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Care and social reintegration of young people living with hiv/aids admitted to the care, research and training centre (cepref) in yopougon

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ABSTRACT : The general objective of this study is to describe the social logics linked to the stigmatisation of young people living with HIV/AIDS admitted to the CePReF in Yopougon. The survey tools used were documentary research, semi-structured interviews and observation. This enabled us to arrive at the following results: Firstly, the study showed that the incurability of HIV is a determining factor in the stigmatisation of PLHIV. Because they seem to be doomed to certain death. The incurability of HIV is the basis for the construction of a discriminatory relationship towards HIV-infected people. Secondly, the mode of transmission of HIV remains a key factor in the stigmatisation of PLHIV. Even though it is possible to be infected with HIV through the use of sharp objects, during a blood transfusion, from mother to child, the sexual route remains the most likely. Thus being infected with HIV is most often attributed by the population to a life of sexual depravity.

***KEY WORDS**: Care, social reintegration, youth, vulnerability, stigma, HIV/AIDS.*

I. INTRODUCTION

As reaffirmed by UNAIDS in its 2008 global report on the epidemic, HIV remains a global health problem of unprecedented scope. Unknown 30 years ago, HIV has already caused some 25 million deaths worldwide and has led to profound demographic changes in the most heavily affected countries. (UNAIDS, 2008) Sub-Saharan Africa remains the region most heavily affected by HIV, with 67% of all people living with HIV and 75% of AIDS deaths in 2007. (Idem) West Africa is relatively less affected, with prevalence rates below 2% in some countries. Nevertheless, Côte d'Ivoire is among the 15 most affected countries in the world. The number of deaths due to HIV/AIDS in Côte d'Ivoire is around 22,000, which corresponds to a mortality rate of about 110 per 100,000 inhabitants. (UNAIDS, 2014).

Projections using the EPP Spectrum software show a decreasing trend for the next 4-5 years after 2014 so that the estimate of HIV mortality is about 20 per 100,000 population from 2020. Approximately 430,000 people are living with the human immunodeficiency virus (HIV), or 2.4% of the population aged 15-49 years (UNAIDS, 2019). According to the Ministry of Public Service, Employment and Administrative Reform and the Ministry of AIDS Control (2006), the HIV/AIDS epidemic poses a threat to fundamental rights at work, particularly with the discrimination and stigmatisation faced by workers and people living with or affected by HIV/AIDS Care for infected workers is not systematic in the majority of companies. This care is not comprehensive and sometimes does not include spouses and families. Only 0.34% of companies have medical and psychosocial care.

In addition, the final report of the national study on the stigma and discrimination index for people living with HIV in Côte d'Ivoire, carried out under the supervision of the Réseau Ivoirien des Personnes Vivant avec le VIH (RIP+), Alliance CI, the Global Fund, the NACP, UNAIDS, the CDC PEPFAR and the Ministry of Health and Public Hygiene, highlights a finding. Indeed, 5.2% of PLHIV are victims of exclusion from social activities or events, 3.5% of which are due to their HIV status alone or in combination with other reasons. 1.8% of PLWHA were excluded from religious activities or places of worship, of which 1.6% were excluded because of their HIV status alone or in combination with other reasons. 6.3% of PLWHA were excluded from family activities, of which 5.2% were excluded because of their HIV status alone or in combination with other reasons. 17.0% of PLWHA were victims of gossip, 12.3% of which was due to their HIV status alone or in combination with other reasons. 11.8% of PLWHA were insulted, reviled, harassed or threatened, 8.0% of which were due to their HIV status alone or in combination with other reasons. 7.1% of PLWHA were victims of physical harassment, 4.4% of which were due to their HIV status alone or in combination with other reasons. 5.8% of PLWHA were subjected to psychological pressure from their husband/wife or partner. 6.5% of PLHIV experienced sexual rejection. 3.5% of PLHIV experienced discrimination from other PLHIV. 7.5% of PLHIV have had a family member discriminated against because of their HIV status. 56.3% of PLHIV have never received support. The main aggressors of PLHIV are their household members 64.4%. (CESI, 2016).

Through these figures, we notice a stigmatisation of PLHIV at all levels of Ivorian society. This stigmatisation is not without risk for HIV-positive people. We can group these risks into three categories, namely perceived risks, social risks and real risks.

Perceived risks are conceived in the discourse of PLHIV through more or less serious unfortunate situations to which the infection is likely to lead and which expose to damage. They are also perceived as possible negative consequences of the infection. For PLHIV, since AIDS is a fatal, transmissible and stigmatising disease, the risks to which it exposes them are health, economic and social. Health risks are those that lead to the destruction of the immune system and physical damage. Economic risks are those that involve the possibility of reduced productivity, cessation of work, reduced income, inability to meet health care costs, inability to make plans and reallocation of resources (Vertigo, 2006).

The social risks, on the other hand, are of the order of shame, dishonour, repudiation, divorce and the breaking of social ties. We are interested here in these last types of risk because, over and above the diversity of risks, those linked to social risks seem to be those to which PLWHA feel most exposed and also those they most fervently wish to avoid. To do this, they adopt two strategies: either to remain completely silent about their serological status, or to reveal it only to a few carefully chosen people in the family circle, according to numerous and complex criteria specific to each PLWHA (proximity of the confidant, confidence in him, degree of education and information on AIDS, ability to provide financial assistance) (Opcit).

More than an imaginary threat, the risk of sharing information about HIV status is real. Indeed, according to a study carried out among women who informed their entourage, 53% experienced a break in social ties. The analysis of the breakdowns shows that socio-economic factors are less of a determining factor in the acceptance or rejection of these women. The breakdowns are more attributed to sociological factors, which the analysis of the life stories makes it possible to highlight (Opcit). In the context of this study, the emphasis is on the real risks to which young HIV-positive people admitted to the CePReF in Yopougon are most exposed.

In line with its public policy of taking charge of and de-dramatising HIV/AIDS, the State of Côte d'Ivoire has approved several structures, both national and international, to carry out actions on the territory in favour of people infected by this pathology. Among these is CePReF. Located within the Maternal and Infant Protection (PMI) unit, now the General Hospital of Yopougon, CePReF was created by the non-governmental organisation Aconda-VS, an organisation partly financed by the French government. The organisation of care at CePReF is based on a family-centred, comprehensive and multidisciplinary approach. It has five components. Firstly, the preventive component, which consists of counselling and HIV testing. Then there is the clinical component, which includes diagnosis and treatment of opportunistic infections, initiation and monitoring of antiretroviral (ARV) treatment based on national programme procedures, and follow-up in day hospital for patients requiring observation. There is also a psychological, social and community component, which involves psychological care, home visits to improve compliance with treatment (in partnership with NGOs), setting up and running discussion groups for self-management of stigmatisation by PWIH, and nutritional and material support.

In addition, there is the research component devoted to monitoring and evaluation and finally the training component concerning the training of actors involved in the fight against HIV (B. N'Guessan, 2008).

In 2004, CePReF received 5,311 patients, including 2,239 women and 468 children. Between ARV treatment, consultations and medication for opportunistic diseases, treatment costs the patient 6,000 CFA francs (about 10 euros) per month, and CePReF does not charge for certain examinations. (The New Humanitarian, 2005) Furthermore, the results of an analysis of the determinants of adherence to antiretroviral treatment carried out among 300 HIV-positive people aged at least 15 years and followed up at the CePReF in Yopougon conclude that 10.9% of these people are victims of stigmatisation and discrimination (B. N'Guessan, 2008).

Finally, during our exploratory surveys at the CePReF in April 2021, we were able to observe that some young people living with HIV/AIDS are abandoned by their fathers, who are obliged to look after their single mothers, who have also been diagnosed as HIV-positive. It is therefore important to note that despite public policies to raise awareness and reduce the stigma of HIV/AIDS, young people living with this infection admitted to the CePReF in Yopougon are stigmatised through the breakdown of social ties and their exclusion from family activities or social events.

In view of the above, we are led to ask ourselves the following questions: Why are young people living with HIV/AIDS in the care of the Yopougon CePReF subject to stigmatisation despite public policies to raise awareness and reduce the stigma associated with this disease? Do the social characteristics of young people living with HIV/AIDS admitted to the Yopougon CePReF explain their stigmatisation? Is the treatment process not a factor legitimising the stigmatisation of young people living with HIV/AIDS admitted to the Yopougon CePReF?

Doesn't the perception of the HIV/AIDS disease by the population explain the stigmatisation of young people living with this infection admitted to the Yopougon CePReF? Does disclosure of HIV status influence the social reintegration of young people living with HIV/AIDS admitted to the Yopougon CePReF? The care and social reintegration of young people living with HIV/AIDS therefore appears to be a challenge for Ivorian society. To conduct a scientific study on the subject requires a preliminary epistemology; that of seeing how researchers have approached the study of the care and socialisation of PLWHA up to now. This will help guide our concern in one direction.

1-Theoretical and methodological approach

Based on Malinowski's functionalism, any society should not be analysed on the basis of its history but on its functioning. The practices that seem the most insignificant therefore have a function. And this function corresponds to a human need: "For the functionalist, culture, i.e. the whole body of instruments, the privileges of its social groups, the ideas, beliefs and human customs, constitute a vast apparatus putting man in a better position to face the particular concrete problems that arise in his adaptation to his environment in order to give course to the satisfaction of his needs. Malinowski's functionalism thus assumes that the function of any practice is to meet the needs of individuals. At the same time, however, it is always the whole of society, and not its separate elements, that meets individual needs. Thus, the care and reintegration of young people living with HIV/AIDS must be the actions of the whole of society.

From a methodological point of view, the study took place in the commune of Yopougon, which is one of the ten communes of the autonomous district of Abidjan, the economic capital of Côte d'Ivoire in West Africa. This commune is located to the north of the city of Abidjan. Its geographical coordinates are: 5° 20' 56" north, 4° 00' 42" west. And SICOGI is a district of this commune bounded to the north by the Port-Bouet II district, to the south by SIDECI, to the east by the New District and to the Niangon district.

The choice of this geographical area is explained by the fact that this district has an internationally renowned centre for the care of PLWHA, where the other care centres at national level refer cases of HIV that cannot be treated with conventional methods. This geographical space is the framework for interaction between PLHIV, health specialists and the population. In this centre, it is easier to meet PLHIV who come for their medical appointments. CePReF is located in an urban environment, a social setting where stigma is increasingly prevalent. Thus, stigma generally emerges in a globalised environment, with increasing mobility and areas of very high human concentration.

Source: BNETD, 2012

Réalisation: N'KA Mathias, 2017

Map 1: ***geographical location of Yopougon SICOGI***

Thus, the study concerned three (03) categories of actors who constitute our target population: The expert population[1] ; local actors concerned by the phenomenon[2] ; the control population[3].

The study took place from 16 July 2021 to 15 July 2022. The survey techniques used were direct observation and semi-structured interviews. In order to understand the social logics related to the stigmatisation of young people living with HIV/AIDS, we adopted content analysis. According to (Luc Van Campenhoudt, Jacques Marquet and Raymond Quivy, 2017), content analysis allows us, when dealing with rich and penetrating material, to harmoniously satisfy the requirements of methodological rigour and inventive depth, which is not always reconcilable. This has enabled us to arrive at the following results.

II. RESULTS

In the scientific field, several studies are related to the care and social reintegration of young people living with HIV/AIDS, but in sociology we approach this logic in terms of social representation.

In the context of this work, the emphasis was placed on the relationship between the disclosure of the serological status of young people living with HIV/AIDS and the population's perception of this pathology. The results of this study can be broken down into three main areas:

Firstly, the identification of the process of caring for young people living with HIV/AIDS admitted to the CePReF of Yopougon;

Secondly, the description of the impact of the perception of HIV/AIDS by the population on the stigmatisation of young people living with this pathology admitted to the CePReF of Yopougon; and finally, the explanation of the influence of the disclosure of the serological status on the social reintegration of young people living with HIV/AIDS admitted to the CePReF of Yopougon.

2-1-Social patterns related to the stigmatization of young people living with hiv/aids admitted to the Cepref of Yopougon

2-1-1-Identification of the social characteristics of young people living with HIV/AIDS admitted to the Yopougon CePReF: Social characteristics of respondents

Age	15 years	16 years	17 years	18 years	19 years	21 years	22 years	24 years
	3	2	3	2	3	1	1	1
Gender	Woman				Male			
	6				10			
Level of education	Primary		College		High School		Superior	
	2		4		8		2	
Professional category	Footballer		Student		Student	Trader		Unemployed
	1		11		2	1		1
Religion	Christian			Muslim			Buddhist	
	8			7			1	
Type of family	Orphan			Single parent		two-parent	Polygamist	
	1			7		6	2	
Mode of contamination	At birth							
	16							
Marital status	Single				As a couple			
	15				1			
Number of people who know about the SS(*)	01 person		02 persons		03 persons		04 persons and more	
	6		6		1		3	

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[1] The General Coordinator of the CePReF, for information on the structure and functioning of his institution; The Chief Medical Officer, to describe the process of caring for young people living with HIV/AIDS admitted to the CePReF of Yopougon; The CePReF nurses, to describe their roles in the care of young people living with HIV/AIDS admitted to the Yopougon CePReF; The CePReF social service agents, to describe their roles in the care of young people living with HIV/AIDS admitted to the Yopougon CePReF.

[2] These actors are essentially young people living with HIV/AIDS admitted to the CePReF. The information collected from them makes it possible to describe how they perceive their care at the CePReF in Yopougon, their relations with their families and with the rest of the population.

[3] The control population was composed as follows

- The parents of young people living with HIV/AIDS admitted to the CePReF in order to identify the impact of their perception of the HIV/AIDS disease on the stigmatisation of young people living with this pathology treated at the CePReF of Yopougon;
- The population in relation to young people living with HIV/AIDS admitted to the CePReF to explain the influence of disclosure of HIV status on the social reintegration of these young people.

2-2-Analysis of the social characteristics of the respondents

The social characteristics of young people living with HIV/AIDS admitted to the CePReF in Yopougon are discernible through several variables. In this study, we focused on the following variables: age, sex, level of education, professional category, religion, family type, mode of infection, marital status and the number of people who know the respondent's serological status apart from the medical staff.

Among the individuals interviewed, two individuals were 24 years old. And, three individuals are between 15 and 19 years of age. This statement by a specialist illustrates the choice of some of the variables mentioned above:

> *"Generally speaking, when they are not yet 25 years old, we manage to follow them correctly. But as soon as we send them to the adults, they disappear and it is when they feel really ill that they reappear". (J.H, CePReF, 12 January 2022 at 10am).*

This refers to the normative dimension, i.e. the rules and standards that structure and guide the care and social reintegration of young people living with HIV/AIDS. In fact, HIV care is provided in two departments at CePReF, namely the children's department, which looks after people aged 0 to 21, and the adult department, which looks after people aged over 21.

With regard to the gender variable, we interviewed 16 individuals, 6 women out of a total of 16 individuals, i.e. 37.5% of our respondents living with HIV are women and 10 men out of a total of 16 individuals interviewed, i.e. 62.5% are men. This could be explained by the availability of respondents during our study and by the ability of women to ensure the confidentiality of their positive serological status compared to men.

The level of education of the individuals interviewed was secondary (high school). This level of education enables them to have the necessary knowledge to follow their medical care correctly and to protect themselves against a new infection. In the professional category, there is a high frequency of students versus employed and unemployed individuals. These data illustrate that beyond the difficulties that their stigmatisation and discrimination could cause, they generally manage to integrate into the social fabric.

The practice of the Christian religion is dominant in this survey. At this stage, it is impossible for us to affirm that religion has an influence on the spread of HIV, especially since the majority of the population of Yopougon is Christian. Single parenthood characterises the family type of the respondents in this study.

This may highlight the family difficulties, the emotional deficit, the economic, psychological and nutritional problems that these young HIV-positive people may face. The words of a young HIV-positive man living with his mother illustrate this:

> *"I live with my grandmother. My father and mother died of this disease. I no longer go to school. I sell clothes at the SICOGI market to meet my needs. The people I sell to don't know that I have this disease. (K.S, CePReF, 10 January 2022 at 10am)*

This statement refers to the symbolic dimension that structures the care of young people living with HIV. Indeed, at the age of 19, this young man, who has lost both his father and mother, is excluded from the school system due to a lack of financial support and is obliged to carry out an income-generating activity in order to meet his needs. These comments also demonstrate the relational dimension that underlies the care of young people living with HIV. In the absence of their parents, close relatives or institutions specialising in the care of PLWHA, they are left to their own devices, leading to a breakdown in social relations between them and those who know their HIV status.

In fact, 15 individuals out of a total of 16 interviewed, i.e. 93.75%, are single, as opposed to one individual living with a partner, i.e. 6.25%. This can be explained by the fact that the average age of the respondents is 18, which is the legal age of majority, and by the desire of these HIV-positive individuals not to contaminate other people and by the desire of the population not to be infected by HIV.

Finally, analysis of the data collected shows that 6 individuals out of a total of 16 individuals interviewed, i.e. 37.5% of young people living with HIV admitted to CePReF, disclosed their serological status to only one person. This ratio remains the same for respondents who were able to disclose their HIV status to two people, compared with 1 out of a total of 16 individuals interviewed, or 6.25% for those who were able to inform three people of their status. This reflects the efforts of these respondents and their parents to manage the confidentiality of juvenile HIV so as not to be subject to stigmatisation and discrimination.

2-3-Identification of the care process for young people living with HIV/AIDS admitted to the CePReF in Yopougon

2-3-1 Conventional HIV care itinerary at CePReF

HIV care at the CePReF follows two thematic routes, also known as care circuits. These circuits are based on the two departments of the centre. There is an adult circuit called the "Adult CePReF" reserved for people over 21 years of age and the child circuit also called the "Child CePReF" for people aged 0 to 21 years. It is this second circuit that essentially deals with the medical care of young people living with HIV admitted to the CePReF. This is illustrated by the extract from an interview with an HIV care specialist at the CePReF:

> *"... medical care for young people living with HIV follows a pre-established circuit. The circuit begins with the registration of the patient at the reception desk. They are then taken to the archive department where a personalised file is kept for them. He then goes to the CePReF's "children's infirmary" for blood samples which are used for an initial health check-up to confirm the patient's positive serological status. He is then taken to the doctor for a consultation. Depending on the results of the doctor's consultation, the patient is either taken to the CePReF's pharmacy to buy and take his or her medication, or taken back to the infirmary for nursing care. Because young people living with HIV can also suffer from other pathologies such as malaria, typhoid fever, etc.". (J.H, CePReF, 12 January 2022 at 10am)*

In the same vein, another specialist in HIV care at the CePReF in Yopougon testifies:

> *"...After six (06) months of treatment, a follow-up assessment including a viral load test is carried out, if this viral load is still detectable, the patient is taken to our therapeutic education service to receive advice in the form of exercises in order to remodel his or her perception of how to take his or her medication correctly, advice on how to have a good diet, a healthy lifestyle...". (K.T, CePReF, 12 January 2022 at 2pm).*

In the same vein, another respondent said:

> *"... therapeutic education takes place once a month for three (3) months for each young person living with HIV. After three (03) months of therapeutic education, a viral load test is carried out. If the viral load is undetectable, it means that the patient has followed the advice; at this point, he/she stops the therapeutic education to continue with a normal treatment. If the viral load is still detectable, the young person living with HIV continues his therapeutic education for another three (03) months...". (G.L, CePReF, 18 January 2022 at 11am).*

All these arguments refer to the normative dimension, i.e. the rules and standards that structure and guide the care and social reintegration of young people living with HIV/AIDS.

2-4- Forms of HIV care at CePReF

HIV care at the CePReF has three (03) main components, namely the medical component, the psychological component and the nutritional component. This is highlighted by the following testimony from a specialist in HIV care:

> *"... HIV care in our centre has three (03) main components, namely the medical component, the psychological component and the nutritional component. We speak of optimal care when the patient is treated in all three areas at the same time...". (J.H, CePReF, 12 January 2022 at 10am).*

This can be explained by Malinowski's theory of functionalism, which assumes that the function of any practice is to meet the needs of individuals. In fact, the practices of the community must make it possible to meet the totality of individual needs. Thus, society's refusal to take individual aspirations into account leads to discrimination against vulnerable people, including young people living with HIV/AIDS.

2-5-Leadership of conventional medicine in medical care

According to HIV care specialists, conventional medicine is still the leader in the treatment of HIV infection. The following verbatim highlights this.

> *"... Since I have been in this position here, I have never heard anyone say that they have been cured of HIV. There are some of our patients who go for treatment or see men of God outside and come and tell us that they are cured but when we test them again we find out that they are still HIV positive...". (J.H, CePReF, 12 January 2022 at 10am)*

The following comments also support this assertion:

> *"... I tell you that I have never seen a patient that we follow here be cured outside. There are many who come to tell us with certainty that they are cured by some treatment or that they have received a prophecy announcing that they are no longer ill. It is true that the health of some of them has improved but when they are tested again, they are still HIV positive...". (Z.N, CePReF, 19 January 2022 at 10am).*

These verbatims refer to the ideological dimension of the care and social reintegration of young people living with HIV/AIDS. This ideological dimension reflects the perceptions and visible representations that give leadership to conventional medicine in medical care. Thus, conventional medicine appears to be an "essential practice" for living with HIV.

2-6-Description of the impact of the perception of HIV/AIDS by the population on the stigmatisation of young people living with this disease treated at the CePReF in Yopougon: Incurability of HIV/AIDS

Conventional medicine now has a substantial therapeutic arsenal to fight the disease. These treatments have greatly improved the quality of life and life expectancy of patients, albeit at the cost of sometimes significant side effects. Unfortunately, HIV is still an incurable infection. This incurability of HIV/AIDS can change the systems of relations between PLWHA and their society. The testimony of one of our surveys illustrates this.

> *"I have a sister who had AIDS. But we all know that AIDS is not curable. Everyone ran away from her. One day when she wanted to get closer to people to take part in an activity, someone said to her: 'Where are you going? For you it's already over". This hurt her until she died of grief, even though she was taking her medication properly...". (K.F, Yopougon, 17 March 2022 at 5pm)*

This testimony reflects the relational dimension, which concerns the different types of relationship that structure and guide the use of stigma by young people living with HIV/AIDS. The indicators of this dimension are: gossip, insults, harassment, threats, abandonment, rejection.

2-6-HIV/AIDS as a disease of supernatural origin

According to some people, supernatural practices are at the origin of HIV/AIDS. According to these beliefs, the PLHIV is infected as a result of the influence of an immaterial entity motivated by his misconduct or by the action of one of his peers. This is evidenced by the words of one of our survey respondents.

> *" .... There is a gentleman who tested positive for HIV, when he was given his result he said he knows who infected him. He went on to say that he knows that it was his uncle, with whom he has a forest problem, who transmitted AIDS to him in sorcery...". (S.V, Yopougon, 21 March 2022 at 4pm)*

These comments explain the ideological dimension that structures HIV. This dimension reflects the perceptions, ideologies and representations of the populations that encourage them to stigmatise young people living with HIV/AIDS. Indeed, the "construction of cultural ideologies" is a factor in legitimising vexatious behaviour towards PLWHA.

2-7-Explanation of the influence of disclosure of HIV status on the social reintegration of young people living with HIV/AIDS admitted to the CePReF in Yopougon

2- 7-1-It is difficult for young people living with HIV/AIDS to live together with the population

Disclosure of HIV-positive status has a negative influence on the community life of young people living with HIV/AIDS. This is evidenced by the following words of one of our respondents.

> *"... I live on good terms with my mum and my older sister but not so much with my dad. Because my dad lives with his wife and when he comes to our house he reminds us of the disease and he is weird with my mum and me because she also has this disease. His reaction is frustrating at times..." (J.O, CePReF, 13 January 2022 at 11am)*

This testimony refers to the symbolic dimension of the relationship between young people living with HIV/AIDS and the public. This dimension refers to the visible manifestation of the stigmatisation of young people living with HIV/AIDS. Indicators of this dimension are: exclusion from family activities, exclusion from social activities or events.

The following comments further support this assertion:

> *"... When I talk with my friends at school or in the neighbourhood and the talk turns to AIDS, I feel embarrassed because they talk badly about those who have this disease. They think that they are all the ones who behaved badly and then they got this disease. I was born with it. My friends don't know I have it. I know that if they find out, I will lose them. So that I don't go out too much and my friends find out one day, my mum made a phone box for me. I am afraid of losing my friends...". (J.H, CePReF, 19 January 2022 at 10am).*

This is supported by the Public Health Agency of Canada (2013) who believes that young people living with HIV raise a number of concerns including isolation from their own community and the HIV community, social rejection after disclosure of their HIV status, loneliness, despair.

2-8-Practices of the Ivorian state as a source of stigmatisation of young people living with HIV/AIDS

In Côte d'Ivoire, as elsewhere in the world, access to the civil service is based on established criteria. The particularity in Côte d'Ivoire is that these criteria, which should be as inclusive as possible, are developed to the detriment of young people living with HIV who aspire to join the civil service. The following statements from our respondent illustrate this allegation.

> *"... With HIV, you can't do anything, especially when it comes to public service competitions. The criteria are selective at our level. Why can't we join the civil service? I took the police exam several times and it was at the medical examination that I was eliminated each time. I was told that people with communicable diseases such as HIV and tuberculosis are eliminated. I couldn't tell the person talking to me that I am infected..." (A.T, CePReF, 12 January 2022 at 11am).*

These statements refer to the relational dimension which is reflected in the relationship between institutions and young people living with HIV/AIDS. The indicators of this dimension are: insufficient legislation in favour of the rights of young people living with HIV/AIDS, insufficient coordination between young people living with HIV/AIDS and the ministry in charge.

2- 9-Psychological crisis of young people living with HIV/AIDS

A child's growth is controlled by several factors including genetic factors (e.g. parental height), hormones (growth hormone, thyroid hormones, sex hormones), nutritional factors, socio-economic factors and psycho-emotional factors. In adulthood, when the individual does not realise that he or she has reached maturity, there will be a tendency to seek psychological affection more than is needed. This is reflected in the words of one of our twenty-four (25) year old respondents.

> *"... When I was with the children, things were fine. But when I arrived at the adults', it's not the same. When you arrive for your appointment, there is someone who takes your booklet to go and get your file to give to the doctor. When the doctor finishes looking at your file, he writes your prescription and then you come and get your notebook. We don't spend time with doctors like when we were kids. I don't know who I'm going to get attached to...". (F.P, CePReF, 24 January 2022 at 9am)*

The comments of this respondent are in line with those of Professors Olivier Bouchaud and Cheikh Tidiane Ndour (2011) who approach the issue of HIV/AIDS as a medically complex chronic pathology, which also has numerous psychological and socio-economic repercussions on the individual and his or her family. This is why, according to them, the care of people living with HIV must be comprehensive, i.e. not only treatment, but also support in managing the reactions to the announcement of seropositivity, psychological support, therapeutic education, nutritional education, economic aid and legal aid.

The words of this respondent living with HIV are corroborated by the words of a specialist in their medical care at CePReF.

> *"... normally, it is from the age of 21 that they are transferred to adults to continue their treatment. But some of them flatly refuse to leave because they are treated like adults there. They think they are still children. That's why you will see young people in our paediatric ward who are well over the age limit. There are others who by the time they get to the adults who have disappeared. They want us to treat them like children...". (Y.K, CePReF, 24 January 2022 at 10am)*

The words of this respondent refer to rules and norms, i.e. the normative dimension of caring for young people living with HIV, which could lead to their stigmatisation. In addition to psychological growth, some young people living with HIV face physical growth. This lack of physical growth in some HIV patients makes them look like dwarfs. One of our respondents, aged 19, said:

> *"... I am afraid that I will not grow any more, because all my little sisters who are not sick like me are taller than me...". (P.N, CePReF, 24 January 2022 at 10am)*

This position is supported by the guide entitled Comprehensive HIV care in resource-limited countries (2011), which argues that the care of HIV-positive people should be person-centred, with the comprehensive care approach creating the most favourable conditions for their participation in care. It must include psychological support, therapeutic education and nutritional education.From the analysis of these verbatims, we can see that young people living with HIV/AIDS face difficulties in social integration, especially those who know their HIV status.

III. DISCUSSION OF FINDINGS

In carrying out this study, we did not intend to claim to have exhausted the issue of care and reintegration of young people living with HIV/AIDS. The depth of the subject, the shortage of time available and the complex nature of the subject would not allow this. However, we can shed some light on it, based on data collected in our geographical, social and temporal fields, highlighting the complex nature of juvenile HIV.

3-1 Identifying the process of caring for young people living with HIV/AIDS admitted to the CePReF in Yopougon

HIV care at the CePReF begins, regardless of the patient's age, with an initial assessment that includes an HIV test. This result is in line with the Guide pour la prise en charge de l'infection par le VIH au Sénégal (2018), which states that HIV care is provided in all health services in Senegal. In reality, all services must offer

HIV testing as soon as there is contact with patients for a consultation, whatever the reason. The emphasis will be on tuberculosis centres, hospitalization services, nutritional recovery services and STI services. HIV serological confirmation should be done and the person put on antiretroviral treatment.

On the other hand, the Document de politique, normes et procédures des services de dépistage du VIH en côte d'ivoire (2016) in application of the 2015 WHO recommendations stipulates that in Côte d'Ivoire the expression of the client's willingness to be tested for HIV must be obtained regardless of who initiates the test (client or provider).

In addition, a follow-up assessment is carried out every six months to evaluate the treatment implemented for each patient admitted to the CePReF. This practice is supported in more detail by the French High Authority on Health (2011) which makes the following classifications:

- Follow-up of patients without antiretroviral treatment: every three to four months if the CD4 count is between 350 and 500/mm3, every four to six months if the CD4 count is above 500/mm3.
- After one year of treatment, if the viral load is undetectable: every three to four months if the CD4 count is below 500/mm3 and every four to six months if the CD4 count is above 500/mm3. If the viral load is detectable, checks should be frequent.

3-2-Forms of HIV care at CePReF

This study shows that HIV care in the CePReF is medical, psychological and nutritional. This position is supported and surpassed on the economic side by the guide entitled Comprehensive HIV care in resource-limited countries (2011), which maintains that the care of HIV-positive people is not limited to medical care but also includes, as part of a comprehensive care approach, support measures aimed at developing and maintaining the autonomy of people with regard to the disease: psychological support, therapeutic education, nutritional education, and socio-economic support. Centred on the individual, the comprehensive care approach must create the most favourable conditions for his or her participation in care, in particular regular treatment and long-term follow-up. In practice, it requires a multidisciplinary approach, based on the intervention of several professionals with complementary skills to cover the different needs of the individual. This point of view is shared by the coordination unit of Mali's sectoral AIDS control committee (2013). Indeed, this unit believes that the care of PLHIV must be comprehensive, addressing the medical, psychological, socio-economic and nutritional needs of patients and their families. It can be carried out either in specialised structures offering most services in the same place or in non-specialised structures where the care is integrated into the general care offer. It requires the establishment of networks between health facilities, social services, non-governmental organisations, PLHIV associations and the community.

3-3- Leadership of conventional medicine in medical care

The leadership of conventional medicine in the treatment of HIV/AIDS is noteworthy. This is supported by WHO (2013), which states that in addition to improving health and prolonging life, there is clear evidence that antiretroviral therapy (ART) prevents sexual transmission of HIV and that the use of antiretrovirals (ARVs) by uninfected people can protect them from infection. WHO (2013) also believes that ARVs provide the best possible short-, medium- and long-term tolerance; improve or preserve quality of life; and reduce mother-to-child transmission of HIV. UNAIDS (2015) concurs, stating that the use of antiretrovirals (ARVs) not only keeps people alive, but also prevents new HIV transmissions. By suppressing the amount of virus in a person's body (viral suppression), HIV treatment reduces the risk of transmission to almost zero. Treatment is recommended for pregnant women living with HIV to prevent mother-to-child transmission.

Finally, according to Plateforme Prévention SIDA (2020), having an undetectable viral load does not mean that one is cured either. Indeed, today, HIV infection remains a treatable infection, but not a curable one. Cure or remission of HIV is a major challenge that is the subject of much research around the world today, but it is very likely that continuous, lifelong antiretroviral treatment will remain the standard approach for many years to come.

3-4- Incurability of HIV/AIDS

To date, HIV remains an incurable infection despite the efforts made by scientists since its appearance in 1983. This is confirmed by UNAIDS (2001) which argues that HIV remains incurable to this day and that the best way to ensure the best quality of life is through palliative care which aims at pain relief, symptom management, psychological support, spiritual support, and support for the family. According to Adam Ashforth (2002), although new treatments can prolong the life of HIV-infected people, there is no cure for AIDS and virtually everyone infected will die of it. The National AIDS and STI Control Programme of the Democratic Republic of Congo (2005) corroborates this assertion, stating that antiretroviral treatment prevents the replication of the virus and slows the progression of the disease. It is therefore not a cure and must be taken for life. Any interruption in the treatment regime or irregular intake encourages a viral rebound and the possibility of the emergence of resistant viral strains. The same is true for Platform for AIDS Prevention (2020), which states that once infected, one remains HIV-positive for life but does not necessarily show symptoms. With current treatments, people living with HIV can have an undetectable viral load, meaning that there are very few replicas of the virus in the blood. Having an undetectable viral load does not mean that you are cured of HIV.

3-5-HIV/AIDS as a disease of supernatural origin

After several decades of existence, several myths are still attached to the origin of HIV/AIDS. For example, Adam Ashforth (2002) argues that as the AIDS epidemic spreads in South Africa, suspicions of witchcraft arise in its wake, so that it also becomes a witchcraft epidemic. Furthermore, Oscar Labra (2011) tells us that moralistic representations of the disease and their association with 'the sinful world of sexuality' refers to the belief that AIDS is a mark of marginality, of sexual perversion. Thus, anyone with AIDS, regardless of how they were exposed to HIV, is transformed into a sexual deviant.

3-6- Difficult cohabitation of young people living with HIV/AIDS with the population

The cohabitation of young people living with HIV/AIDS is not always easy in the community. It most often leads to stigmatisation and discrimination.

Alain Coulon (2002) confirms this by stating that the deviant is the one who is caught, defined, isolated, designated and stigmatised. This is one of the strongest ideas of social control, by designating certain people as deviant, it confirms them as deviant because of the stigma attached to this stigmatisation. So much so that it has been said that social control, paradoxically, generates and reinforces deviant behaviours, whereas it is originally instituted to combat, channel and repress them: we become as we are described. The International Labour Office (2015) argues that traditional gender roles that encourage women's social and economic dependence on men can discourage women from accessing HIV-related health services. Studies of women in sub-Saharan Africa have shown that fear of a negative partner reaction (abandonment, violence, rejection, loss of economic support, accusations of infidelity, etc.) was the most frequently cited barrier to HIV testing and disclosure of HIV status

3-7- Practices as a source of stigmatisation of PLWHA

Some practices of states or private institutions can be considered as sources of stigmatisation of young people living with HIV/AIDS. We see this in the words of the International Labour Office (2015). Indeed, it argues that job applicants should not be denied access to employment solely on the basis of their actual or perceived HIV status. In Hoffmann v. South African Airways (2000), an applicant was refused employment as a cabin assistant on the basis of his HIV-positive status. The South African Constitutional Court ruled in favour of the plaintiff and emphasised the devastating effects of employment discrimination. The International Labour Office (2015) also argues that some employers require HIV testing, particularly for access to specific occupations. In some circumstances, job applicants and workers may be subjected to such testing without their knowledge or consent, thereby violating their fundamental right to privacy and confidentiality. This allegation is supported by the NGO Aides (2015), which argues that, beyond these representations and preconceptions, access to certain training courses and jobs is still legally prohibited in France, in direct contradiction with the principles of French law. These prohibitions notably concern the circus arts, the judiciary and the army.

3-8-Psychological support for young people living with HIV/AIDS

Counselling is an essential link in the care of young people living with HIV. UNICEF (2002) concurs, stating that because young people are particularly socially and psychologically vulnerable, voluntary and confidential testing and counselling must be sustained and follow-up provided. Post-testing support services, especially for young people who are HIV-positive, should provide a safety net to ensure that their health, psychosocial and financial needs continue to be met. Marie-Ève blanc (2004) goes beyond the position of UNICEF (2002) by stating that psychosocial support should not be considered only with regard to the sick, but should be conceived in relation to the overall care. It concerns all the actors in the care of PLWHA. It has four main functions: to manage side effects and avoid therapeutic failure; to improve adherence and compliance with treatment in order to limit resistance and therefore costs; to manage quality of life (palliative care at the end of life); to support the health care team, the patient, his family and his entourage. Each actor in the care of PLWHA must find his or her place in psychosocial support.

IV. CONCLUSION

Analysis of the data collected from young people living with HIV/AIDS, health professionals and the population revealed that there are socio-cultural factors that impact on the stigmatisation of young people living with HIV/AIDS. Indeed, the stigmatisation of young people living with HIV/AIDS is the result of the ideology of the population, which is often influenced by the impact of its perception of the HIV/AIDS disease on the one hand and by the disclosure of the positive serological status of the patient on the other.

Firstly, this study has shown that the incurability of HIV is a determining factor in the stigmatisation of PLWHA. This is because they appear to be doomed to certain death. The incurable nature of HIV is the basis for the construction of a discriminatory relationship towards people infected with HIV.

Secondly, the mode of transmission of HIV remains a key factor in the stigmatisation of PLHIV. Even though it is possible to be infected with HIV through the use of sharp objects, during a blood transfusion, from mother to child, the sexual route remains the most likely. Thus being infected with HIV is most often attributed by the population to a life of sexual depravity. Sexual depravity is proof of immortality, so anyone infected with HIV is likely to be marginalised.

Furthermore, it appears from this work that the main issue in the stigmatisation of PLHIV is the management of disclosure of HIV status. These people must be able to disclose their HIV status only to their confidants. Indeed, the construction of stigmatising relationships towards a PLHIV stems from their inability to ensure the confidentiality of their positive serological status.

Finally, it could be said that our hypothesis is not verified because to achieve stigmatisation of PLHIV, disclosure of HIV status alone as a factor is not sufficient. Similarly, the perception of the disease by the population in isolation cannot explain the stigmatisation of PLHIV either. But these two factors must be put together to reflect discriminatory behaviour towards this section of the population.

This is why public authorities, non-governmental organisations and the WHO must pool their efforts to de-dramatise HIV/AIDS, guarantee the confidentiality of the serological status of infected persons and do everything possible to find a definitive remedy in the short term.

Addressing HIV-related stigma and discrimination is essential to slowing the impact of the epidemic. Stigma and discrimination have a negative impact on the entire process from prevention to care and treatment, and greatly exacerbate HIV-related suffering. Stigma, discrimination and human rights violations are closely linked, reinforcing and legitimising each other. Multi-faceted and sustained action over time is needed to prevent stigma and challenge discrimination when it occurs in particular contexts, and to promote and protect human rights.

Ongoing assessment and documentation remain important. While stigma reduction is often not the sole or primary objective of some programmes, many HIV prevention and care activities have a positive impact on stigma and discrimination and are unintended consequences of the main objectives. Nevertheless, elements to address stigma and discrimination could be integrated more systematically and explicitly in project and programme design.

For our part, the quickest way to end the HIV epidemic is to be part of the accelerated vision that UNAIDS has set for itself for 2030. This accelerated approach aims both to scale up HIV prevention and treatment services and to end HIV-related discrimination.

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