Trial and routine : on the problematic relation between routine care and "private actors" within West-African health services (Burkina Faso)

Frédéric Le Marcis, George Rouamba

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Zum Titelbild/Front picture *Curare* 36(2013)3:
The photo shows the setting of an interview between Prof. William Sax, South Asia Institute, University of Heidelberg, and Walid Darwish Zamzam, who practices Islamic healing in UK. Mr. Zamzam gave a lecture on „Islamic Healing: a practitioner's point of view" at Heidelberg on 02 July, 2013. The interview can be found on pages 168–171 of this issue.

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Inhalt / Contents
Vol. 36 (2013) 3

Gesundheit und Öffentlichkeit: Medizinethnologische Perspektiven

Buchbesprechungen / Book Reviews

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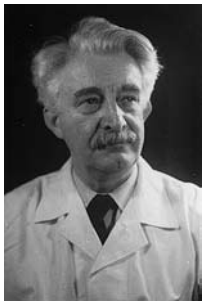
Addenda und Errata zu *Curare* 36(2013)1+2:

• *Addendum: BMI vom Schreibtisch:*

In *Curare* 36(2013)1+2 auf S. 12 und in der Anmerkung 23 zitiert die Autorin Debora Frommeld in ihrem Beitrag *„Fit statt fett": Der Body-Mass-Index als biopolitisches Instrument* Zeitungsberichte über Verbeamtungswünsche, die wegen eines abweichenden BMIs abgelehnt werden. Im geschilderten Falle handelte es sich um einen Polizeianwärter mit einem ausgeprägt trainierten muskulösen Körper. Wie zu erfahren ist, gelang es dem Bewerber, nach einem Gerichtsverfahren doch noch eingestellt zu werden. Hier die beiden Quellen: http://www.derwesten.de/wr/wr-info/zu-muskuloes-fuer-den-polizeidienst-id76939.html • http://www.derwesten.de/wr/staedte/schwelm/muskelspiel-vor-gericht-gewonnen-id348813.html

• *Addendum und Erratum zu Autor Valšík:*

Der Erstautor des Artikels "Popular Medicine and Traditional Mutilations in Egyptian Nubia" von Valšík J.A. & Hussien F.H. in *Curare* 36(2013)1+2: 86–92 heißt nicht Jan A. Valšík, sondern Jindřich A. Valšík (s. S. 89). Eine neuere Diplomarbeit ist seinem Leben und Werk gewidmet (Diplomovka-Vymazalová-Valšík), Brno (Brünn) [http://www.uschovna.cz/en/package/P8X3L3SBFK7ELFBL-MAT]. Information von Assoc. Prof. Rado Beňuš, Bratislava, Head of the Department of Anthropology of the Faculty of Natural Sciences of CU, where Prof. Valšík used to work. (benus@nic.fns.uniba.sk).



Jindřich A. Valšík (1903–1977)

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- Ekkehard Schröder*, Psychiater, Ethnologe (Potsdam) ee.schroeder@t-online.de – S. 164
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Trial and Routine. On the Problematic Relation between Routine Care and "Private Actors" within West-African Health Services (Burkina Faso)

Frédéric Le Marcis & George Rouamba

Abstract Starting with the description of a clinical trial dealing with Prevention of Mother-to-Child Transmission of HIV in Burkina Faso, this paper aims to discuss a recurrent aspect within the West-African public health services: the confusion of research and care and its implications. Analysis of the inclusion of this clinical trial is within the context of everyday care shows how rationales of research and daily care merge and transform the way care is organized and how they affect the aspect of trust and confidence which is at the heart of care interactions. This case is discussed with other activities like vertical programs structuring health care practices. This discussion argues for a shift in our understanding of health care services in Africa that included paying attention to the tensions and contradictions they contain. Acknowledging the multiple actors and logics present in the health care sector, this paper raises the issue of the possibility of a coherent and fair national public health policy.

Keys words clinical trial – health services –PMTCT/HIV – trust – Burkina Faso

Klinische Studien und Alltag der medizinischen Versorgung – eine problematische Beziehung zwischen „privaten Akteuren" und nationalen Gesundheitsdiensten in Westafrika.

Zusammenfassung Am Beispiel einer klinischen Studie im Rahmen des Programmes zur Prävention der Mutter-Kind-Übertragung von HIV in Burkina Faso wird ein häufig wiederkehrender Aspekt der staatlichen medizinischen Versorgung in Westafrika beschrieben: die Vermischung von Forschung und medizinischer Versorgung und deren Implikationen. Die Analyse der Einbettung dieser klinischen Studie in die tägliche Versorgung von Patienten zeigt auf, wie Forschungsabsichten und medizinische Maßnahmen sich vermischen und dabei die Versorgungsqualität und das Vertrauen in diese beeinflussen können. Diese Studie wird zudem mit anderen vertikalen Programmen verglichen, die damit einhergehen und die staatliche medizinische Versorgung in Afrika beeinflussen. Im Hinblick auf die Ergebnisse unserer Analyse scheint es notwendig, unser Verstehen der medizinischen Versorgung in Afrika zu revidieren und über die bisherigen Diskussionen hinaus die Widersprüche und Anspannungen in den nationalen afrikanischen medizinischen Versorgungssystemen in den Blick zu fassen. Aufgrund der vielfältigen Akteure und Programme in den staatlichen Gesundheitssystemen in Afrika erhebt sich die Frage nach den tatsächlichen Möglichkeiten einer kohärenten und fairen nationalen Public Health Politik.

Schlagwörter klinische Studie – Gesundheitsdienst – PMTCT/HIV – Vertrauen – Burkina Faso

Introduction: Health Care Services in the context of AIDS as chronic condition

Since the beginning of the 2000's due to the increasing access to antiretroviral therapy in West Africa, the treatment of AIDS and how AIDS is framed in the public realm has entered a phase that can be defined as "normalization". This echoes the experience of the introduction of antiretroviral therapy in the West (Fee & Fox 1992). In 2010, 49% of people in need of antiretroviral therapy were receiving ARV's in sub-Saharan Africa (OMS 2012: 99). After a period in which the epidemic was the center of concern and which received extensive calls for mobilization in various media (billboards along roads, radio messages, posters in health care centers), AIDS now seems to be losing its status of exceptionality. Locally, this is undoubtedly the effect of a less alarmist view of HIV infection supported by the dramatic decrease of the HIV rate in West Africa. UNAIDS (Joint United Nations Program on HIV/AIDS) assumes that twelve West African countries have a HIV rate of less than 2%. Moreover the decrease in the number of new infections is significant: In 2011, there were an estimated 1.8 million [1.6 million–2 million] new HIV infections in sub-Saharan Africa compared to 2.4 million [2.2 million—2.5 million] new infections in 2001—a 25% decline (UNAIDS 2012). This is partly due to the lassitude felt by populations and health professionals alike in response to calls for vigilance. This situation must, among other things, be under-

stood in light of the international context and the difficulties experienced by developed countries in keeping their financial commitments to the Global Fund[1]. In Burkina Faso, at least on paper and seen from the point of view of treatment, the epidemic also seems to have lost its status of exceptionality. For instance, in 2010, the protocol for Prevention of Mother-to-Child Transmission of human immunodeficiency virus (PMTCT) was rolled out in health districts all over the country, and concerned 92% of health care centers (Direction de la Santé de la Mère et de l'Enfant, 2011: 24). PMTCT is part of the general package of prenatal consultations offered to pregnant women. The fact that AIDS is now viewed as an illness like any other chronic illness could be seen as positive. However, in the context of generally ineffective public health services, this can be counterproductive and may lead to a reading of AIDS as a banality. Seen as part of chronic illness, the treatment of AIDS could be seriously compromised. In fact there are other issues at stake with the qualification of AIDS as a chronic disease. Firstly the offer of services increases does not necessarily imply the reduction of inequalities in terms of exposure to risk or access to care. Secondly the chronicity of the disease and its integration into the general activity implies a heavy financial burden for health services and a complication of treatment for life long patients (Colvin 2011). Observations by ethnographers in health institutions usually raise questions regarding the quality of health services from the description of actors' practices. They are sometimes described as violent (Jewkes *et al*. 1998), or generally inhospitable and involving clientelism, over-charging and a lack of respect for patients (Jaffré & Sardan 2003). In a recent article, Valéry Ridde proposes moving beyond such a reading that focuses solely on the actor. Drawing inspiration from the work of Anselm Strauss (1992), Ridde seeks to account for the negotiations at work in the roll out of health policies in the health districts of Burkina Faso. For instance, based on a localized empirical survey, Ridde analyzes the mechanisms, rationales and constraints that structure the negotiations between health equity policies and how social actors take ownership of these policies (Ridde 2011). This expanded concept of negotiation may also be used to account for the ways that health care providers reconcile the mission assigned to them which is to provide patients with both curative and preventive care with day-to-day life in the centers where they work. In so doing, the aim is not to limit the analysis to practices but to understand practices in light of the environment in which they happen. What does it mean to concretely care for patients as civil servants when your mission is not only driven by national health policies and health district supervisors but subjected to norms and practices linked to logics introduced within health services by private actors like clinical trials researchers or NGO' workers. Adriana Petryna has discussed the impact trial industry has on ethics variability. She noticed that: "… Differences in the organization of institutions authorized to deal with health problems (state bureaucracies, welfare agencies, insurance companies, medical facilities, and religious and humanitarian organizations) result in policies that not only differ in form and content but also can shape different courses of health and disease and influence the outcomes of both" (Petryna 2005: 184). While Adriana Petryna is interested in the way "global dynamics of drug production play an important role in shaping contexts in which ethical norms and delineations of human subjects are changing" (ibid. 184), our aim in this paper is slightly different. Our empirical entry is the scale of care interaction. From there we look at the impact of clinical trial implementation in specific health services not only as the product of pharmaceutical industry but as an actor amongst others playing an influential role within health services as a producer of norms of care, practices of triage and of supervision.

To introduce this question, we begin by describing and analyzing the interactions between a trial focusing on Prevention of Mother-To-Child Transmission of HIV (PMTCT) and a health care center (CSPS, in French a *Centre de Santé et de Promotion Sociale*) on the outskirts of Ouagadougou. This health care center was a recruitment site for the trial team. Our aim based on these two case studies is to comprehensively reflect on a particular aspect of health care services in Africa: that of the impact of an increased privatization of some of its activities by diverse actors on the concept of public health care.

Anthropologists already very early have extensively discussed medical pluralism and Asian fieldwork in fact provided the first sites for this (Leslie 1977). Working in China, Arthur Kleinman proposed to use the notion of medical systems as cultural sys-

tem and thus allow for comparison between healing practices (Kleinman 1978). Anthropologists and historians working in Africa drew inspiration from the work of Anthropologists in Asia. John Janzen for example forged the concept of "therapy managing group" to analyze how patients were making choices in the midst of multiple medical offers in Zaïre (Janzen 1978). At the same time, East Africa became the site of historiographical work on the production of health and the encounter of African population with colonial medicine (Feierman 1979, Feierman & Janzen 1992). In Burkina Faso, as elsewhere on the African continent, multiple sources of making meanings and producing care in cases of misfortune or physical ailments do co-exist. They range from self-medication with plants to soliciting street drug vendors, to soliciting healers who rely on their knowledge of the world of the bush as well as consulting Muslims healers, Christian priest or even formal private and/or public health centers. The uses of such resources are not mutually exclusive and vary according to factors ranging from financial capacity, family and personal experience to levels of education (Pouliot 2011). Without compromising the complexities of cure and healing offers in Burkina Faso, we will focus on the provisions of biomedical care within public health services.

The data presented in this article relies on fieldwork conducted in Burkina Faso[2]. Fieldwork consisted of ethnographies carried out in five health districts throughout Burkina Faso. In each of these districts two health centers were chosen for their PMTCT performances, one in urban area and the other in a rural area. We spent one month in each site and observed the day-to-day activities related to mother and child health. Our ethnographic data collection included the systematic recording of educational talks known as *causeries* which served as a basis for collective HIV counseling sessions. In addition to this, we observed individual advice sessions and conducted a series of individual and collective open-ended interviews, both formal and informal, with health care professionals and patients. All of the recordings were transcribed in Moore and/or Jula, and then translated both word-for-word and more comprehensively.

We will begin with a general overview of Prevention of Mother-To-Child Transmission of HIV in Burkina Faso and present the outlines of this clinical trial and its installation in a rural health care center which lies approximately twenty kilometers from the capital, Ouagadougou. The description and analysis of a clinical trial and its transformation into a routine health care center makes it possible to discuss the consequences of the co-presence of care and research within the health care system in a more general manner. The presence of the trial within National Public Health Services invites one to examine the question of its nature beyond the trial's impact on provider-patient interactions. Indeed, in this case part of the care appears to be delegated to actors whose rationales are partly in contradiction with public services rationale. The contradiction is highlighted in the context research-public service where care offered by the public services is supposedly all inclusive whilst the research rationales imply rather limited inclusionary targets.

Through this example, we aim to provide valuable insights on a dynamic that underpins Public Health Care Services on the continent. They are not solely providing care for the largest number of patients, but they also determine and select which patients the research activities located within their units/health care centers should have access to. Despite such contradictions, researchers attached to the various public health care services do influence their objectives through the supervision they organize and the practices they introduce.

Prevention of Mother-To-Child Transmission of HIV: Global contexts and local stakes in Burkina Faso

In 2009, UNAIDS estimated the number of children infected at birth or during breastfeeding to be 370.000, and that half of all people living with HIV in sub-Saharan Africa were women (UNAIDS 2010). As Karen Booth stated, "In the case of AIDS, motherhood is an international problem, figuring as it does in the transmission of HIV around the world. Once framed as integral to the pandemic, HIV in mothers becomes an arena for international debate. However, motherhood is fundamentally domestic; its control and its protection are private matters subject to the sovereign—whether he be the nation or the father" (Booth 1998: 125). A brief review of recent shifts in the prevention of mother-to-child transmission of HIV in Burkina Faso illustrates this statement.

The provision of HIV/AIDS care in all 13 regions of Burkina Faso is spread among 90 medical establishments. These range from public to private religious and community-based medical establishments and include 45 pediatric sites as well. Of the 31,543 recipients of antiretroviral treatment (of which 1,399 are children) at the end of 2010[3], 51% of the total number of recipients were located in the Center Region where the prevalence rate is above the national average. PMTCT began as a pilot project in Burkina Faso in 2002. It was introduced in the three major cities of Ouagadougou, Bobo Dioulasso and Ouahigouya. In 2013 and just over a decade later, PMTCT has been rolled out to all 63 health districts in Burkina Faso but to varying extents. At the end of 2010, for example only 1,492 medical establishments out of a total of 1,614 medical establishments, offered PMTCT. These sites are not equally distributed across Burkina Faso and are over-represented in urban areas. Moreover, though the rate of enrolment among women is rising from year to year, it remains below the national target: 56% in 2010, compared to the target of 80%. Despite the progress made, PMTCT is still a priority for the Burkina Faso Ministry of Health (Direction de la Santé de la Mère et de l'Enfant, 2011). This was the context in which the new WHO recommendations published in 2009 were received. These recommendations emphasize improving mothers' health while protecting their children from HIV infection as best as possible. The main recommendations can be summarized as follows:

- Start antiretroviral therapy (ART) as early as possible so that pregnant women who are HIV+ can be treated and thereby prevent HIV from being transmitted to their children during pregnancy.
- Extend the duration of antiretroviral prophylaxis for HIV+ pregnant women whose immune systems are not too weak and who do not need ART for their own health to lower the risk of mother-to-child transmission of HIV.
- Provide antiretroviral drugs to the mother or child to lower the risk of HIV transmission during maternal breastfeeding.

Burkina Faso, like the other countries in the subregion, implemented these international recommendations. This is evident in the changes in its PMTCT policy announced in June 2011 in Ouagadougou. At the end of the 2006–2010 PMTCT-program, the Burkina Faso Ministry of Health, through its Directorate for Mother and Child Health (DSME), presented its new program for 2011–2015, which included the international recommendations. The new 5-year plan proposes the protected exclusive maternal breastfeeding protocol (exclusive maternal breastfeeding during the first six months with prophylaxis followed by the introduction of complementary foods and eventual weaning at 12 months), without excluding the possibility of formula feeding but ceasing free distribution of infant formula. The DSME's forecast in 2011 counted 19,072 cases of HIV+ women. The goal of the national prevention of mother-to-child transmission of HIV program for 2011–2015 aims to lower the residual HIV mother-to-child transmission rate to less than 5% by the end of 2015 (DSME 2011). To do so, the Burkina Faso Ministry of Health intends to overcome the problems identified during the 2006–2010-program by improving the establishment of universal access to PMTCT. The objectives are:

- "(1) Voluntary HIV screening of at least 60% of the women who are of childbearing age and who use family planning services.
- (2) To increase the screening rate among pregnant women seen during prenatal checkups from 56% to 90%.
- (3) To ensure treatment in compliance with the protocol of 100% of pregnant women who test HIV+ during the prenatal checkup (PCU).
- (4) To ensure early HIV testing among at least 80% of children born to HIV+ mothers.
- (5) To treat 100% of children born to HIV+ mothers according to the protocol." (DSME, 2011: 30).

The question of the establishment of protected exclusive breastfeeding arises from the application of the treatment protocol for the children of HIV+ mothers. On this issue, the 2011–2015-program specifies:

> "As part of the third PMTCT program for 2011–2015, Burkina Faso has opted for safer breastfeeding. However, if the conditions for artificial feeding are met (affordable, doable, acceptable, lasting and safe), mothers that so desire may chose this mode of feeding; in this case, families shall contribute (financially, materially, technically, etc.) to the proper implementation of this choice" (DSME 2011: 31).

Given the standard of living of most women in Burkina Faso, the cost of artificial feeding of 19,600

CFA Francs per month (29,80 €) for only 7 small boxes of formula is rather exorbitant. In Burkina Faso, 43.9 % of households live below the poverty line calculated at 108.454,00 CFA Francs per year (165,33 €), or approximately 2.085,00 CFA Francs per week (3,10 €) (Institut National de la Statistique et de la Démographie 2009). (2006–2010). Under the circumstances, where artificial feeding is beyond the reach of most households, it limits the choice offered by the Ministry to protected breastfeeding. In this context, the plan during the first three years of the program is to begin by systematically treating all women whose CD4 counts are below or equal to 350 cells/mm^3. Secondly, it is to provide prophylactic treatment during pregnancy starting in the fourteenth week, or as early as possible when delayed, for women at WHO clinical stage I or II. Lastly it is to treat those at WHO clinical stage III or IV. Their children will receive daily doses of Nevirapine or AZT (Zidovudine, Retrovir) from birth to 6 weeks if they are not breastfed. If they are breastfed, they will receive daily doses of Nevirapine until one week after the cessation of all exposure to breast-milk.

The objectives set out in the new four-year PMTCT program emphasize the difficulties encountered by the program on a daily basis and include:

– Still too few screening of pregnant women.
– Lack of information on PMTCT among the general population.
– Problems managing supplies (frequent interruptions in the supply of reagents and tests).
– The challenge of "lost patients" (women who tested positive but do not continue with the protocol).
– Partial and/or incomplete knowledge of the PMTCT protocol among health agents, excessive individualization of PMTCT responsibilities in centers.

These problems are partially due to the status of the HIV epidemic in Burkina Faso where, despite it is widespread from an epidemiological standpoint (1 %); the almost non-existence of awareness campaigns and the virtual absence of patients in rural areas masks its visibility to actors in such areas. This is in fact the situation of the health care center located on the outskirts of Ouagadougou where we conducted our fieldwork: there was only one poster mentioning the epidemic. This was underlined by the head nurse on duty who remembered his involvement in the fight to reduce the HIV epidemic while working in Ouagadougou at a pilot PMTCT site in the 2000s. He now acknowledges that priorities have shifted since then and that the major HIV/AIDS projects that ensured the motivation of health care agents through a system of bonuses had ended. He is still as a health care agent albeit in a different capacity. His attention is now focused on malnutrition, and he is regularly called out of the health care center to assist an "American" project in combating malnutrition, for which he receives per diem that also help supplement his salary.

The absence of addressing the epidemic felt by health workers is also expressed in the comments of one of the coordinators for the trial including patients in the health care center where we conducted our ethnography. While we were discussing the difficulty of organizing a cohort of mother-child pairs in Ouagadougou resulting from an insufficient number of patients, he remarked, "this is the last time I organize a PMTCT trial in Burkina Faso: there are no longer enough new patients." This comment should be understood in a context of a relatively small number of new infections, which makes the possibility of having a statistically pertinent number of HIV mother and child couple in this cohort very difficult. In 2011, the Directorate for Mother and Child Health (DSME) indicated that in the *Centre* (region where the MILK trial was taking place in Burkina Faso), among the 61.528 women attending antenatal consultations, 88 % went for an HIV test (n: 54.126). Among them 1.58 % were found to be HIV positive (n: 853) (Burkina Faso and ONUSIDA 2012: 32).

The MILK trial was introduced in four different African countries and inaugurated in Burkina Faso on 1 January 2009. In Burkina Faso for example, this was done against the backdrop of an intense international debate on the virtues of exclusive maternal breastfeeding with accompanying prophylactic therapy and a latent but hardly-visible epidemic[4]. It was a phase III clinical trial, which is a randomized controlled multicenter trial. It aims to look at the effectiveness of an intervention and its value in clinical practice. As such it is expected to deal with large numbers of patients and be statistically relevant. In Burkina Faso, the MILK trial has enrolled about 1.500 patients and is funded by the French Research Agency for Research on AIDS (ANRS). The MILK trial is organized by a consortium of African and European Researchers. It aims was to

study the effectiveness and tolerance of two extended post-exposure prophylaxis treatments on postnatal transmission of HIV-1 among children born to HIV+ mothers who were breastfeeding, not eligible for tri-therapy, and who received perinatal antiretroviral prophylaxis. Anticipating the changes in international recommendations and taking a stance within the framework of the prevailing debates at the time, the team of researchers wished to compare the effectiveness of two therapies in 2009[5].

The Burkina Faso team therefore needed to establish a cohort of pregnant HIV+ women who had decided to exclusively breastfeed their newborns and were willing to administer one of the two preventive treatments proposed to their babies.

Faced with the difficulty of recruiting patients, the MILK team expanded its recruitment zone to 52 health care centers in Ouagadougou and its surrounding areas. One of the health care centers where we conducted our survey was located approximately 20 kilometers from the capital where income generation activities were few and often restricted to market gardening. Moreover in this deprived area only one public health center offered antenatal consultations.

Day-to-day Prevention of Mother-To-Child Transmission of HIV

The health care center in this village located on the outskirts of Ouagadougou consists of a dispensary, a maternity ward, and a drug store. Seven people work there: one State-licensed nurse, a certified nurse, a certified midwife, a mobile health agent who is also in charge of the Expanded Program on Immunization EPI (in French the "*Plan Élargi de Vaccination*") a village midwife, a drug store manager, and a community worker. From the seven-member team, only the certified midwife and the village midwife are directly involved in PMTCT, which happens in the maternity ward. In the health center, the posters covering the walls are warnings about malaria during pregnancy and promote the use of mosquito nets as a measure of prevention. The other posters deal with issues of maternal health, family planning, immunization, sexually transmitted infections and information on the State subsidized fee-scale for childbirth. In the ensemble, these posters refer to issues of domestic hygiene, family planning, filariasis, malnutrition but only one poster on youth-health mentions HIV/AIDS.

PMTCT forms part of the routine activities conducted by health care professionals in the maternity ward. HIV screening like urine and blood tests is offered free of charge to all women during prenatal checkups[6]. The HIV screening test is performed in a private room and at the same time with others like the cervical dilation exam. In accordance with the antenatal care protocol, prenatal checkups always start with a collective counseling session, locally called a "*causerie*"—loosely translated as a collective counseling session—, where the health agent uses the opportunity to remind pregnant women of the importance of good practices as set out in some of the posters adorning the walls of the health center. Part of the protocol requires the health agent to answer any questions the attendees may have but in reality these are rare or quasi-nonexistent. From a logistics point of view, each *causerie* is normally devoted to a specific subject that includes issues related to HIV as well as the steps to take when one is HIV+. During our fieldwork we noticed that women attending the causeries were officially required to choose between exclusive maternal breastfeeding for 6 months or feeding formula. We noticed that the causeries are conducted as a matter of routine, which the certified midwife regards as time-consuming and unrelated to her health care activities. With the result that they are frequently delegated to other actors like association volunteers. In addition, we noticed that causeries in some instances are not organized. In such cases, the reasoning used to explain this ranges from not having enough time to not enough women present to hold a causerie.

The idea of causerie activities as time consuming should be understood in the context of Health Center's specific temporalities. Although antenatal consultations are officially supposed to take place on a daily basis, in reality, they usually take place twice a week during market days. This can be understood in practical terms where women combining the two visits create the amalgam market-clinic especially if they come from far away villages as our fieldwork shows. To this should be added the fact that in rural areas at least, these routine activities take place only during mornings, which results in the afternoon being reserved for emergency cases only. Moreover, educational talks/causeries, like administrative work, are perceived as taking health workers away

from their primary professional mission: that of curing. As the midwife at the maternity ward where we conducted our ethnography remarked while complaining about her excessive workload, "No matter how much work it takes to hull early corn[7], I'll do it, but it is because of you that I hold the *causeries*, otherwise I wouldn't do it today." Here, the *causerie* becomes a show put on for the researchers who are seen as evaluators for whom one must behave "as if." Through this comment, the permeability of the line between routine activities and activities seen as secondary can clearly be seen. This is further confirmed by observations conducted in other health centers throughout Burkina Faso.

After the *causerie*, the certified midwife sees the women individually and conducts various tests, including HIV screening, saying that the test is "good for the child and good for the country". However, this way of conducting the test does remove the potential inclination to ask questions about the test and the women's comprehension thereof. Alice Desclaux and Chiara Alfieri argue in favor of advice given to women that would help them understand their HIV status and in turn empower them regarding the disease and its consequences. They hold that poor quality of advice—ranging from prescriptive to comprehensive advice—offered to women raises the question of what women really understand (Desclaux & Alfieri 2009).

HIV screening like other related services is further challenged by supply shortages. Frustrated health care agents often mention the frequent supply shortages as reasons for not offering services like screening to patients. In theory, health care centers would keep an inventory of drugs and medical supplies and order them according to an audited need. However, the accessibility of drugs and medical supplies for patients at health care centers is dependent on well-run systems and the availability thereof at the district store—in French *the dépôt répartiteur de district*—and the central store—in French the *Centrale d'achat de Médicaments Essentiels Génériques* or *CAMEG*—, in Ouagadougou. The availability of drugs and medical supplies at the local level remains a matter of urgent concern within the Burkinabe health system (Burkina Faso and ONUSIDA 2012: 42).

This shortage is so frequent that health care agents have reluctantly "internalized" it as a routine characteristic of their working environment. In unexpected ways, the shortage of drugs and medical supplies has led to a paradoxical situation where health care agents regard it as a norm rather that as an exception. Our fieldwork has demonstrated that attendees enquiring about the availability of milk formula from Health District Officials during a district meeting were simply informed of that the formula was available. The non-distribution of milk formula was attributed to a non-demand. It almost seems like the health care agents at the local level regard the unavailability of supplies as an accepted norm rather than as an exception. It testifies as well about the poor communication within health care system.

AIDS, and PMTCT, are therefore not seen as exceptional any longer. They no longer form the object of specific attention from the health workers. They are no longer supported by vertical programs or financial incentives. In fact PMTCT has become part of an ensemble that, for pregnant women as well as for health workers now forms part of a degree of normalization that incorporates a "minimal package of tests" (urine, vaginal palpation, weight, etc.). This shift in treating PMTCT as any routine illness does influence a non-stigmatization perception of the illness. As Campbell et al. argue citing the South African context: "people's experiences and multiple HIV programs can gradually facilitate a demystification and normalization of AIDS in the public sphere" (Campbell *et al*. 2012: 130) in ways that the generalization of treatment impacts on the way health workers engage with the AIDS sufferer (ibid. 130). But normalization also carries the risk of AIDS neglect. Indeed, discussing the degree of availability to health care in South Africa, Goudge and colleagues state that regarding care for chronic conditions in developing countries outside of South Africa studies point to (a) lack of medication, lack of adequate clinical care as well as high workloads and poor doctor motivation as examples of barriers to health care for the chronically ill (Goudge *et al*. 2009: 90). Furthermore, at a macro level, the normalization of AIDS and its transformation into a chronic epidemic raises the question of the capacity of health systems to fund treatment and secure resources (Colvin 2011). However at a micro level like in Burkina Faso, normalization of the pandemic can have at least two serious consequences: First, as an ordinary illness within the Burkinabe Health Service, it will be exposed to the same ordinary prob-

lems as any other ordinary health service (shortage of staff, lack of motivations and capacities, etc. …). Second it might be neglected in favor of newly implemented vertical programs like malnutrition for example. This shift in the status making AIDS an ordinary illness is evident in the public discourse and in the minutes of the Council of Ministers meeting of December 29, 2010[8].

The trivialization of AIDS was not without concern. At a PMTCT meeting organized in the district where we conducted our research, it was the head of a PMTCT for a Regional Health Directorate who reminded the staff of the importance of struggling against the scourge of AIDS: To wage a "war against HIV" she urged and "do everything so that women who don't want to take the test, will take the test". The appeal by the head of the Regional Health came across as a plea against the normalization of AIDS. Normalization of AIDS underplays the seriousness of the illness. The consequences of diminishing financial incentives are factors, which make it difficult for concerned people like the head of the PMTCT to motivate her staff. All she has at her disposal are memories of the fighting spirit of the early fight against AIDS to try and rekindle the fight against the epidemic.

The Trial's Place in the Daily Routine

Initiating the trial within the maternity ward did not radically change the health care center's day-to-day operations. However, it did have direct and indirect consequence on professionals' practices, how work was organized, how patients were seen, and finally on the quality of the care provided.

When it comes to HIV screening, the arrival of MILK helped strengthen the tendency to simplify explanations. Indeed, at the time of the survey and prior to the publication of new recommendations in Burkina Faso, the midwife simply announced a set of facts even though she was aware of the research nature of the MILK project. We attended the causerie of 19 November 2010 where the MILK trial was presented to women as if it were a project that was practically part of national guidelines, a new treatment protocol that the women were invited to follow. On the question of HIV status of the women she simply stated: "We have new guidelines. When you are HIV+, you will be sent to the pediatric hospital in the seventh month of your pregnancy. There, there is a project that will take care of you so that your child is not infected." It was interesting to note that the discourse of the health care agent tended to conflate the logics of research and health care. Women sent to the MILK project did not have any or very little information regarding the treatment conditions. Professionals involved in the trial consequently took time and care to explain the inclusion conditions at length. Conscious of the importance of women understanding and being part of the treatment conditions led them to assess their understanding of the trial at regular intervals. The program coordinator thus emphasized the ethical importance of informed consent and the scientific interest of informed participation by mothers, which was the only guarantee of strict observance by the mother-child pairs of exclusive breastfeeding with prophylactic treatment and the production of valid results. Refusals to participate were rare.

This outcome is surprisingly different compared to the data collected elsewhere. In Senegal for example, Alice Desclaux (2010) reported that the Senegalese HIV+ mothers she spoke to expressed discontent with exclusive breastfeeding with prophylaxis. They saw it as a higher risk than formula feeding as with the milk formula option, non-transmission of HIV/AIDS is totally ensured. From a personal perspective, they weighed up the advantages of the two methods of feeding an infant and viewed breastfeeding as restricting and milk formula as liberating. The milk formula option allowed them a greater sense of freedom of movement as they could leave the infant in the care of a babysitter.

The debate breastfeeding or milk formula is also applicable in Burkina Faso, with nuanced differences. A study, conducted by Tomasoni and colleagues in Ouagadougou amongst patients at Sainte Camille health center, showed that 68.3 % of HIV+ women questioned understand that HIV is transmitted from mother to child and therefore favor artificial feeding. (Tomasoni *et al*. 2011) One should notice that milk formula was available at the survey site and this is an important consideration as it raised the question of economic accessibility to this practice. Nevertheless this data is confirmed by women we met at the "*Aide-moi à être mère*" [help me be a mother-]association, an association taking care of HIV+ mothers. Some of them were attending Sainte Camille health center. In a not too distant past, breastfeeding was

considered as the norm in Africa and interpreted as a customary practice that African women were attached to. It was seen as a risk for HIV transmission. Today, the presence of HIV/AIDS and the risk of HIV mother to child transmission have influenced African women to consider alternatives to breastfeeding regarding the feeding of their babies. Research conducted by Tijou Traoré *et al*. (2009) and Desclaux (2013) demonstrates that HIV+ mothers/women are concerned about transmitting HIV to their children and to ensure their safety prefer the milk formula option. And this despite the fact that the risk of transmission from an epidemiological perspective is now considered relative.

> "Personally, I prefer 'white man's milk' [powdered milk] to breast milk. Because after I gave birth, I breastfed my child but didn't know that I had it [the virus]. The child lived one year and two months before dying. I continued to live without knowing I had it [the virus]. After my [second] delivery, they told me not to breastfeed my child. At the time, my breasts hurt and I didn't have enough milk to breastfeed. So, I bottle fed my second child. So far, my child is doing well and I am happy with his health. As for me, I prefer bottles. I don't know how other women prepare baby bottles but I [said with a degree of pride in her voice] don't leave my utensils lying around. When I make my milk, I have my towel to roll around the bottle of formula and keep it in my child's clean towel, so that the flies do not land on it... or I get a [covered] dish to put it inside." (Woman 1, group discussion, *Aide-moi à être mère*, July 16, 2011)

The ethical practices of the MILK professionals are not in question here. Indeed, the women are informed of their inclusion and their understanding of the trial is assessed several times. This example however, allows one to examine the limits of the notion of informed consent and emphasizes the fact that the women's understanding of the trial is related to the meanings they attach to it as well as the context within which they locate their understanding thereof. As such their understanding thereof does not translate into a single homogeneous concept of what the MILK trial is. Furthermore there are also other factors to consider that deal with questions of power between care providers and patients with the trial experience and the notion of trust in the relationship between non-scientists and clinicians and/or researchers in the care relationship.

Patient's referral to a Trial and Delegation of Trust

What motivates individuals to be part of a trial? Why individuals who do not necessarily understand the complexities of the trial they are in, continue to participate? To answer this question, Mathilde Couderc (2011: 330) referring to trials located in Senegal assume that people do in fact agree to be allowed to use what they see as a "project" to assess otherwise unattainable resources. According to this understanding the aspects of benefiting from the ensured quality medical care and of receiving a fix amount for their transportation cost to the health care center would influence women to participate to the Milk trial. Indeed, women in the MILK trial speak more of the "project" and its benefits and less of a trial. Couderc takes this reasoning a step further and argues that the pragmatic dimension of patient-subjects' adhesion to the clinical trial acts as a primary motivation for their participation: "The factors that intervene in the decision of HIV+ people to participate in clinical research therefore depend on how they are perceived (trials seen as social assistance) and the advantages they see: possibility of improving their health and receiving better access to care (quality care for free). Other factors enter into consideration such as the status of the person that steers them toward the project (trust in the attending physician) and the nature of the relationship with members of the research team" (ibid. 341).

The same rationale also applies to health care agents. For instance, the maternity ward midwife steers pregnant HIV+ women to MILK although she privately admits that she prefers replacement milk. According to her, replacement milk is the only thing that is entirely non-transmitting, and that, among other things, exclusive breastfeeding only pushes back the moment when cessation of breastfeeding must be explained and HIV+ status revealed. Health care agents are not reluctant to express their preference when it comes to using breast-milk substitutes in the case on HIV+ mothers. In fact Alice Desclaux and Bernard Taverne made a similar observation more than ten years ago (Desclaux & Taverne 2000: 498).

The rationale for referring patients is not solely based on the conviction that the approach is well-founded, but also on the fact that each patient steered toward and effectively enrolled in the trial can earn the referring agent up to 15,000 CFA Francs (22,8 €). The amount received by the health professional depends on his or her level of involvement and the material efforts made for inclusion from informing the patient, setting telephone meetings for the patient with the trial to physically accompanying the patient to the enrolment site.

However, this rather utilitarian reading can be nuanced: We should bear in mind that the transfer of patients from care to the trial, beyond the financial dimension, has a hierarchical component that can be described as the transfer of a patient by a low-legitimacy health care agent to another actor higher on the ladder of medical legitimacy. In our case, the first is a certified midwife who trained for 2 years to become an auxiliary midwife and then had 10 years of experience before training again for another 2 years to become a certified midwife. On the opposite, the second is a doctor, both a researcher and a clinician. In this way, what we interpret as a reciprocal relationship where the patient agrees to entrust his or her body and receive in exchange the means to maintain it and the health agent steers the patient and increases his or her income in so doing can be understood as a form of delegation of responsibility from a low-legitimacy actor to an actor with greater legitimacy within the hierarchy of public health services. Indeed, we can raise the question of the relative weight of the certified midwife's opinion compared to that of a researcher-clinician belonging to an organization playing a central role in the functioning of PMTCT locally and paying her extra money for her involvement in the "project". While both financial and power dimensions of this relation are important, the health care agent's trust in the trial team also needs to be considered.

The notion of trust is also relevant to understand the fact that mothers turn decisions about the care to provide their children over to the MILK team. In her comparative analysis of three clinical trials in Senegal, Mathilde Couderc emphasizes the importance of trust in the relationship between included patients and the monitors of clinical studies. She also mentions the impact of the patient's trust in the referring doctor on the quality of the patient's adhesion to the trial. However, she does not fully take into account the implications of this notion of trust and its ramifications beyond the trial for the nature of consent (Couderc 2011). The same can be said of Catherine Molyneux and her co-authors work on a clinical trial of malaria vaccines in Kenya (Molyneux *et al*. 2005). The importance of the notion of trust is emphasized but only envisaged in the relationships forged within the trial.

In the framework of the studies on care interactions in the public health care system in Africa, the non-recognition of trust as central to relationships (Gilson 2003) can be explained by a critical tradition in the social sciences that display a tendency to decry dysfunctions and analyze that which does not work (Jaffré & Sardan 2003) rather than describe that which works or how it works. Finally, the contrast generally observed between care relationships in the health care system and in the framework of trials minimizes the importance of trust in ordinary care relationships even though it is central to the health care system on various levels from the provider-patient relationship to the relationship between the population and health care institutions in general (Gilson 2003).

Participating in trials, we note is of advantage to both the researcher and the individual. The researcher needs to generate credible data regarding the trials whilst the individual sees pragmatic advantages therein. Pascal Ducournau discusses the question of an individual's consent to participate in a genetic database. He argues that whilst it is possible to hypothesize a participant's agreement to be part of the research as linked to a lack of information, pedagogy or vulgarization regarding the trials or simply a pragmatic desire to "use" the advantages that come with participation (which is of interest to our research); it is also important to understand that an individual's consent can also be based on an accepted "not-knowing." "The 'not-knowing' can also be deliberate and backed by a concept of medical, ethical and moral responsibility in which this responsibility is assigned to medical actors. This positioning of the question of responsibility is, among other things, at the opposite end of all ethical declarations […] that attempt to make the bio-politics of informed consent play the role of 'safeguard' in the contemporary system regulating progress in and use of genetic technology" (Ducournau 2009: 309). This notion of "not-knowing" or "not willing to know" has a long history in medical anthropol-

ogy. It was discussed in Murray Last's now classical paper first published in 1981. Murray Last was discussing Malumfashi medical culture (Nigeria), which is characterized by the cohabitation of Maguzawa "traditional" medicine, Islamic medicine and biomedicine. He preferred the term medical culture rather than medical system to describe this spectrum. Compared to biomedicine, Maguzawa medicine appears highly de-systematized and fragmented. Discussing the coexistence of these diverse medical practices, Murray Last proposes to "rank them in a hierarchy of organization and access to government funds" (Last 1981: 387). He found that the closer the medical system was to government funds, the more systematized it became. This situation refers for Murray Last to the respective history and legitimacy of medical practices. Thus, he argues that "the connection between not knowing and/or not caring to know and a hierarchy of medical systems lies in my argument that the medical at the bottom of the hierarchy can become de-systematized and that one striking symptom of this is a widespread attitude, to be found among patients and to a lesser extent among practitioners, of "don't know", "don't want to know." In our own societies lay disinterest in the intricacies of medicine is commonplace, but the public recognizes that there is a system. What I am suggesting here is that under certain conditions traditional medicine is not recognized even as a system, yet it can still be practice widely and be patronized by the public" (ibid.). For the author, the criteria used to assess the systematization of a medical practice are: first the existence of a group of practitioners relying on a common corpus of theory and set of practices, second the fact that patients recognize this group as such and although they may not be able to explain its theory they accept it and thirdly that this theory is mobilized to explain and treat all illnesses (ibid. 389). In Burkina Faso, as in the case described by Murray Last, National Health Services are on the side of the most systematized medical practices. Without denying the fact that all practices may be influenced by each other and together form one medical culture, one cannot but note the fact that National Health Services are the object of governmental intervention in pursuit of systematization. Our case suggests extending Murray Last's argument of the "not-knowing" in the biomedicine context attitude to include the notion of trust. To trust professionals within public health services is to rely on actors whose knowledge, norms and practices can be trusted because of their systemic nature. The shift from care to research in breaking this understanding results in misleading the patients.

The question of referring a maternity patient to the clinical trial enables us to emphasize two main points: If the patient fails to remark on or ask questions related to the brief explanation on PMTCT, it could be because the patient trusts the "knowledgeable" person and expects that the proposed treatment is "good for her and her child." In such cases, the patient does not necessarily want to ask for a detailed explanation on how HIV is transmitted from mother to child. Steering a patient in a clinical trial toward the clinician researchers is a delegated responsibility of the certified midwife, which is manifested in the transfer of trust from the care provider to the researcher. This resonates with Philippe Amiel's (2002: 221) research on clinical trials in France where "the actors, for different reasons, establish among themselves an agreement on the 'medical' (in the 'therapeutic' sense) nature of the situation, which is an obstacle to clear specification of the research approach as distinct from health care." In this sense, the attention professionals give to the trial during the explanation could ultimately miss its target because, while it complies with the letter of formal research ethics, it avoids the issue of the responsibility associated with the delegation of the relationship of trust inherent in the patient's transfer from a strictly medical and curative relationship to a relationship in which health care and research are intermixed. Beyond the permeability of the frontier between care and research and the notion of delegation of trust, the clinical trial in the context of day-to-day life in health care centers also raises issues in regard to health care organization, supply and equality.

The Trial's Impact on the Organization of Health Care: Treatment Delayed = treatment Denied

Health care center staffs are heavily solicited. Apart from their daily activities at the health care centers, they also participate in other health associated activities that help to augment their income. During the month spent at the health care center, in addition

to daily patient care, the health agents were called upon for the meningitis immunization campaign (December 6–15, 2010, 3,000 CFA Francs per day, i. e. 4,5 €), and for the distribution of mosquito nets in the villages within the health care establishment's zone of jurisdiction (December 17–22, 2010, 3,000 CFA Francs per day, i. e. 4,5 €). In addition, some were occasionally mobilized by local NGO projects: a project fighting malnutrition run by an American NGO (each day spent with the project gives rise to the payment of a *per diem*), and family planning activities with the NGO 'Marie Stopes International' (the referring health care agent is paid 300 CFA Francs (0,45 €) for each woman he or she refers to the NGO for contraception). The toll of such activities on the health care center environment is obvious. They compete with the day-to-day activities of the centers by diminishing their staff capacity to provide uninterrupted health care. During the mass immunization campaign of the Expanded Program on Immunization (EPI)[9] for example, the male head nurse was the only person on duty at the dispensary as his colleagues had gone to the villages to vaccinate children. If these activities impact heavily on the health center ordinary functioning, it is as well highly appreciated by health workers who increase their income by participating to them. Thus, the certified midwife of the maternity ward told us that her participation in the vaccination campaign and mosquito net distribution allowed her to increase her monthly salary by 40,000 CFA Francs (60,90 €), which is a little more than half her basic salary. The impact of these campaigns on other preventative and care activities is of concern as their activities are either reduced or postponed. The MILK activities (and the financial incentives paid for each woman enrolled) add to an ensemble of demands that, in addition to the activities themselves, generate the need to produce time-consuming written reports. The dependency of the health care system on these competing activities and their impact on the systematic use of *per diem* on the health care system's operations was recently discussed for Burkina Faso (Ridde 2011: 134–135).

These activities because of the possibility of additional income they create for participating health care staff are also the subject of jealousy. The MILK trial was no exception. The incentive conditions may vary from one health care center to another. In some cases, the health care center collectively benefits from its participation in the trial in the form of equipment and supply deliveries, but in the case that interests us, the health care agents receive individual incentives. This situation helps reinforce the individualization of PMTCT in the center whereas frequent staff absences would call for collective coverage of this activity. This individualization further goes against the PMTCT program, which states that all health care agents should offer this service. Indeed, the tendency to individualize activities, and the control over resources it allows, can harm the quality of care. This was the case when an HIV+ woman gave birth on a Saturday morning when the certified midwife was away on rest day.

The mobile health agent in charge of the Expanded Program on Immunization was the only person on duty that day. In addition to the fact that the midwife was not there to help with delivering the baby, the health agent while consulting her records learnt that the woman had not been screened for HIV and this only after the baby was delivered. He administered the test and discovered her HIV status. Not familiar with the PMTCT protocol, he contacted the certified midwife by telephone (she was in Ouagadougou for the weekend). Having received instructions from the midwife, he discovered that the drugs available were out of date. Instead of advising him to look for Nevirapine® in a neighboring health center, the midwife preferred to postpone its administration to coincide with her presence at the clinic, the following Monday. She would administer the drugs to the child and refer the pair to the MILK trial when she got back. This raised a number of questions, as the effectiveness of Nevirapine is limited to the drug being administered within 72 hours of birth. A conflict of interest arises as the delay was motivated by personal gain: By referring the pair to the MILK trial she secured her referral bonus. The midwife's action, in maximizing her share of the referral bonus in the MILK trial, raises questions of ethics and responsibility. A more effective PMTCT policy is one that is in favor of the recipients- the mother and the child. However, the referral bonus, which was probably introduced to optimize the number of pairs (mother and child) receiving treatment, presents a serious concern. Our study shows the conflict of interest that pervades this practice where health care agents in delaying treatment could also be denying patients the essential life giving treatment. Moreover, apart from the

specific context of clinical trials within health services, this example highlights two points: first the impact of the individualization of PMTCT responsibility in health centers associated with paid training. The health agent on duty that Saturday had not been sent for training on PMTCT and was not aware of the protocol although PMTCT is an activity that is supposed to be shared by all health agents. Second the impact of the diminution of HIV incidence in rural health centers: as new HIV mothers are not often seen in this health center, Nevirapine use to care for babies born from HIV positive mother is not receiving enough attention from health agents and the drugs kept become outdated.

Limits of a Systemic Set of Practices within Public Health Services

The presence of clinical trials in an already fragile public health service context can have unintended consequences. They mobilize already limited capabilities for specific interests and modify health care supply in relation to research topics. Such trials further transform the concept of the patient from an individual in need of treatment to a limited resource. At the same time, in a context of Aids routinization, they help renew the interest of health workers for people with AIDS when they are more involved through "incentives" in other vertical actions such as family planning or malnutrition. Lastly they may unintentionally increase inequalities in access to care by accentuating triage within public service as they decide who gets recruited and therefore access to the trial commodities. On a close analysis of trials within health care services, it is possible to discern different rationales. The example we discussed of maternal breastfeeding with prophylaxis does bring into relief the notion of trust and the importance of questioning recurrent aspects of health care services in Africa and our perceptions thereof.

From the point of view of trust, in the context of a health care offer where public service health care rationales and research rationales are consistently intertwined, the insistence on the ethical dimension of informed consent actually masks the dimension of trust in the provider-patient relationship. When a health care provider steers a patient towards a particular trial, the distinction between "trial" and "research" becomes fuzzy. Responsibility for the patient is transferred from the care provider to the researcher and relies on the reproduction of a trusting relationship that would deserve to be formulated in these terms by all parties subject/object and researcher alike. Indeed, it reminds the researcher of his or her position of responsibility for the patients, as in a form of contract. Citing Adriana Petryna "… Patients' informed consent should be supplemented with informed contracts on the part of local investigators" (Petryna 2007: 37). It is therefore important to note the relational dimension of ethics compared to a normative vision of ethics, conceived in a limited manner as an ensemble of rules to respect.

Clinical trials and other actors like NGO's are at the heart of health care services in developing countries. This raise questions about the implementation of coherent and fair national health policies and about the governance of Health Systems. Health System specialists D. Balabanova *et al*. state that: "Governance underlies all health system functions in addition to broader social development, although the meaning of governance in relation to health systems is diverse and contested. It includes the regulatory and managerial arrangements through which the health system operates, including how overall goals are set and monitored and how various components of the health system interact to achieve these goals" (2013: 1–2).

Good governance is a crucial aspect in ensuring seamless delivery of health care initiatives as part of the broader social development programs. In an ideal situation, the State would be in charge. However, our fieldwork has demonstrated that the delivery of health care initiatives is seriously compromised when confusion reigns. We have noted that the question is not only who governs health system but who makes them work, who sets the norms, regulates the practices and with what consequences on the relation of the public to the public health services? This translates into the synergy required between a health care system that incorporates principles of good governance reflected in the State and an effective health protocol that is effective and unambiguous.

According to Didier Fassin "… biolegitimacy has become a crucial issue on the moral economies of contemporary societies" (Fassin 2009: 50). The right to live he holds has become the "generalized mode of governing" (ibid. 50). In the example we cite above, health services organized by the State

in many ways experience difficulties in delivering and/or implementing their mandate. The fragility of the Public Health Service consequently facilitated the introduction of alternate health actors. The presence of diverse actors (be they NGOs or clinical trial) as supporting structures is not without risk. They have their own operational logics, which are often different to the official health services. As a result, the number of health protocols in a region function independently, often working against each other as well defying attempts to synergize them. In theory, the different actors, present in the region, are guided by the idea of supporting health care supply. This 'altruism' does bring its own logic, which—as we have noted—becomes a set of competing logic in a terrain where logic does not exist singly. The presence of multiple logics in a terrain introduces its own logic of operations. Indeed actors implementing National policies are not State actors but private ones (NGO's, clinical trials) acting within Public Health Services. This situation fosters local arrangements with guidelines and creates parallel protocols (on recourse to care, advice, as well as new supervision bodies) that distance the upper levels actors of the national health care services even further from the local actors.

The presence of multiple actors within the field of public health care delivery puts into question its legitimated status. This co-presence results in multiple rationales of diverse actors crisscrossing and all independently convinced of their role in "serving" public health care services. The resources and expertise they provide seem to be reason enough for them to believe this. The reality is however far from this imagined service the different actors believe they provide. In this respect, we agree with Jean-Pierre Olivier de Sardan (2009) that it is in the interest of a functioning health care system in Africa that we revise our notions of the State in Africa. In this vein, we should reimagine the expected vocabulary referring to health services whose practices would be nationally defined at the central level and re-think this hybrid subject in a new light based on the practices that take place within it and the multiple local and international rationales it harbors.

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Notes

1. It was in this context that new sources of funding deemed more sustainable were imagined to finance, for example, access to drugs via UNITAID (Gérardin & Poitot 2011).
2. This data was collected as part of the ANRS project 12228 "*Accès aux soins maternels/infantiles et suivi des femmes infectées par le VIH/Sida au Burkina Faso. Une initiative multidisciplinaire pour contribuer à la réduction de la TME (2010–2012)*" [Access to maternal and child health care and monitoring of women with HIV/AIDS in Burkina Faso: a multidisciplinary initiative to help lower MTCT (2010–2012)]. This program was co-directed by Frédéric Le Marcis (IRD, ENS-Lyon), Marc-Eric Gruénais (Univ. Bordeaux Segalen) & Fatoumata Ouattara (IRD). Frédéric Le Marcis, Fatoumata Ouattara, Adama Traoré and George Rouamba carried out the ethnographies alone or in teams.
3. SP/CNLS-IST, Bilan de la mise en œuvre du PNM 2010, Ouagadougou, April 2011.
4. We have followed a policy of anonymity for the trial in question and the people interviewed during our research. The name of the trial has therefore been changed.
5. For a thorough description and analysis of the trial and its logics in a science studies perspective, see Brives (2013).
6. In 2002, the Burkinabe government did abolish all antenatal consultation user fees (De Allegri *et al*. 2011: 211). The HIV test being part of the ANC, it does not require any payment from the women. One should nevertheless pay attention to the local applications of these policies which often end up in extra fees paid by the women (Ridde 2013). In our case at the beginning of the ANC, Women had to pay for their booklet 300 CFA Francs (0,45 €).
7. Hulling early corn is hard work because the grains are still fresh and solidly attached to the cob.
8. "The second report covers the examination and adoption of a decree adopting the Prospective Study on HIV/AIDS in Burkina Faso. From its recognition as an epidemic in 1986, the Burkina Faso State has consulted with the World Health Organization (WHO) and adopted policy guidelines for better knowledge of the pandemic and effective response to it. This strategy has led to a regression of the illness in our country. The HIV infection rate has fallen from 7.17% in 1987 to 1.6% in 2008, with the rate continuing to drop. The main traits that emerge deal mostly with institutional, socioeconomic and cultural factors, human and financial factors, the consequences of run-away urbanization, poverty and population movements. The adoption of the present decree aims to cause HIV/AIDS to be seen as an ordinary illness, eliminate all forms of exclusion of HIV+ people, and finally facilitate treatment of people infected and/or affected by the pandemic," (minutes of the Council of Ministers meeting on December 29, 2010).
9. In French, *la stratégie avancée de vaccination du Plan Elargi de Vaccination (PEV)*.

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Frédéric Le Marcis & George Rouamba**: L'essai et la routine. Sur la relation problématique entre routine du soin et «acteurs privés» au sein des services de santé ouest-africains (Burkina Faso),** p. 211–226 (rédigés en anglais).

Partant de la description d'un essai clinique portant sur la Prévention de la Transmission du VIH de la Mère à l'Enfant au Burkina Faso, cet article traite d'un aspect récurrent au sein des services de santé en Afrique de l'Ouest: celui de la confusion entre recherche clinique et soin ainsi que ses conséquences. L'analyse de l'insertion d'un essai clinique au cœur des soins quotidiens montre comment logiques de soin et de recherche se mêlent et transforment la façon dont la prise en charge est organisée et en quoi cela impacte la notion de confiance au cœur des interactions de soin. Ce cas est discuté avec d'autres activités comme les programmes verticaux qui structurent les pratiques de soins de santé. Cette discussion invite à rompre avec notre compréhension des services de santé en Afrique et appelle à une attention accrue portée aux tensions et contradictions qu'ils abritent. En reconnaissant les multiples acteurs et logiques présents dans le secteur des soins de santé, cet article pose la question de la possibilité d'une politique nationale de santé cohérente et juste. (a)

Mots clefs essai clinique – services de santé – PTME/VIH – confiance – Burkina Faso

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