Panel 12: Private health care in sub-Saharan Africa: between constrained accessibility and enhancement of health care?

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Private Clinics: A Neglected Actor in AIDS Care in Benin?

(Draft – do not circulate without author's authorisation)

Introduction

As a consequence of the implementation of structural adjustment programmes in Benin in the early nineties, the private health care system has been strongly developing in the country (Boidin, 1996; Decaillet, 2000). The state's inability to recruit newly graduated health personnel led to the opening of numerous private clinics and health centres as an alternative to the scarcity of employment in the public sector (Boidin, 1996; Ministère de la santé, 2006). The lack of public control over this development enabled the emergence of an anarchical, highly diversified private health sector which encompasses private-for-profit and faith-based hospitals, formal and informal structures, NGOs and firm health care centres, as well as public servants moonlighting in private practices.

The diversity of this sector and the lack of a proper data collection system make it complicated to precisely know the personnel employed in these structures, the kind of activities that are practices, the state of their infrastructures (Dossou, 2011). One striking statistic though, regularly emphasized by private practitioners, relates that “67% of users prefer to go to the private sector for health care” rather than to the public. Even though it was not possible to confirm this data, it is known that an important number of patients who enter the health system favour private over public health care (Marek T. et al, 2006). Of course, as we have already acknowledged, “private sector” in this context is a comprehensive yet vague notion. It is therefore difficult to cut a clear line, for example, between the proportion of users choosing a faith-based hospital and those choosing private-for-profit structures. These numbers nevertheless strongly indicate a general trend: the private sector appears as a lesser evil for many users. The well-known flaws of the public sector (corruption, treatment of patients, lack of resources, regular strikes...) can probably account for a large part in the decision to turn towards private

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1 Data on the private sector in Benin is really scarce and hard to gather, even when it comes to simple statistics about the number of private clinics existing in Benin. It has not been well taken into account by the public data system which concentrated on public structures and it is also complex to collect since many structures are either informal or not properly registered with the health authorities. Data on the private sector in Benin is therefore either limited or outdated.

2 As legitimising their place in the health system, this number has been repeatedly referred to by several directors of private clinics during interviews I held with them (April 2011).

3 Based on the 1996 "Demography and Health Survey", this paper shows that 41% of the poorest families and 53% of the richest families who entered the health system chose private health care. Not entering the health system nonetheless remains the most common choice.
health care (Jaffré, Olivier de Sardan, 2003). Beyond what it tells us about the state of the public sector however, it also underlines the necessity to think in terms of complementarity between the private and public health sectors to develop a comprehensive view of the national system. In this view, it seems that a service made available to the general population should therefore also be accessible through the private providers of the country.

Looking at the sub-sector of AIDS treatment and care, this issue takes a particular importance. In the context of the international initiative towards universal access to treatment, Benin has implemented a national policy which aims at reaching 75% of patients who need a treatment by 2010 (WHO, 2003; CNLS, 2010). In order to reach urban as well as rural areas, a strong emphasis has been put on the decentralisation of AIDS care to the peripheral level of the health system (PNLS, 2010). In 2011, the national response to AIDS encompasses more than 80 health care centres where AIDS treatment and care is offered (interview with the head of a department at the national programme on AIDS, 12 May 2011). Among these centres, only a handful are faith-based hospitals, three are NGOs and one is a private clinic. This mapping of AIDS care therefore seems contradictory with the previous goal of "universal access". How can this seemingly negligence of private medical actors be explained? Is it a strategy from private actors or were they cast aside? And what does it tell us about AIDS care in Benin and the collaboration between private and public health sector?

This paper will focus on private-for-profit clinics and their role or more precisely their lack of implication in the national AIDS care system. It aims at analysing the reasons why actors that play such a significant role in the health system have been put aside or have preferred to remain uninvolved when it comes to AIDS treatment. Our hypothesis is that this negligence is, on the one hand, representative of the difficulty for private and public sectors to work together and, on the other, of the complexity to make activist and managerial logics coincide in implementing a sustainable treatment policy.

This work is based on three fieldworks between March 2010 and May 2011 conducted in Cotonou in the context of a PhD research focusing on the sustainability of Benin’s national policy for access to AIDS treatment. Overall, more than 70 in-depth interviews were conducted with different categories of actors involved in the national policy (donor and international non-governmental structures, state actors, non-governmental actors, health personnel in health care centres). As far as the private clinics are concerned, we only included in our study health structures that would have the capacity to provide AIDS care, and so we concentrated on private clinics of a certain size: run by a medical practitioner, with a diversified staff, sufficient infrastructure, laboratory to run medical exams... We also put aside faith-based hospitals since, despite their private status, they are often integrated in the national pyramid of care when they serve as district-level hospitals. The focus on Cotonou and more generally the Southern part of the country can be explained by the concentration of private health structures in these

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4 Recent data about the number of AIDS centres was not available at the time of the writing. Data from 2008 listed 59 centres including 7 faith-based hospitals, 4 NGOs (including one with 2 centres), one military hospital and one private clinic (PNLS, 2008). About 8 new centres are included each year and a few NGO projects came to an end since then. So there are more faith-based hospitals today (10?), 3 NGOs, one military hospital and one private clinic.

5 In the rest of the paper, “private clinics” will therefore refer to what we previously called “private–for-profit clinics”, unless stated otherwise.
relatively richer departments (Decaillet, 2000). All clinics are also members of the “association des cliniques privées du Bénin” (association of private clinics in Benin), an association that aims at unifying private practitioners. We chose this group because it represents the private clinics we are interested in, and also because all clinics selected for the new Global Fund project (see below) are members of this association.

This research took advantage of a newly-started project within the current round funded by the Global Fund to fight against HIV/AIDS, tuberculosis and malaria (Round 9). This project aims at increasing the integration of the private sector in the fight against AIDS. As far as the private sector is concerned, its main components in care and treatment are: the improvement of health insurance mechanisms and the reinforcement of the AIDS care provision by private clinics. The goal is to choose 20 clinics with which to develop these health insurance mechanisms. Among these 20 clinics, the project will select 5 clinics that will be provided with a medical practitioner and a lab engineer in order to start an AIDS care programme in their structure. At the time of our fieldwork, the project was in its early stages, having just selected 10 participating clinics (interview with a person from the management unit for the private component of the Global Fund, 18 April 2011).

This paper is organised as follows: the first part looks at the broader context in which AIDS care takes place to underline the fact that the private sector is regularly set aside when it comes to elaborating and implementing health and AIDS policies in Benin, thus highlighting the gap between the private and public sectors. The second part will show that this peripheral role of the private sector can be best explained by the complexity of making activism and management logics coincide within the same policy.

1- The private health sector, a actor generally set aside?

To better understand the reasons behind the lack of involvement of the private sector in AIDS care, it is necessary to look at the broader context, both in the health sector and the AIDS sub-sector in Benin.

This more general view over the health sector functioning highlights the difficulty for a public health sector ran by a public health ministry to take into consideration private actors over which, by definition, it has little control and almost no overview. As mentioned in the introduction, the private sector developed in the beginning of the nineties as an alternative source of employment for newly-graduated health personnel in the context of structural adjustment and reduction of national health spending. The end of the more controlling marxist-leninist regime that governed Benin from 1972 to 1990 can also explain the development of a sector no longer submitted to strict regulations (interview with the director of a private clinic, 26 May 2011). This expansion of the private sector was neither controlled nor shaped, nor anticipated and planned for by the state. As a result, the private sector is a “nebula” of structures varying in size, status, equipment, infrastructure, personnel, qualifications... (Decaillet, 2000). The lack of regulations makes it particularly easy for any graduated doctor, who has the financial means to do so, to open a clinic (interview with the director of a private clinic, 26 May 2011). There is no reliable track of the number of private health structures or of their activities in Benin, even less in Cotonou where the sector is expanding without any control. And not until 1997 did a law
actually attempt to regulate this part of the health sector. This attempt, however, was limited since all corresponding application decrees were not issued (Ministère de la santé, 2006). Confronted to this blurry sub-sector, the ministry of health which is supposed to elaborate the national health policy is generally unable (unwilling?) to acknowledge the private sector and include it in its activities. The yearly health statistics report published by the ministry of health, for instance, concentrates almost exclusively on public structures (Ministère de la santé, 2008).

What is more, in this “nebula” context, the cooperation between the private sector and the ministry of health is far from ideal. There is no real mechanism implemented to compel private structures into cooperating with the public sector, neither for data collection nor for policy implementation. The other way around, there is also no mechanism that would encourage the public sector to integrate the private sector more closely (as mentioned previously, the health statistics fail to take the private sector into account). A European project funded by the 8th European development fund attempted to create a public-private partnership. According to private clinics directors I interviewed, its effect had not been tremendous and up to now, little remains of this project (interviews with directors of private clinics, 4 and 13 May 2011). This could almost be qualified as an on-going turf war between the private sector and the ministry of health. Not only is the cooperation failing but health policy is mainly elaborated at the national level without references to the private sector. Private practitioners or their representatives are rarely invited to participate to a national level policy meetings (interview with the director of a private clinic, 13 and 26 May 2011).

Perceptions are also playing a role in this divide between private and public health care. As far as the ministry of health is concerned, private-for-profit clinics are only looking to make a profit out of health problems. They are regularly opposed to private humanitarian hospitals which are supposed to have a more social intake on health. The association of private clinics in Benin rejects this distinction on the motive that humanitarian hospitals are providing the same care as they do for similar prices (except for consultations) while they benefit from tax reduction and state subsidies (interview with the director of a private clinic, 4 May 2011). In return, they denounce the inefficiency of the public sector and its malfunctioning which prevents, according to them, proper cooperation between public and private actors. And private practitioners generally have the tendency to stay aside from the public sector, refusing also to participate to activities that are seen as time taken away from their own practice for useless purposes (interview with the director of a private clinic, 4 May 2011). Doctors in the private sector generally mentioned in-training activities organised by the ministry of health only to regret that they would be so seldom invited and that when invited, it would be so untimely that attendance would not always be possible (interviews with directors of private clinics and doctors of faith-based hospitals, April and May 2011). Paradoxically, they regret the way the ministry of health “mishandles” the private sector. They wish for a public intervention that would clear up the private sector from informal health structures that do not meet certain standards (interview with the director of a private clinic, 27 May 2011). What best characterises the relationship between the private-for-profit and public health sectors is the notion of divide. Each sector works in parallel, not seeing the other as complementary and only occasionally crossing that divide to collaborate.
This notion of divide is also present in the national AIDS policy. The particular history of this sub-sector of health explains the isolation of the private sector. The HIV/AIDS pandemic was discovered in the early eighties. Its new character explains that knowledge about the epidemic had to be progressively build. AIDS care has therefore been constantly evolving, being reinvented and improved as the understanding of the epidemic increased. On-going progress in AIDS research afforded better insight on the epidemic and helped develop AIDS care step by step. In the case of Sub-Saharan Africa, the lack of evidence on treatment in Africa let the field open to prejudices about African patients and health systems. Common knowledge stated that, contrary to developed countries, AIDS treatments should not be made available in developing countries (especially Africa) since patients would not be able to follow their treatment properly and health systems would not have the capacity to provide proper care and follow up. These individual and structural supposed failures would result in virus resistances and ultimately make the epidemic worse. It took a paramount lobbying effort by AIDS activists and NGOs to actually show that it was possible to offer proper AIDS care in Africa. By starting their own AIDS care projects, NGOs proved that it was possible to make treatment available to African patients. Lobbying at the international level was also necessary to switch the priority for “prevention only” to “prevention and treatment” programmes. The central role of activist NGOs and medical experts shaped this model of AIDS care.

Treatments started to be available in Benin in 2001. A few Beninese doctors confronted to HIV-positive patients turned toward the French doctors under whose supervision they did their specialisation internship. These doctors mobilised their own network for support and funding (Bonvalet, 2010). AIDS care therefore started as an interindividual networking of French and Beninese doctors, all working in public hospitals. As AIDS care progressively developed, more and more health centres were included in the circuit of care. Public hospitals were however chosen first as a result of this cooperation between doctors who worked in public hospitals. From the point of view of foreign intervention, it is also compulsory, or at least relevant, to cooperate with the ministry of health and therefore with public hospitals, starting at the top of the health pyramid. Developing a care policy following the health pyramid from the national to the local level necessarily neglects private clinics since they have not been included into this public health scheme. There was also probably a turf war between the public and the private sectors, or at least a fear by doctors in the public sector and in the ministry of health that private practitioners would sell treatments, that were heavily subsidised, at a higher price and generally misappropriate AIDS care without any control over their practices (interview with the director of a private clinic, 4 May 2011; Burgha, 2003). Even the example of the only private clinic in Benin having undertaken AIDS care did not seem to change much and communication between private practitioners and the national programme on AIDS is still limited: a high-ranking doctor at the national programme on AIDS is still certain that this clinic stopped including new patients two years ago while all they did was to stop for a short period of time (interview with the head of a department at the national programme on AIDS, 12 May 2011). Cooperation with the local structure representing the national programme of AIDS in the department is also complicated and the relationship is quite strained (observational study of a meeting with an international donor at the private clinic, 4 February 2011).

The model of AIDS care that has been privileged is however starting to show its limitations. More
and more public health centres are included into the national scheme of AIDS care but hospitals in Cotonou, which were the first included and therefore the most advanced, show signs of exhaustion. Personnel is scarce and overwhelmed with patients. Care is still seen as the prerogative of the minority of health personnel that has been trained for it. Quality of care is therefore difficult to provide, especially in a context where care is constantly evolving in order to meet new challenges of this chronic disease (virus resistances and treatment adaptation, inclusion of virologist exams in the care package...). At the other end of the spectrum, peripheral centres often need to deal with a distance problem that is not easily overcome. They have trouble retaining qualified personnel in their structures, implementing all activities, having access to far away lab exams... (Observational study of a supervision mission, Atacora, 16 and 17 May 2011). This scarcity context brings up the question of complementary resources and health structures that could participate to the AIDS care pyramid. Private clinics could actually offer this complementarity since they generally already have a well equipped infrastructure with trained personnel and often various medical specialists. They could therefore help diversify the supply of care. Beyond the need of complementary structures, AIDS care has generally been first implemented through vertical programmes in special units and structures (Kerouedan, Eboko, 1999). Thinking AIDS as a chronic disease though, it becomes a priority to integrate it into the “normal” health system and therefore include all levels of care (decentralisation) and all kind of actors (private clinics) in AIDS care. Interviewed directors have also often emphasized that the confidentiality they are able to maintain in their structures is higher that what can be afforded by public hospitals which have long dedicated a building to AIDS care and treatment (interviews with the directors of private clinics, 4 and 13 May 2011). The inclusion in the newly-funded Global fund national project of a component aiming at including the private sector in the fight against AIDS and in AIDS care is the sign that national actors have fully recognized the need to diversify the supply of care. Five clinics will be provided with a supplementary doctor and lab technician so as to start providing AIDS care in their structure.

The complicated relationship between the public and the private components of the health sector and the historical development particular to the AIDS domain are elements of context that can help explain the lack of implication of the private sector in AIDS care. We will now look more deeply into the logics of action that lead actors of care to show that the managerial logics of private clinics can only appropriate the activist logic of public AIDS care with great difficulty.

2- Activism vs management: why it is so difficult for private clinics to deliver AIDS care

The history of AIDS is a history about activism. Since the discovery of the first cases in the beginning of the eighties, innovations in the domain of AIDS prevention and treatment have been strongly pushed for by activists involved in the fight against AIDS. Even though activism is far from being a unified logic for action across time, place and issue, it is necessary to acknowledge the paramount role played by different actors all following a logic of action that can be best characterised as “activism”. As far as Sub-Saharan Africa is concerned, starting AIDS therapies and AIDS treatment
policies became possible, as mentioned previously, thanks to the lobbying and activism of different NGOs and structures involved in the fight against AIDS.

Among doctors themselves, not all were/are involved in the fight against AIDS. If career strategies and other reasons would need to be more deeply studied for their role in this choice, activism is quite often part of it. In Benin, we already emphasized that, in the absence of any AIDS treatment policy, it was doctors who, confronted to HIV-positive patients, mobilised their international professional network in order to trigger a policy in the beginning of the decade 2000. With little to no official mobilisation towards AIDS treatments at the international as well as national level, the first steps taken to ensure treatment to AIDS patients in Benin were due to an activist logic. The head of the paediatric department at the national reference hospital in Cotonou contacted the French paediatrician in whose service she did her internship during her medical studies. He, in turn, mobilised AIDS experts from his own network in order to start a treatment pilot-project in a few hospitals in Cotonou (Bonvalet, 2010). This small group managed to convince the French cooperation programme to fund their pilot-project and, more generally, to persuade the Beninese national programme on AIDS (and the ministry of health) to elaborate a national policy for access to treatment. Even before that, the doctor who identified the first case of AIDS in Benin also tried to mobilise resources and expertise in order to take care of these first patients, even though there was, at the time, no treatment available. At a time when no one wanted to hear about AIDS, he founded an NGO to gather funds to provide a few patients with support and care and start an AIDS clinic (interview with the former head of a hospital service, 22 March 2010). Even after the national programme on AIDS started to elaborate and implement a national treatment policy, French and Beninese AIDS experts kept on lobbying for the improvement of care. Most notably, the introduction of more costly but more precise follow up exams for AIDS patients was a long-lasting battle. The basic WHO model only included CD4 count in the exams necessary to know whether to put a patient under treatment. Viral load testing, however, offers more relevant information when it comes to measuring the efficiency of the chosen regimen. As often, better care comes at a higher cost and AIDS experts had to convince the national programme of the benefits of implementing viral load testing in Benin even though at the time it was not part of the main WHO recommendations (interview with a French paediatrician specialised on AIDS, 6 May 2010).

These few examples show the importance of activism as a driver for action in the context of AIDS. Even though they take the case of medical experts and doctors involved in AIDS care, they are not the only group of activist actors in Benin. In parallel to these efforts towards the start of a national policy for access to treatment, there were several pilot-projects implemented by NGOs. Doctors without borders led a three-year project in the countryside to show that decentralised access to treatment was possible. Médecins du Monde funded another project to help implement care in peripheral centres more quickly and efficiently (interview with the medical coordinator of an international programme on AIDS, 17 March 2010). Activism, however, is not just the prerogative of actors that are outsiders in the AIDS policy system. It is important to emphasize the fact that most people (often doctors) occupying high-level positions in the national programme on AIDS are also taking a rather activist stand. For the majority of them, they spent all or most of their career working for varied programmes and projects to fight against AIDS. AIDS is more than just another disease, it represents a personal engagement. At the hospital
level, this is also a discourse that is often heard among health personnel involved in AIDS care. AIDS asks for more than just medical skills. It needs “abnegation”, “engagement”, “self-sacrifice”. It is a “fight”, much more “time consuming” than in other services, in which you need to help the patients, even sometimes “give them something out of your own pocket” without getting paid more for it (interviews with health personnel in Cotonou, March-April 2010). AIDS is therefore presented as a total engagement that goes into the same direction than an activist position. Further research is nonetheless necessary to better understand logics behind and professional strategies undertaken by health personnel working in AIDS services.

The question of activism in AIDS policy can be best discussed around the issue of free access to AIDS treatments. Among the reasons for not making AIDS treatments available in African countries came the issue of their cost: how could low-income countries and their poor population afford such costly treatments? Two courses of action towards free access were undertaken. On the one hand, steps were made towards the price reduction of treatments through the production of generic drugs in certain developing countries and through lobbying of pharmaceutical laboratories. On the other, free access to AIDS treatment and care was advocated by different actors (experts, civil society organisations, researchers, NGOs...). Free treatment, it was argued, would increase the number of people under treatment in low-income countries as well as rates of inclusion and adherence, and eventually help stop the spread of the pandemic (Taverne, Diop, Vinard, 2008). This stand towards free access was definitely an activist position since it privileged health (we need to increase the number of patients under treatment) over management reasoning that would favour cost-efficient activities. The first point of view looked at public health, the second at economically sound interventions.

In Benin, the network we already mentioned, constituting of doctors, also lobbied for free access to treatments in opposition to the system of patient's proportionate financial participation that was then existing. By lobbying international and national governmental actors, they managed to convince both Benin's authorities to introduce free treatment in their official AIDS policy and international donors to fund the initiative. Free access to treatment was officially declared in December 2004, which is a real political choice since it only became part of the WHO strategy in 2006 (PNLS, 2010; Taverne, 2010). It is interesting to look at what can be seen as an “activist initiative”. At the time, national actors were not all convinced by the provision of free AIDS treatment (interview with the head of a hospital service, 30 April 2010). However, the fact that international donors (mostly France and the Global Fund) agreed to this arrangement, which was also being supported by the Beninese and French experts involved in AIDS policy, helped achieve this goal. Since then, free access to treatment has been described as a political success of the Beninese AIDS policy: studies have been conducted by the national programme to show how this initiative played an paramount role in the expansion of access to treatment at the national level and was then broadly advertised as a success (interview with a former coordinator of the national programme on AIDS, 23 April 2010). It became a national consensus to such an extent that it is nowadays difficult to call it into question.

Where are private clinics in all that? How can private-for-profit structures get involved in a policy that privileges an activist stand? Private clinics are by definition structures that are seeking profit in their
activities, which appears to be in contradiction with the activist logic that underlines the definition of AIDS policies. “Free access to treatment” obviously does not mean that the antiretroviral drugs and all the necessary supplies suddenly come at no cost at all. It only means that the patient at the end of the circuit of care does not bear their cost. To that purpose, international donors and the state take charge of these costs. In Benin, international donors represent about 65% of the funds allocated to the fight against AIDS, among which the Global Fund is the most important donor (CNLS, 2010). Without the latter, there could be no antiretroviral drugs since they are buying most of the drugs at the national level (interview with a person from the head office for buying essential medicines, 20 May 2011). The state mostly participates through its infrastructures and health personnel. Therefore if a private clinic wants to start AIDS care, it will have to compensate the participation of the state: once included in the AIDS care circuit, this structure will have access to supplies provided by the Global Fund. However, nothing is planned as far as infrastructures and health personnel are concerned. A clinic therefore needs to use its infrastructure, to make its personnel work without making any profit out of it (interview with the director of a private clinic, 13 May 2011). Looking at the broader picture, the issue of free access to care is quite similar in public hospitals. With the general health policy of users’ fees and cost recovery launched by the Bamako Initiative, hospitals have been trying to generate resources to self-sustain, at least to a certain extent. The AIDS services are therefore representing a problem for directors who do not want to invest in a service that will not generate resources to the hospital. There often are tensions between the administration and AIDS services around these issues (interview with a doctor in an AIDS service, 10 March 2010). This issue however did not easily become an openly discussed problem: accepting the fact that AIDS care is (too?) costly for the state is not really compatible with an activist logic that emphasizes the necessity for universal access now. For a very long time, public structures did not even want to mention the problem of the cost of care (interview with the director of a private clinic, 27 April 2010). As the problem becomes more and more obvious though, the problem starts to be taken into account and a study about the real cost of care was supposed to take place last year. The non-respect of the yearly budget plan and the lack of agreement between the funding structure and the national programme on AIDS over the consultants did not permit this study to be realised (discussion with the head of a department at the national programme on AIDS, 10 February 2011). This might actually be the sign that the issue is not yet completely consensual.

As mentioned previously, one private clinic, though, has been involved in AIDS care since the beginning of access to treatment in Benin. This involvement however is the result of an activist logic within the management logic that usually shape private clinics. Although aware of the cost it represents for his clinic, the director decided long ago that he will provide AIDS care in order to fight AIDS. To reach this goal, he used similar strategies as actors following activist logics in other structures: he turned toward his own network and started a partnership with a French association that was set with the single purpose of providing the clinic with funds to support AIDS care (interview with the director of a private clinic, 27 April 2010). The cost of AIDS care for this private clinic is tremendous. Antiretroviral drugs are being provided through the national programme on AIDS although in case of shortages, the clinic will use its own resources to provide, for instance, the necessary reagents for lab exams (interview with the director of a private clinic, 4 May 2011). At all times, the rest of the free package of care has to be
supported by the clinic. Medical consultations, which are free for HIV-positive patients included in the circuit of care, are one of the main problems for the clinic since these patients need them on a regular basis. A quick calculation of the cost of AIDS care for the clinic shows that it is the equivalent of the salary of a doctor and a lab technician (interview with the director of a private clinic, 4 May 2011). This represents a real engagement for private clinics and without the project funded by the Global Fund which compensate these losses, new clinics would never have entered AIDS care (interviews with the directors of private clinic, 13, 19, and 27 May 2011). Moreover, to them, HIV-positive patients in a country with a rate of HIV-infection at less than 2%, is not necessarily a priority. Providing AIDS care is part of a strategy to provide the most extensive range of care possible so as to not need to refer patients to public structures (interview with the directors of private clinics, 13 and 19 May 2011).

Moreover, the suspicion that exist between the public ministry and the private sector can also be found between the national programme on AIDS and private clinics. For instance, in the national guide for “policy, norms and procedures to care for people living with HIV/AIDS in Benin”, it is written that HIV-positive patients will have to pay their consultations in the private sector if they choose to go there (PNLS, 2010). This is the sign that it has been long recognised, even if not publicly advertised, that free access to treatment would present private clinic with a dilemma. In practice, however, the director of the only private clinic where AIDS care is provided, chose not to make HIV-positive patients pay for their consultations since it could be used as an opportunity by people who do not believe the private sector to be handling AIDS care properly (interview with the director of a private clinic, 4 May 2011).

Involving private clinics in AIDS care in Benin is complicated both because of the strained relationship that exists between the private and the public sector and because of the activist logic that drives AIDS policy. The new project funded by the Global Fund is the sign that this issue is now becoming a public problem and starts to be taken into account by different categories of actors. Subsidising 5 medical practitioners and 5 lab technicians for 5 years at the level of a country, however, is far from being the response everyone calls for when it comes to integrating private actors in AIDS care and AIDS care into the national health system. Beyond the activist and the management logics exists a context of development aid that favours short-term projects, multiple international actors and anarchical functioning of the health sector. Creating a sustainable model of AIDS care is therefore quite complicated when actors, whatever their logic is, realise that they are almost completely unable to think in the long-term and anticipate the next years. A striking example of this problem was the recent shortage of antiretroviral drugs in Benin provoked by a bad anticipation of the transition from one financing round of the Global Fund to the next (discussion with the medical coordinator of an international programme, 1 April 2011). In this context, even if actors manage to bring together activist and management logics, this will never be enough to solve the sustainability issue which is the real long-term problem when faced with a chronic disease.
BIBLIOGRAPHY


