri KPAHI, Head of Sanitary Action at the Regional Health Department, on 20/02/2018 in Korhogo**

monitoring of HIV-positive patients before the war in the centre of the country, to open a branch in the north in Korhogo at the height of the crisis.

"Why did we open the branch? Because here in the north, the contamination rate was going to be high. There was no monitoring and the death rate was going to be high and the women who were infected would carry on having children and there was no follow-up"[18].

Having taken over from public sector actors during the crisis, the associations acquired a clear expertise in the management of HIV/AIDS, from raising awareness to therapeutic and psychosocial monitoring, and screenings. In spite of the return to normality, they carried on their activities with the support of sponsors who funded this struggle against AIDS in Côte d'Ivoire.

In terms of screenings, the volume of activities was remarkably high. For the year 2017, AIBEF carried out 839 screenings in its Voluntary Screening Centre (CDV), 671 tests in prenatal consultations and 253 tests in postnatal consultations. In total, this organisation carried out 1763 tests in a single year. To reach such scores, unlike the public sector, the association led a number of awareness campaigns amongst the population. All of the patients who were found to be positive were accompanied in this centre, which was managed by qualified personnel. The situation was similar in the SAS centre, at IDEAL Inter, and in many other associations whose premises responded to the demands of a medical treatment of HIV-positive patients. Health personnel appointed to the public operated as individual contractors.

Outside screenings focused particularly on rural areas that were difficult to access, where there were no health centres, or, if they did exist, where populations were reluctant to be screened and monitored in the event of being HIV-positive, fearing that the required confidentiality in the treatment of the disease would be broken.

In these conditions, it was therefore up to associative actors, by way of their community agents, to manage the screenings and monitoring of the patients. They therefore took the place of the public health system which had limited room to manoeuvre.

Even in the towns, NGOs found innovative ways to provide care in the fight against HIV/AIDS in order to distinguish themselves from the existing screening and management activities in public institutions. Hence, the NGO IDEAL Inter intervened amongst certain so-called marginal groups who did not feature in AIDS programmes throughout the region. Indeed, the taboo surrounding Lesbians, Gays, Bisexuals and Transgenders (LGBT), which is even more pronounced in this region where communities set themselves up as guardians of predetermined moralities, does not allow for the development of a system of medical follow-up for individuals belonging to these groups. The violence done to these people and the denial or minimisation of the existence of the phenomenon lead affected individuals to hide away. It is therefore a group that does not feature in any of the categories targeted by public actors. In these conditions, it is civil society which acts as a vanguard in the fight against AIDS in these

[18] **Interview with Mamadou KONE, Director of the SAS centre in Korhogo, on 15/02/2018**

particular groups, by developing strategies such as the creation of an LGBT association by the NGO IDEAL Inter, which was hence able to win their loyalty in order to better treat them.

Aside from screenings and medical care, associations also invested in the psycho-social monitoring of people infected by HIV, an activity which they have the monopoly on. With only one social assistant assigned to the CHR in Korhogo, the public sector is remarkably incapable of delivering this service. Hence, supported by partners, NGOs started working in all the hospitals in the region, intervening in different services in charge of HIV-positive patients. This is one of the successes of NGOs who claim to have understood, better than the public sector, the key role of psycho-social monitoring for patients' survival.

"The doctor writes his prescriptions. It's up to you whether to take them or not. Whether you take them or not, it's your problem. If the doctor gives you an appointment and you don't come, it's not his problem: he doesn't care. And then he, even if he doesn't see you, what indicator, what mechanism of control does he have in the hierarchy? He's not bound by a contract, he's not linked to an indicator. He has no pressure. Whereas an NGO… To give an example, when you say that "I am following 500 people living with HIV" and that you have a project, with 500 people living with HIV, when the partner arrives, he's going to look at the contractual indicators. He's even capable of going with you into the community to check what you are saying. But how many doctors will say that "I have 100 people I have administered medication to", and his director replies, "Listen, we're going to go and check whether these people really came to the CHR", no. So we're linked for today, for tomorrow, for life"[19].

Of course, the problem raised by our respondent is a transversal problem which undermines the health system in a general way, but it is felt more acutely in this area where the sum of services linked to the psycho-social monitoring of people living with HIV is exclusively managed by NGOs. We can therefore say, without fear of misspeaking, that NGOs have taken the place of the public health sector with regards to the psycho-social monitoring of HIV-positive patients. The end of their intervention in these hospitals would mean the end of psycho-social monitoring for people living with HIV.

Civil society in the fight against tuberculosis

Having begun its activities in the field of health in 2004, by managing the implementation of CARE projects against AIDS, CARITAS became involved in the fight against tuberculosis in 2010. To this day, out of the 500 patients at the Antitubercular Centre in Korhogo (CAT), CARITAS manages the community monitoring of 410 patients, of which 20% were referred to the CAT and to the Screening Centre for Tuberculosis (CDT) by them. The majority of the people being monitored come from rural areas. To break the cycles of contamination, the charity developed approach and screening strategies amongst friends and relatives of the declared sufferers.

[19] **Interview with Mamadou KONE, op. cit.**

The monitoring of sick people implemented by CARITAS is crucial, because it prevents relapses due to interrupted treatment. The treatment of tuberculosis in Côte d'Ivoire lasts for six months. Except that after four months, certain patients, noticing a significant improvement in their state of health, put an end to the treatment. There follow relapses which have ensured the persistence of the disease in the deprived areas of the region. This is why CARITAS has developed a strategy to monitor tubercular people undergoing treatment at home. Volunteers develop surveillance techniques to ensure that the treatment is being observed by the patients. Regular household calls are carried out and the patients' loved ones are made aware of the stakes so that they can report any deviation from the treatment.

Support for people with physical and mental difficulties

Support for people with physical and mental difficulties remains an enormous challenge for the health sector and social services in Côte d'Ivoire. Social services for education and training are as rare as specialised health centres. In these conditions, these people are discriminated against and do not enjoy the same opportunities as everybody else. In the north of the country, which remained a pocket of resistance for polio for a long time, a number of children suffer from the after-effects of the disease. Alongside those suffering from physical handicaps, there are also those with mental retardation and other congenital pathologies. The cultural conceptions surrounding these diseases which affect children from birth or at a young age blame bad luck, curses or divine punishment. For this reason, many of these children are abandoned or ostracised by their parents.

In order to address these problems, the DON ORIONE centre, which opened in 1994 in the context of the treatment of polio after-effects, now welcomes people suffering from various handicaps, namely mental retards, the hearing impaired, deaf-mutes, children with Down syndrome, autistics, people with psychomotor handicaps, etc. This structure is the only not-for-profit organisation in the region taking care of these people. The absence of such a service in the public sector shows how important the organisation is, and how busy. According to its managers, the centre is currently at the point of saturation since, unlike before (rejection of sick children by their families, stigmatisation, ill-treatment, abandonment), parents are now referring their problem children to the centre. The success of early monitoring which led to newfound capacities for a number of children ensured the renown of the Don ORIONE centre in Korhogo.

The indispensable help of NGO in the fight against malnutrition

Malnutrition is one of the difficult health problems that preys on the region. By way of proof, the World Food Programme opened an office in Korhogo in August 2016. It is the only WFP office in the interior of the country. The organisation deploys its largest programme in Côte d'Ivoire there through different projects:

- A project for school canteens in rural areas;
- A project for the reinforcement of agricultural groups;
- A nutrition project for HIV-positive people and their families;

- A project for the systematic distribution of food and fortified flour to all children between 6 and 23 months over three months, corresponding with the lean season for farmers.

The current programme involves 1419 children from 6 to 23 months to whom we distribute food and fortified flour over three months. [...] Out of the 613 school canteens supplied by the WFP throughout the country, 534 are managed by the Korhogo office which operates throughout the region"[20]

Long before the arrival of the WFP in 2016, it had been up to local NGOs to lead the fight against malnutrition. Incidentally, it was their lobbying that led to awareness being raised regarding the reality of this phenomenon, and that prompted the WFP's intervention. *Notre Terre Nourricière*, *l'Animation Rurale de Korhogo* (ARK), *Wo Pile Sanga*, and *l'Animation Rurale de Napié* (ARN) are the main civil society organisations recognised as active in the fight against malnutrition. The two first ones focus their activities on raising awareness whilst the latter two are involved in care for children suffering from malnutrition.

Wo Pile Sanga, which means "Help the children" in the Sénoufo language, emerges as the leader amongst them. With an estimated personnel of 105 volunteers and 10 interns, the NGO cares for nearly 3000 children, including orphans and vulnerable children with AIDS, children suffering from malnutrition and cases of abandoned babies. That being said, the fight against malnutrition is the pillar upon which the association was built. It is now a reference throughout the region.

"In all of the north of the country, I am a nutrition consultant," said its director. "My partner is HAI (*Health Alliance International*, an American NGO). Because I am the one who coaches and trains health personnel. So when I arrive and there are difficulties, everyone has their difficulties and we sort them out. And because the NGO is officially recognised, we all have the documents, so there's no problems with anyone. We work with the District, the Department of Health, we have the number of the official Journal and everything. [...]. For the whole of the north, the person who does nutritional education, management, culinary demonstrations, it's the NGO *WO PILE SANGA.* You can ask anywhere, if people are being honest they'll tell you, she's the one"[21].

This manager of nutrition, a former volunteer for the local Committee of the Red Cross with more than thirty years' experience in humanitarian aid, broke with the direction of the local Committee in 2006 following a misunderstanding, and opened the doors of her association in 2007. Since the departure of international humanitarian workers, the NGO has recentered its activities and now focuses on nutrition and care for orphans and children made vulnerable by HIV/AIDS. Its efforts in the fight against child AIDS and malnutrition were rewarded by the State

[20] **Interview with Philippe SEONE, Head of the WFP office in Korhogo, on 15/11/2017 in Korhogo**
[21] **Interview with Salimata Coulibaly, Head of the NGO *WO PILE SANGA*, on 06/03/2018**

with the organisation of two award ceremonies by the Vice-President of the Republic and the Minister of Health.

"It was a surprise for us, a great surprise. And that was in the context of nutrition. One was for HIV and the other was for nutrition [...] it's a long story. When everyone was saying that there was no malnutrition in Côte d'Ivoire, I was the only one who said that there were still people suffering. In the end they said "well, if you say they're suffering, give us proof". And I brought the proof little by little, until people accepted that there was malnutrition in Côte d'Ivoire and then the work began. The people from the ministry, when they come they see, they go by. But when they're looking for data, they come to me. Up until the day that someone called me to say, "here is your recognition". I was happy… Because not everybody gets recognition"[22].

The presence of community volunteers in the pediatric services in health structures in the region, where they intervene and guarantee the training of state agents, clearly illustrates the weight and hold of NGOs in this domain where State infrastructures are lagging behind.

In light of the above, we can see that associations have oriented themselves towards a specialisation in certain activities. This specialisation is a response to their resilience and repositioning strategies in the new health environment. Yet beyond these specific domains, they intervene in the overall management of recurrent health problems in the region.

The overall management of health users

Alongside humanitarian service in the health sectors defined above, according to projects and programmes for action, NGOs are also involved in the management of health users, following the public hospital model.

In this area, AIBEF, which has been present in the regional field for over three decades, has the best offer from civil society. This structure has established a hospital in Korhogo, where it registers an average of 400 consultations a week[23].

Aside from these general medicine consultations, there are also a number of consultations in specialised services such as gynecology, ophthalmology, odonto-stomatology, maternity, the dental clinic, the ENT service, etc. As an association primarily involved in family planning and reproductive health, AIBEF is at the vanguard of the fight against uterine cancer. It leads a number of awareness and screening campaigns in both rural and urban areas. In 2017, it carried out 769 screenings for uterine cancer[24]. All of the positive cases with cancerous lesions were directly managed onsite. Only the advanced cases were referred to the Regional Hospital Centre (CHR).

[22] ***Id.***
[23] **Internal AIBEF document on service provision statistics**
[24] ***Id.***

All these activities highlight the importance of health NGOs and associations in this part of the country, but also their repositioning on the national scale which has been reconfigured following the crisis. Far from being mere cog in the system, or organisations that are constrained by the departure of international humanitarian workers, they continue to provide considerable help for the populations. It is therefore understandable that they have a particular relationship with the State sector.

The relationship between humanitarian and public health sectors, symptomatic of the strategic positioning of NGOs in the general health system

This relationship is generally one of strong mutual assistance in the field. The expertise acquired by the humanitarian workers makes them an essential link in the health system which is under reconstruction in the region. Currently, all of the State health structures include community actors who participate, at various levels, in the medical care of the populations. At the general hospital in Boundiali, the general medicine, pediatric, and dermatology services include community agents who collaborate with medical personnel in the context of care for HIV-positive patients and cases of malnutrition. We met one of them, whose volunteering began during the crisis. After more than a decade spent in the hospital, he is now recognised as the reference for voluntary screenings and screenings at the care provider's initiative. His testimony reveals his position in this structure.

"I'm in charge of everything that has to do with screenings, reports and advice," he says. "When a patient comes in for a screening, he asks in general medicine, and they tell him you have to see Diallo, he's in charge of screenings. Now, alongside that, each patient who comes for a consultation is offered a screening, and if they accept, they are told to go and see so and so. Now in hospitalisation we also do visits. Every morning I go through the wards, I suggest screenings to those who are hospitalised as well. Whoever agrees is screened right there in their bed"[25]

In 2009, with a few friends, he started the NGO *Save Life* to formalise their intervention in the health sector under the banner of civil society.

With the exception of the *Don ORIONE* centre, all of the NGOs are engaged in a process of collaboration with the public sector. The reconstruction of infrastructures and the redeployment of health personnel have certainly reduced the influence of NGOs in urban areas on the one hand, but on the other hand, they have provided them with a platform that enables them to work effectively. These humanitarian aid operators, whose projects are financed by international sponsors, use the facilities of public establishments to reach a significant number of targets. Moreover, this collaboration allows NGOs to have access to public health personnel who help them in their facilities as independent contractors. Indeed, since they are unable to occupy public buildings due to the progressive restoration of the public system, NGOs have

[25] **Interview with Mamadou DIALLO, on 26/02/2018 in Boundiali**

set up headquarters whose commodities are favourable to the sustainability of their medical activities. Regional health authorities therefore temporarily assign them doctors, nurses and midwives to enable them to continue their work with the same efficiency. It can be said that the presence of the State provides support in terms of logistics and expertise for the associations.

In the same way, community agents in hospitals and health centres supplement the limited personnel and provide a better follow-up of patients in the communities. In some areas such as nutrition, it is the NGOs that train State health personnel who are assigned to this task in the field.

At the Regional Health Department, the valuable help of NGOs is recognised, even though it is relativised, so as not to give the impression that the good functioning of the system in inherent to their intervention. To the question of whether the public health sector may suffer if NGOs were to discontinue their activities, the response of the Regional Health Department, advanced prudently and with some embarrassment, clearly illustrates the strategic positioning of civil society in this domain under reconstruction.

“One might say in one sense yes, because the support they provide is really invaluable. Because they are able to go into the remotest areas to spread the message to the population. And also they are the ones in the community. So by this fact, they are very much listened to. They have that possibility. But also no, because at the level of the health system we also have relays that we call community health agents who are also present in the population, but there are also not enough of them to be able to carry out all of these community activities with the populations”.

This testimony clearly shows the decisive role of these NGOs in the face of the failure of the community health policy in Côte d’Ivoire. For NGOs, there is a consensus regarding the interdependence which has been built up over years of collaboration. For them, it would be pretentious to declare that in the current state of affairs, one sector can function completely independently. Nevertheless, this collaboration, which resembles an interdependence, does create difficulties, both in the field and at the level of ministerial regulation.

The difficulties of collaboration at the local level

In the field, associations are regularly accused of overstepping their boundaries in the implementation of projects. This situation creates disagreements which do not facilitate the good coordination of the sum of activities. The Regional Health Department denounces the inconsistency of certain associations who interrupt their activities, from one day to the next, due to lack of funding, without having given warning beforehand in order for measures to be taken. Indeed, certain associations who are unable to meet their agents’ *per diem* do decide to suspend their activities until they receive more funding for a new project. For the officials at the Regional Health Department, this situation leads to great dysfunction in the collaboration and planning of common activities.

It is clear that since the departure of the international humanitarian organisations, NGOs that existed only as subcontractors for projects have experienced great difficulties which threaten their survival. Our interviews with certains heads of struggling NGOs and direct observation have been particularly edifying. Certain structures only exist in name, since they are preoccupied with finding ways to avoid bankruptcy.

The NGOs, for their part, place the blame on the actors of the public system, who, according to them, consider them opportunists and fifth wheels. They do not feel that they get given enough credit for the work they do. For some heads of NGOs, civil society appears in the national collective imaginary and that of the health personnel as an profit-seeking enterprise. According to them, the disregard for humanitarian work has resulted in the treatment of some of their volunteers in certain health structures, where they are seen as subaltern workers. They therefore feel frustration with regard to certain behaviours which tend to trivialise their actions, when in fact these actions are in fact essential for a quality health system.

All of these difficulties shed light on the question of the coordination of activities by ministerial regulation, and the institutional framework for collaboration. Indeed, the problems raised by the actors in the field stem from the system in general, which has difficulty in integrating everyone’s aspirations in order to develop a clear focus for activities which would be accepted by all actors, and the follow-up of which would enable each party to comply with its instructions.

A collaboration with ministerial regulation on the basis of mutual misunderstanding

To facilitate collaboration and better manage humanitarian health activities, the ministry in charge of this domain proceeded to create a cooperation framework. Indeed, the surge of international NGOs and the emergence of national NGOs led to a kind of cacophony in the field. Each structure developed programmes and implemented them according to their own priorities and their sponsors’ demands. For this reason, coordination problems for the sum of all the activities according to need raised issues for both the State and the aid recipients. To prevent the humanitarian market generated by the war from descending into chaos, the Ministry of Health decided to develop a framework for the management and follow-up of participants in the health sector. Hence, in June 2012, the NGO Service was created by Ministerial decree N°154 /MSLS / CAB of June 15th 2012. The creation of this service was in response to five goals:

-Guaranteeing the respect of partnership policies and procedures between the Ministry of Health and civil society

-Ensuring that the service provision carried out by NGOs was in line with the activities of the Ministry

-Ensuring that NGO initiatives were made in close collaboration with the health districts throughout the country in the framework of the Ministry’s matrix of priority actions

-Ensuring that the missions included in the Memorandums of Understanding or in contracts with the Ministry were respected

-Ensuring the coordination, follow-up and evaluation of NGOs and community associations.

In order to reach these goals, NGOs have to be recognised by the Ministry of Health. This recognition involves a procedure which they must submit to. Indeed, any NGO having completed the procedure enters into the contractual framework of the Ministry which enables it to benefit from the advantages linked to this status, including exemption from custom tax and grants from the Ministry.

Yet it must be noted that a number of the associations we met were operating outside of this contractual framework. Indeed, as mentioned above, having been created by international organisations in order to carry out their projects, local NGOs continued to benefit from projects funded by their sponsors without necessarily fulfilling all of the Ministry’s conditions. As long as they were carrying out international NGO projects in the field that were recognised by the Ministry, they did not seem to mind about their legal status. But the dearth of fully-funded projects and the demands of sponsors wishing to collaborate with recognised associations led them to improvise in ways that shed light on the communication breakdown in this collaboration.

According to the associations, the procedure to obtain approval is long and extremely complex. The director of a very active NGO in Korhogo showed us the receipt for his request for approval dated May 17th 2017, which had not been followed up to this day. Like the others, he lamented the arduous and lengthy administrative process for the treatment of requests, which discouraged applicants from seeking approval from the Ministry of Health. For the associations, these are intentional stumbling blocks intended to deny them State grants. These statements, which do not correspond to reality, reveal a number of situations.

The first situation is a result of the severance of local NGOs from the financing international NGOs. The latter’s withdrawal and the dwindling of funds dedicated to humanitarian activities in the region led to upheavals in the sector. The less solid associations disappeared from the NGO health platform and others, although still active, are under lots of pressure. According to an official from the Ministry of Health, “NGOs are waiting for projects. They don’t come up with projects to submit to the sponsors”. In these conditions, a ministerial grant would be a life-line in lean times.

The second situation is the misunderstanding of the procedures to obtain approval. This procedure is indeed relatively long, but a number of associations ignore it, though it remains available on the website of the NGO Service. Indeed, after obtaining a receipt from the Ministry of the Interior, NGOs must proceed to request a Certificate of Recognition from the Ministry of Health.

"This document is the first link in the chain of the contract between non-State actors, basically not-for-profit actors (NGOs and associations) and the Ministry of Health and the Fight against AIDS (MSLS). Obtaining it enables the NGO to be registered in the NGO file and to begin its activities in the health sector. To get this document, the NGO's activities must essentially cover the health field. The NGO statuses must guarantee:

- The coherence of the aims and means of the NGO
- The existence of rules for democratic functioning
- Disinterested financial management (namely clarifying the duplication of functions of volunteers and employees) [26].

Only after fulfilling these conditions can NGOs hope to obtain approval. But the request for approval is not effective or obtained as soon as they are recognised by the Ministry.

"The document is granted after three (3) years of existence and is valid for five (5) years. After five (5) years of existence, the NGO must renew it. This renewal is not systematic and NGOs may be refused the document. The authorities have six (6) months to notify NGOs of its refusal or acceptance. It is also permitted for NGOs to bid for MSLS grants. To obtain approval, NGOs will be led to streamline their actions, in order to fit them into MSLS programmes. These grouped actions in the following fields may enable them to join a ministerial programme"[27].

The main criteria allowing for the granting of approval are, amongst others, the promotion of the rights of sick people and health system users, prevention, aid, support, training, information, participation in the development of public health policies and the representation of health system users in hospitals or public health establishments. The document delivered in collaboration with the legal service completes the conditions for grant requests.

Moreover, consisting of 150.000.000 FCFA (roughly 203.000 euros) for all the NGOs operating throughout the country, the grant, which incidentally is paltry given the costs of an NGO, is not a recognised right of the association. For this reason, it is not allocated automatically. For the Ministry, it is a fragile, but not immediate means of conditional funding. The ignorance of all of these aspects is the result of misunderstanding.

The third situation revealed is the absence of intervention on behalf of the Regional Departments in the facilitation of the procedure to obtain approval. Whilst Regional Departments collaborate locally with associations, they are nevertheless excluded from the process of recognising them by the Ministry, of which they are the decentralised representatives. NGOs struggle to understand this paradox, whereas the Regional Departments prefer not to voice their opinion on the matter.

[26] **Ministry of Health, NGO Service, *Guide des ONG : la clé*, p. 20 [online] www.serviceongsante.ci**
[27] ***Id.***

All of these situations indicate a deficit of information, the adverse effects of the long dependence on international NGOs, and a remarkably negligible national contribution to the functioning of local NGOs. These non-exhaustive difficulties are obstacles to the dynamic of collaboration between associations and the public sector on the one hand, and on the other hand, within the associations themselves, since they cannot participate in certain calls for tender without approval from the Ministry of Health. Notwithstanding all of these difficulties, NGOs pursue their activities in the field by constantly reinforcing and rethinking their repositioning strategies.

Conclusion

This study enables us to grasp the changes that have taken place in the humanitarian field in Côte d’Ivoire since the emergency period. Indeed, the process of national reconstruction and the good health of the Ivorian economy since the crisis have led the government to opt for a humanitarian transition which implied the retreat of international NGOs from the theatre of operations. Their departure led to changes in the humanitarian sector. Because the crisis situation and the mass intervention of INGOs had led to the emergence of local actors who benefited from their support, these local actors had to develop resilience strategies to avoid bankruptcy on the one hand, and on the other hand, to continue to deliver humanitarian services whilst adapting to the new environment. This study of the case of health in the north of Côte d’Ivoire illustrates the repositioning strategies of NGOs, and especially local NGOs, in the new project of humanitarian transition.

Indeed, the study shows that the experience acquired with the international organisations which led to their emergence and/or boosted their action during the decade of crisis, and the weaknesses inherent in the reconstruction of the public health system, have made associations indispensable actors in the region. They continue with their activities independently, occupying the health sectors where government action is weak or nonexistent. These parallel interventions enable them to benefit from the confidence of sponsors and to innovate in the development of strategies in order to acquire projects. Moreover, they collaborate with the public system by occupying an important place in the health system in the region. Their activities in nearly all of the hospitals and amongst communities make them both stopgaps for the shortcomings of the public system, and substitutes in areas where public action is lagging behind. This is why, far from having been reduced to mere cogs in the system, the reconstruction has reinforced their efficiency by bringing about a collaboration resembling interdependence.

Nevertheless, those associations that had not considered resilience and repositioning strategies in the face of the departure of international humanitarian organisations succumbed to the withdrawal of the international funding on which they depended. In the absence of turnkey projects to subcontract, they were forced to give up or suspend their activities in the

hope of a hypothetical opportunity. The humanitarian transition, initiated by the State which was anxious to promote the image of a country in which external humanitarian assistance was a distant memory, proved fatal for local structures whose existence was linked to this external assistance. The NGOs that acclimatised to these changes were those whose existence predated the crisis, or recent ones whose promoters had significant experience in the humanitarian field. Their background enabled them to survive the changes and to impose themselves in the region. They therefore became references in a number of health domains.

The aforementioned difficulties, which led to the failure of local structures that had been remarkably active under the direction of the INGOs, seem to be less a result of the absence of an approach focused on local partnerships, as was the case in the first hours after the departure of the INGOs (D. Adou, 2016), and more because of the structural weaknesses of these partnerships. Collaboration platforms between NGOs on the one hand, and on the other hand, between NGOs and State structures, exist with a view to guaranteeing credibility and managing the action of civil society. But these partnerships struggle to resolve the equation of a partially implemented humanitarian transition. The question of the management of post-emergency humanitarian situations (J-F Matteï, 2005) remains pressing in this context where the State’s expressed good intentions remain no more than lip service. Certainly, the repositioning strategies of civil society in the northern part of the country and the collaboration model with the public health system illustrate the existence of conditions favourable for humanitarian transition. But this will require joint efforts and more significant State investment since the departure of international actors did not automatically lead to a humanitarian transition which, it must be said, cannot be reduced to the passage between emergency aid and development policy, to the relay of savoir-faire, international funding and operational practice (F. Akindes & V. Troit, 2017).

This study therefore provides an angle on the state of affairs of humanitarian transition in Côte d’Ivoire. The narrative surrounding the State’s newfound capacities and grand projects, set to lead to emergence by 2020, necessarily implied the retreat of international humanitarian organisations whose presence was a conspicuous contradiction of the official narrative. For this reason, humanitarian transition aligned itself to State capacities, together with the will to avoid humanitarian dependence (D. Adou, op. cit.). The Emergency Presidential Programme (PPU), considered by OCHO as the battleaxe of this transition in Côte d’Ivoire, has produced good results, especially with regards to infrastructure rehabilitation, but the analysis of the current situation of civil society and of governmental actors reveal problems with their capacity to respond to emergency situations. Though it has had good results and positioned itself as an essential link in the system, the State’s lack of support for civil society, civil society’s dependence on international sponsors, its incapacity to mobilise national resources, the difficulties in collaborating and the institutionalisation of the transition are real obstacles to a successful transition. Côte d’Ivoire is focusing on its strengths for a successful transition, but what is needed above all is a redefinition of the tasks ahead, a pooling of efforts and a strong civil society whose collaboration with the State would enable the growth of national capacities to respond to emergency situations.

Bibliography

ADOU Djané, F., (2016), « Transition humanitaire en Côte d'Ivoire : Idéologies et pratiques des acteurs à l'épreuve de la demande locale », French Red Cross Fund, *Les Papiers du Fonds*, n°3, 17 p.

AKA, K. A., (2010) : « L'accessibilité des populations rurales aux soins de santé dans le département d'Abengourou (Côte-d'Ivoire) », *Les cahiers d'Outre-Mer*, n°251, p. 439-460

AKINDES, F. ; TROIT, V., (2017), « La transition humanitaire en Côte d'Ivoire, éléments de cadrage», in FOUQUET, T. et TROIT, V., Ed., *Transition Humanitaire en Côte d'Ivoire*, Paris : Karthala, p. 9-24,

ATLANI-DUAULT, L., (2003), « Les ONG locales, vecteurs de « bonne gouvernance » dans le Second Monde ? », *Journal des anthropologues*, 94-95, p. 183-190.

BA, G. S. ; POULET K. ; INIS N. A. (2017), « Appréhender les ONG comme espace de gouvernance : de l'ethnographie des pratiques à celle des contraintes à l'autonomie », French Red Cross Fund, *Les Papiers du Fonds*, n° 12, Février 2017, 22 p.

BINATE, I., (2018), « Les ONG islamiques en Côte d'Ivoire en période conflit : acteurs et enjeux », *Repères*, Scientific review of the Université Alassane Ouattara, vol. 1, n°1, p. 193 – 230

BOINET, A., and MIRIBEL, B., (2010), « Analyses et propositions sur l'action humanitaire dans les situations de crise et post crise », Report for M. Bernard Kouchner, Minister of Foreign and European Affairs, 82 p.

BNETD, Emergency Presidential Programme, (2013) *Projet d'appui à la carte sanitaire primaire*, Final report, 202 p.

BUFFET C., (2014), « De l'urgence à la résilience : changements de cadrage », *Humanitaire*, n°38, p. 70-77

CARBONNIER, G., (2004), Privatisations, sous-traitances et partenariats public-privé: charity.com ou business.org? *Revue Internationale de la Croix-Rouge*, 86(856), p. 725-743.

CHOUMOFF, A., (2011), *L'action humanitaire, une industrie comme les autres ?* Masters in Creation and Contemporary Technology, ENSCI, 77 pages

CORBET, A. ; AMBROSETTI, D. ; BAYLE G. ; LABAZE M., (2017) « Agents de l'État et acteurs humanitaires : enjeux d'une interdépendance négociée. Étude de cas à Gambella », Fonds Croix-Rouge française, *Les Papiers du Fonds*, n° 8, February 2017, 26 p.

DAHOU, T., (2003), « Clientélisme et ONG », *Journal des anthropologues*, 94-95, p. 145-163.

DORIER-APPRILL, E. ; MEYNET, C., (2005), « Les ONG : acteurs d'une « gestion disputée » des services de base dans les villes africaines ? », *Autrepart*, n° 3, p. 19-38.

ELBERS, W. ; ARTS, B., (2011), « Comment joindre les deux bouts : les réponses stratégiques des ONG du Sud aux conditions imposées par les bailleurs de fonds », *Revue Internationale des Sciences Administratives*, n° 4, vol. 77, p. 743-764.

Floridi, M. and Verdeccha, S., (2010), *Étude de faisabilité du programme d'appui à la société civile en Côte d'Ivoire*. Mapping report, July 2010. European Union, ECO3, 165 pages [En ligne] www.eeas.europa.eu/delegations/cote.../annexes_mapping_tome2_fr.pdf

FOUQUET, T. and TROIT, V., éd., (2017), *Transition Humanitaire en Côte d'Ivoire*. Paris : Karthala, 355 p

FICK, U., S/D., (1993), *La perception quotidienne de la santé et de la maladie : théories subjectives et représentations sociales*. Paris : L'Harmattan, 399 p

GHIGLIONE, R. and MATALON B., (1998), *Les Enquêtes sociologiques. Théories et pratique*. Paris : Armand Colin, 301 p.

GUIBERT, J. and JUMEL, G., (2002à, *La sociohistoire*. Paris : Armand Colin, 184 p

HOURS, B., Ed., (2003), *Systèmes et Politiques de santé : De la santé publique à l'anthropologie*. Paris : Karthala (Collection : Médecines du Monde), 354 p.

MATTEI, J-F., (2005), « L'urgence humanitaire et après? Opinion », *littérature, Économie et humanisme*, n° 375, Paris, éditions Hachette, pp 84-87

MATTEI, J-F., & TROIT, V., (2016) « La transition humanitaire », *médecine/sciences* 32, n°2, p. 211 – 215

(2014), *L'humanitaire à l'épreuve de l'éthique*. Paris : Les Liens qui Libèrent, 180 p

MINISTRY OF HEALTH, (2014), *Évaluation de la gouvernance du secteur santé en Côte d'Ivoire*, Evaluation report, April 2014, 77 p.

MINISTRY OF HEALTH, NGO Service**,** *Guide des ONG : la clé*, 47 p [online] www.serviceongsante.ci

OCHA (2013), *Côte d'Ivoire 2013, besoins humanitaires en phase de transition* [online], http://reliefweb.int/sites/reliefweb.int/files/resources/CIV, consulted on November 30th 2014

(2012), « Côte d'Ivoire, rapport humanitaire mensuel, février-mars 2012 », coordination savelives, n°2, 9 P.

REVEL, J., Dir., (1996), *Jeux d'échelles. La micro-analyse à l'expérience*. Paris : Gallimard/Seuil, 256 p.

UNICEF, «Vulnérabilités, Violences et Violations graves des droits de l'enfant» [electronic version], p.6 www.unicef.org/french/.../Rapport_UNICEF_SC_Violations_Nov2011_FINAL.pdf,

USAID, (2008), *Côte d'Ivoire : évaluation des prestations de services*, Rapport d'étude, mars 2008, 58 p.

ZRAN, T. A., (2016), «L'impact des mesures de redressement économique sur le secteur de santé en Côte d'Ivoire de 1980 à 1995 », in OUATTARA T., Dir., *Contribution aux débats sur les enjeux du monde contemporain : héritage colonial et santé*. Paris, EDILIVRES, P. 273 – 314

(2014), *L'histoire du VIH/sida en Afrique subsaharienne : le cas de la Côte d'Ivoire de 1985 à aujourd'hui*, unique doctoral thesis in Contemporary History, Université Félix Houphouët-Boigny, Abidjan- Cocody, 674 p.