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Worksite HIV testing in Côte d'Ivoire: from medical power to social control

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Worksite HIV testing in Côte d'Ivoire: from medical power to social control

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Abstract

The literature about workplace health initiatives generally stresses the mutual benefits of these programmes for employers and employees. This is also the case for HIV Counselling and Testing (HCT) workplace initiatives in sub-Saharan Africa. This article aims to critically analyse the worksite as a beneficial HIV testing place, questioning if the workplace – as a place characterized by its authority and dependency relationships – enables employees to freely consent to and participate in HIV testing. It questions which types of power occur in health worksite programmes in Sub-Saharan Africa, examining *disciplinary power*, *pastoral power* and *managerial/neoliberal power*. This study is based on a qualitative survey conducted over a period of 12 months (between November 2011 and May 2013) among 30 large private companies in Côte d'Ivoire (HIV prevalence 3.2% in 2015). This article argues that private companies still represent a constraining "apparatus," which enables the use of disciplinary and pastoral power, specifically by medical staff upon low skilled employees. However, worksite HCT programmes can also give the employees (generally more skilled) the opportunity to increase the « techniques of the self » with regard to their own health via the normalization of HIV testing and the pressure of their colleagues' social control. The example of the HIV/AIDS workplace programmes in Côte d'Ivoire illustrates the deep ambivalence of workplace health programmes, between public health opportunities and human rights risks.

INTRODUCTION

In 2001, the International Labour Office (ILO) made the following recommendation:

> *"Testing for HIV should not be carried out at the workplace except as specified in this code[1]. It is unnecessary and imperils the human rights and dignity of workers: test results may be revealed and misused, and the informed consent of workers may not always be fully free or based on an appreciation of all the facts and implications of testing" (ILO 2001, 14).*

Indeed, during the 1990s, private companies based in Sub-Saharan Africa usually tested their employees for HIV – for discriminatory purposes – without their knowledge or consent (Aventin 1997; London and Myers 1996). At a time when antiretroviral (ARV) treatment did not exist, and when a diagnosis of HIV was directly linked to imminent death, some firms sought to save on the costs related to the disease (absenteeism, healthcare expenses, weak productivity, funerals, turn over, etc.).

Twelve years on, in 2013, the ILO and UNAIDS launched the programme known as "VCT@work" ("Voluntary Counselling and Testing at work"), with the goal of testing five million of the world's workers by 2015. Regarding this agenda, Michel Sidibé, Executive Director of UNAIDS, stated,

> *"If workplaces embrace this new initiative, it could signify one of the most important advances we've seen in expanding access to HIV testing within a healthy, enabling environment and linking to on-going support including treatment".*

In one decade, the perspectives of international organizations, researchers and stakeholders regarding worksite HCT changed radically. While until the early 2000s, the worksite was perceived

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[1] Namely, under 1) epidemiological studies, 2) voluntary testing (which should then be carried out "by community health services and not at work") or after occupational exposure.

as a dangerous testing place because of the possible human rights abuses of the employer, over the course of the 2000s, it became a privileged place to implement HCT programmes (Bhagwanjee et al. 2008; Gavin George and Quinlan 2009; Arimoto et al. 2013; Weihs and Meyer-Weitz 2014). This turnaround can be partially explained by the expansion of ARV availability in sub-Saharan Africa and the proactive engagement of private corporations – such as the *Compagnie Ivoirienne d'Électricité* (CIE) in Côte d'Ivoire, the Anglo American Corporation, Debswana, Heineken or Lafarge in Sub-Saharan Africa – to provide worksite prevention and treatment services (Rosen et al. 2007). However, the turnaround also reveals the deep ambivalence of workplace health programmes, between public health opportunities and human rights risks.

The biomedical and economic health literature concerning workplaces in both the North and South generally outlines the mutual benefits of workplace health programmes, which are said to enhance the company's productivity and profitability, to improve the health of employees and to strengthen public health (Coates et al. 2007; Hartwell et al. 1996; Rosen et al. 2003). However, the critical literature cites several problems: the risks of the breach of confidentiality, the abuse of authority and companies pressuring employees, the issues of control, surveillance and intrusion into private life (Allender, Colquhoun et Kelly, 2006) and the differential treatment between qualified and unqualified employees (Daykin, 1998)

The critical studies that examine issues about worksite health programmes in sub-Saharan Africa are limited; this research field is dominated by biomedical literature, leaving very little room for other sciences. Yet, this regional context is specific. Private companies still maintain the strong paternalistic features they developed in colonial and postcolonial times to balance weak public politics. Moreover, the development of Corporate Social Responsibility (CSR) and Corporate Citizenship (CC) in the late 1990s increasingly constrained multinational firms, requiring them to implement programmes with clear social and societal benefits (Jacquemot 2015) in order to re-establish their legitimacy (Hommel 2006). Finally, the epidemic context of HIV/AIDS has led to exceptional responses, with the full and active participation of civil society, the business community and the private sector in addition to the government (United Nations 2001).

The object of this article is to analyse – using the example of HIV testing – the issues related to workplace health programmes in Sub-Saharan Africa, focusing particularly on power relationships. It aims to critically analyse the worksite as a beneficial HIV testing place, questioning whether the workplace – a place characterized by its authority and dependency relationships – enables employees to freely consent to and participate in HIV testing. To this end, I will rely on the power-related concepts of *disciplinary power*, *pastoral power* and *managerial* or *neoliberal power* developed by Michel Foucault. *Disciplinary power* is based on coercion techniques, where individuals are constrained in a docility-utility relationship with the authority in order to develop their capacities and strengthen their performance. The concept of *pastoral power* introduces a moral dimension : derived from a religious and Christian perspective, it bears close resemblance to the concept of "paternalism", which assumes the legitimacy of a public or private actor to make decisions on behalf of an individual in the name of his own good. The company will take over and manage the entire life of its workforce in exchange for their unconditional obedience (Foucault 1975, 139; Revel 2007, 35). Lastly, *managerial* or *neoliberal power,* or "*governmentality,*" introduces a qualitative leap. This "governmentality" refers to the internalization of norms, in which (social) control substitutes for discipline. The individual takes an active role in his own government (Le Texier 2012), acquiring "techniques of the self" (Foucault 1992). This type of management, conducive to the growth of human capital, is behind the advent of capitalism and capitalistic firms (Foucault 2004). We therefore ask, in the health worksite programmes of Sub-Saharan Africa, which types of power occur?

METHODS

This study is based on a survey conducted over a period of 12 months (three field missions carried out between November 2011 and May 2013) in Côte d'Ivoire, where the mobilization of the private sector occurred early (the first ART access programmes began in 1998 at the Compagnie Ivoirienne d'Electricité – CIE) and at a relatively large scale[2]. The HIV/AIDS epidemic in Côte d'Ivoire is relatively important for the West African sub-region (3,2% in 2015), but more moderate than in southern African countries. The Ivorian private sector is dynamic, and this country has long been regarded as an "economic miracle" due to its lucrative economy based on coffee and cocoa.

The study was conducted among actors within 30 large private companies. I used a qualitative methodology to gain a deeper understanding of the experiences of employees, employers and medical staff regarding HCT in the workplace. The goal was to study companies with various characteristics related to their size (from 40 to 6,100 employees), the level of employee qualification (mostly high level/mostly low level), the geographical location (in Abidjan/other towns/in rural areas), the history of the company's involvement in HIV/AIDS (past/recent) and the company's status (multinational company; formerly partly state-controlled and now totally or partially privatized).

I carried out semi-structured interviews within companies with medical staff (n=35), management (n=9), heads of AIDS committees (n=17), and employees living with HIV (n=23). I also conducted interviews outside companies with public policy makers (n=12), private sector organizations (trade unions, business combinations) (n=4), health care professionals (n=7) and members of civil society (n=8). In addition, I conducted observations of on-site HIV testing campaigns (n=6) in private companies located in Abidjan, Bouaké, Yamoussoukro and in a rural area. The names of the 30 private companies, as well as the names of all persons quoted in the text, are anonymized to preserve confidentiality.

First, I will present the different modalities of worksite HIV testing (1). Next, I will study the powerful medical worksite apparatus and the temptation for test providers to use disciplinary and/or pastoral power (2). I will look into the limits of this "dispositif" and study the advent of HIV testing as a "technique of the self"(3).

RESULTS

Modalities for providing HIV testing in private companies (Côte d'Ivoire)

In Côte d'Ivoire, private companies use four types of strategies (singly or in combination) to provide HIV testing (Figure 1):

a. *Client-initiated HIV testing within a medical centre, which constitutes a centre for Voluntary Counselling and Testing (VCT)* (n=15). As with the Voluntary Counselling Testing centres in other locations, this type of offering does not provide effective HIV testing because of the fear of stigma. In our sample, only one company reported a focus on this mode of offering HCT.

b. *Provider-initiated HIV testing related to clinical symptoms during care consultations* (n=27). Company medical staff proposes HCT to employees. When they accept, the HCT blood sample is taken and the results are reported either inside the company (by the company medical staff) (n=17) or outside (when the employee is referred to an off-site facility) (n=10).

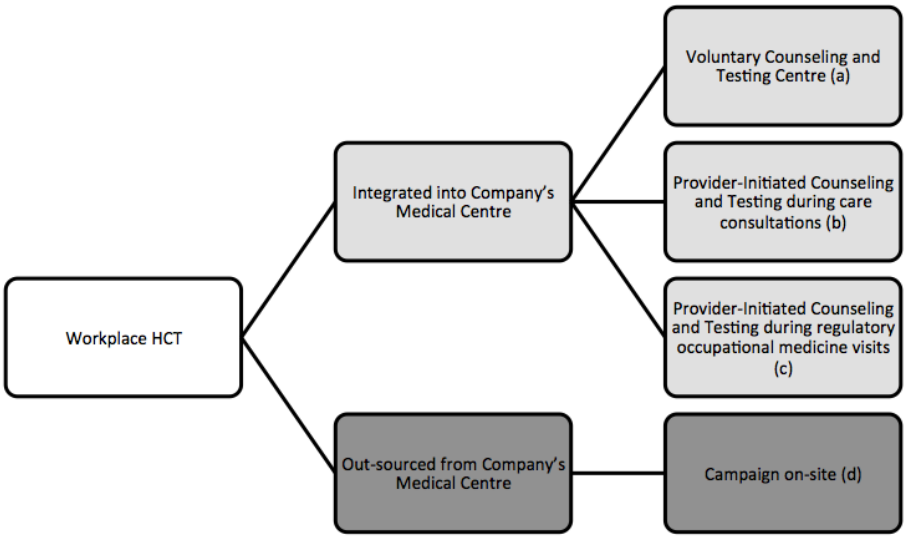
c. *Provider-initiated HIV testing during regulatory occupational medicine visits (pre-employment, annual, upon return from leave, etc.)* (n=15). This offering can be systematic (i.e., offered to every employee) or non-systematic (i.e., based on clinical suspicion or employee

[2] By 2004, twenty private companies had set up an ARV access pro-gramme; in 2010, the Ministry of Health estimated that 242 private companies had established an HIV/AIDS unit.

behaviour), on-site or off-site. The testing rates vary across the companies (from 1% to 95%). This modality is very specific to HCT at the worksite.

d. *Occasional campaigns onsite* (n=15). These campaigns are mainly organized by external service providers (health facilities, associations) (n=14) and rarely by the company's medical staff (n=1). Usually, these campaigns include an awareness session followed by rapid HIV testing. If the test is positive, the employee is referred to specialized HIV/AIDS facilities. The testing rates vary across the companies (from 1% to 85%).
e. In our sample, two companies do not offer HCT facilities.

Figure 1. Strategies to provide HIV testing in private companies (Côte d'Ivoire)



The major difference among the private companies is whether they choose to integrate into or to outsource their HCT services from the company's medical centre. In the former case, the company's medical personnel complete the testing, improving the internalization, routinization and sustainability of the initiative (a, b, c). In the second case, external providers propose the testing during awareness campaigns, with the main goal being to improve confidentiality and the employee's confidence in the test and to provide technical expertise on HIV (d).

The company: a constraining apparatus

When an organization chooses the option of integrating HCT services into the company's medical centre, it tends to favour and to pursue disciplinary and/or pastoral practices with low qualified workers. This approach is primarily seen in the agribusiness multinationals (rubber tree, palm oil, bananas, pineapple, cane sugar, etc.) that employ a large and unskilled labour force. Traditionally, these companies used to take care of their employees' entire lives and families (housing, education, health, electricity access, etc.) due to the lack of decentralized public services, and they continue to play this role to some extent. This approach is also seen in some industrial and services firms with a strong tradition of paternalism, most of which are former parastatal enterprises from different sectors (energy, transport, hotel, commerce, communication) and some of which have built health facilities close to public or private hospitals. In those cases, where the employer was already accustomed to managing its employees' health, the integration of HCT into the company's medical centre was a natural choice. Although UNAIDS recommends the use of HCT on a voluntary basis, this hurts the medical apparatus of private companies in some respects.

The social authority of physicians, which is usually particularly strong in sub-Saharan Africa (Olivier de Sardan and Jaffré 2003) is strengthened in private companies, specifically those that employ unskilled labour. There are several reasons

for this phenomenon. First, because they report directly to the Human Resource Manager, physicians have increased authority over their patients. For employees, obedience to the physician's advice, offerings and orders (including the offer of an HIV test) can be seen as an implicit obligation *vis-à-vis* their employer. Second – and this represents the specificity of HCT in the workplace – regulatory occupational medicine visits (pre-employment, annual, upon return from leave, etc.) for preventive purposes provide opportunities to offer regular HIV testing to all employees. Physicians can use the annual occupational medicine visit as a "disciplinary technique" to improve the health and productivity of their workforce. For example, a doctor who proposed HIV testing during the annual occupational visit stated:

> *"For us, our policy is based more in occupational medicine, which can help us to constrain and inconvenience the patients to collaborate... and for him, the drama is he needs this paper to validate his ability to work (physician, industrial company)".*

This Provider-initiated HIV testing during regulatory occupational medicine visits led to controversy among the company doctors in Côte d'Ivoire. Some of them note the intrinsic impossibility of offering voluntary and informed HCT in the context of compulsory visits regulated by occupational medicine. For them, those visits are too ambiguous, and the employees could perceive HCT as obligatory and as a condition for receiving the medical fitness certificates that enable them to work. In support of this position, a physician declared:

> *"The Labour Code enforces an annual medical check-up as a worker's right. So, it's a legal activity! Besides that, HIV testing is a voluntary activity, i.e., the HIV testing must be informed! Personally, I don't mix apples and pears (physician, service company)".*

Thirdly, diffuse and continuous monitoring of employees is facilitated within companies: doctors have regular contact with their patients (in the formal context of the medical centre, canteen, offices, corridors, etc.) and information is relayed within workspaces. The semi-captivity of the employees facilitates the physician's work. If an employee shows symptoms of HIV, his colleagues or his management can alert the doctor.
Generally, disciplinary power works with pastoral power because the restraining techniques are used to improve the health of the employee and to protect him, but at the same time, they serve to intensify the productivity of the firm. For example, referring to the way in which HIV testing was offered to its employees, the physician of an industrial company with a staff ratio of 50% workers stated,

> *"Because, as I told you, these are workers, so they believe almost anything that comes out of my mouth, so when I say 'it would be good for you to do it', they do it" (Physician, service company).*

Thus, the medical apparatus enables the use of both disciplinary and pastoral power. It is in this way that at the site of an agribusiness firm with 6,100 employees, 95% of the workers agreed to be tested, although the doctor reported that he had not emphasised the voluntary nature of the test. In another case, the physician of a commercial company compared the HIV testing campaign that he organizes – where all the workers wait in a single-file to be tested – to a vaccination campaign.

The company: a place to develop the "techniques of the self"?

Workplace HIV programmes: programmes under control

However, private companies that have implemented HIV/AIDS programmes confront different types of external constraints, which counterweight the apparatus' power. First, the exceptional collective mobilization around HIV/AIDS (Smith and Whiteside 2010) enabled the companies and their physicians to be cautious around HIV/AIDS issues. Health professionals, NGOs/associations, and international cooperation organizations have been directly involved

with companies to support the implementation of their programmes – which is rarely the case for other health issues. While the government has very limited control of company activities, other external actors have played a safeguarding role against possible abuses. Indeed, workplace HIV testing has long been a sensitive and problematic issue because of employers' misuses of results in the 1990s (Aventin 1997). In Côte d'Ivoire, the private sector was deeply affected by the scandal of the *Société Ivoirienne de Raffinage* (SIR) that occurred in the 1990s. In the case of this company, routine HIV screenings conducted by the company's doctor, without the consent of the employees and for discriminatory ends, were denounced publicly in the local newspapers[3] and led to the resignations of the doctor and the Chief Executive Officer. In the 2000s, everything related to HIV was – and remains – very sensitive, and this is one of the reasons that half of the companies in my sample have chosen to outsource HIV testing to external providers. Moreover, as one of the main reasons that private companies initiated HIV programmes was to improve their image and legitimacy in the eyes of their employees, the surrounding communities, and national and international public opinion (particularly in the context of the advent of Corporate Social Responsibility) (Bekelynck 2014), they have been most vigilant about limiting any actions that would have been counterproductive.

Between social control and HCT norm internalization

As in many other private firms in sub-Saharan Africa (Feeley et al. 2007), over the course of the campaigns, the acceptability of worksite HCT among employees in Côte d'Ivoire has increased, which is directly associated not only with knowledge of the disease but also with improved trust in employers. The more workers witness safe campaigns over time, the more confidence they have in getting tested. Moreover, collective emulation strongly boosts HCT uptake, as already described in South African companies (Weihs and Meyer-Weitz 2014; Arimoto et al. 2013). When launching the campaigns, management staff often set an example by getting tested themselves.

However, this collective emulation often turns into social control, with the employees questioning each other to determine whether their colleagues have already been tested. For instance, wearing a bandage or a gadget distributed at the end of the HCT, such as a tee shirt or a cap, becomes a distinctive sign that an individual has been tested, and thus it becomes a control instrument. Some workers question their colleagues: "you didn't get tested!" This group effect is ambiguous: on the one hand, it reduces the stigma of an individual who gets screened alone and who would be suspected of shameful behaviour, and on the other hand, it becomes more difficult to maintain confidentiality (Alice Desclaux 2014). In addition, the pressure on individuals to be tested no longer comes from the vertical authority of the employer and the company's physician; instead, it comes horizontally, from colleagues (Obermeyer et al. 2013). This emulation can be perceived as strong social pressure from one's colleagues, especially for HIV-positive workers who already know their status or who have discovered it during these campaigns. Colleagues scan the reactions of employees who have just been tested to guess their status, and "suspicious" behaviours are scrutinized. A result that takes a long time to announce is perceived as dubious. Some workers may spontaneously ask their colleagues for their results as they leave the HCT room. Employees aware of their HIV infection may re-test to avoid attracting suspicion from colleagues. Sometimes people in charge of HCT will provide negative result slips to individuals who test HIV-positive so that they can show evidence of their HIV-negative status after the test.

Also, this social control reveals a gradual normalization of HIV testing. For some employees, testing can be perceived as a desirable and valued action. They show pride in being tested; others wait for the regular worksite campaign to be screened; while others present themselves as "serially tested" – one who gets tested at every available opportunity. Companies – especially multinational firms in the banking, insurance,

[3] Cf C. Etou, "Le personnel veut la tête du DG". La Voie n° 982, 3 janvier 1995, p. 5 ; S. Fofana, "Les employés demandent le départ de Daouda Thiam", Le Jour, n° 20, 5 janvier 1995 : 9.

telecom, oil or cocoa sectors – have become a place where workers get tested on their own free will, now that HCT is internalized as a positive norm and no longer as a suspicious act.

Differentiated HIV uptake between qualified and unqualified workers

I noticed that managers subvert worksite HCT more than do unskilled labourers and that HCT uptake rates tend to be higher among companies with unskilled labourers, regardless of the type of testing offered. Here, the universal offer of testing has been grafted onto a dualistic health system, that is, onto a system where the low qualified workers usually use the corporate medical centre, with the support of a mutual company or occasional assistance if necessary; while the more skilled staff use external health facilities and external health insurance. In addition, within a workplace environment characterized by its physical closeness, the risks associated with confidentiality breaches are a major barrier to HIV testing, and the more skilled employees have the means to bypass the workplace system. These means are economic, as seen in the costs related to testing and transportation (especially for isolated sites); cognitive, as seen in the skilled employees' greater knowledge of alternative places to get tested; and also social, as seen in the skilled employees' opportunity and ability to negotiate more autonomy within their company and with physicians. Indeed, in the companies' medical centres, the threat of a confidentiality breach appears at different levels. At the organizational level, there is a lack of systematic anonymisation, the contiguity of the medical centres can favour the spread of rumours, and employees who consult an "HIV specialist" may be treated with suspicion. At the staff level, the involvement of many actors (doctor, nurse, caregiver, social worker, pharmacist, insurance agent, laboratory staff, medical secretary, maintenance staff) – who are not always trained in confidentiality management – can reduce confidence in the system. Finally, at the social level, informal networking between employees and doctors, who are considered work colleagues, can impede the use of workplace HCT, especially among qualified workers wishing to manage their sexual and reproductive health in a socially neutral space. Moreover, during workplace HCT campaigns, the fear of a confidentiality breach remains high. The locations are not always safe from colleagues' eyes and ears. For example, the pre-test and post-test counselling rooms are not always closed or are only protected by a curtain, and several employees may simultaneously be tested in the same room. For all these reasons, qualified staff are often less likely to use workplace HIV testing, instead opting – if they are ever tested – for testing in other facilities.

DISCUSSION

In sub-Saharan Africa, private companies are among the few entities implementing preventive medicine, in a context where the main funders are focused on targeted screening (for "key" or "vulnerable" populations and in particular geographic areas), with the main objective being to start with the treatment of infected individuals (Barnhart 2016). In private companies, the medical centres promote better access to care; regulatory visits provide a unique opportunity for HIV prevention and prevention of other chronic diseases (diabetes, hypertension, viral hepatitis, cancer, etc.); and on-site HCT campaigns can easily reach the labour force of a country. The HIV testing offered by these medical centres is also effective, as it further enables the identification of asymptomatic people. The share of employees tested at their workplace is increasing, highlighting the normalization of HIV testing in this specific context. Although workplace HIV testing has long been a sensitive and problematic issue because of the associated human rights risks (discrimination and stigma), the strong mobilization of some private companies in the fight against HIV/AIDS has enabled effective and innovative HCT at work. Private companies remain one of the few places (outside of antenatal care) where routine HIV testing is offered to the general population and is not correlated with clinical symptoms or membership in a vulnerable group. Thus, offers of

worksite HCT give employees the opportunity to increase the "techniques of the self" with regard to their own health; this occurs via the promotion of the positive norm of HIV testing and, more specifically, through the norm of preventive screening.

However, and secondly, private companies are not "neutral" HIV testing sites. In many ways, the ethical principles regulating the offering of HIV testing are contradictory to the core characteristics of private companies. The closeness of places and people makes the principle of confidentiality fraught. The voluntary and informed nature of the HIV test contradicts the instruments of power and governance of companies. As in other contexts (McCoy et al. 2005), most of the companies have chosen to initiate HIV/AIDS programmes alongside their current medical systems, stressing the limits of the private company as a health facility. The full integration of HCT into companies' medical centres – and specifically during occupational medical visits – is highly controversial. Getting tested on a worksite remains an act full of caveats, whether justified or not. In sum, although companies offer numerous opportunities for medical care, those opportunities do not always counterbalance the inherent constraints of the workplace and prevent fears related to HIV testing (confidentiality breaches, stigma, discrimination).

Finally, while private firms based in Sub-Saharan Africa are currently perceived in the public health literature as homogeneous entities and good places – per se – to implement HIV and public health initiatives (Coates et al. 2007), this study highlights the context of authority-obedience relationships and social control in which the individuals getting tested in their worksite are embedded. More specifically, it stresses that even if HIV testing is theoretically uniformly proposed to all staff, the type of power the company wields over its employees is different according to their level of skill. The power exercised will tend to be more disciplinary and pastoral for the low-skilled workers and more neoliberal or managerial for the more skilled employees. Despite recent significant advances in worksite health programmes – particularly through HIV programmes – which have led to many efforts at anonymization and increased respect for confidentiality, firms still form a powerful apparatus that can oversee, control and constrain employees, specifically within company medical centres. As a semi-closed institution, where the professional and private lives (health, sexual and reproductive life) of workers are merged, the company retains some hierarchical power and social control – primarily on low-skilled employees. Also, this is more evident for the sector of activities that employ a low-skilled and more dependent workforce and that have a "reserve army of labour" in the words of Karl Marx, such as the agribusiness and industrial sectors. In return, there is a differential adhesion to worksite HIV testing programmes according to the level of qualification of the employees, which is typical of worksite health initiatives (Daykin 1998). This is consistent with other studies stressing that managers and supervisors generally prefer to maintain social distance from their subordinates in order to preserve their symbolic capital and their authority (Roussel 2007). If they agree to get tested, they simultaneously consent to transform their politics and social bodies into a purely biological body (Agamben 2003). This process of "desubjectification" could deepen their subjugation to their employer and promote their assimilation with low-skilled workers. Moreover, the promotion of an HIV testing standard by the companies is inevitably intrusive, conveying a positive judgement about responsible workers who take care of their health and – a fortiori – a negative judgement about those who refuse testing (Allender, Colquhoun, and Kelly 2006). The workplace screening campaigns – which often take the form of festivities or collective time – have a symbolic function: they strengthen the company's social cohesion by collectively adverting the threat of disease and death (Bryon-Portet 2014). Additionally, companies remove individuals from the lonely environment of the test and provide them with collective support (Osty 2003). Beyond attending to its employees' health, the firm reaffirms its moral authority, renewing its role as a protector and guide that helps its employees to overcome their fears (Rajak 2010) and that gives them the opportunity to take care of themselves.

CONCLUSION

In a context where the private sector is increasingly called upon to be involved in health governance (Guilbaud 2012), this research outlines the specifics of the work area as a place of testing. If private companies represent an obvious opportunity for HIV testing, the example documented here is probably not generalizable to all private companies in sub-Saharan Africa, and, given the current state of occupational health, to other pathologies. It is indeed the "exceptionality of HIV/AIDS" (Smith and Whiteside 2010) that has profoundly shaped the response of private companies. However, the latter are not so much regulated by traditional and structural regulatory mechanisms (legislative, labour inspectors, trade unions) as they are by informal and private mechanisms (internal charters, HIV/AIDS activists and professionals) (Bekelynck 2017). If the mobilization of the private sector in health is needed in specific situations (epidemic emergency, isolated companies, absence of state response), more research is necessary to re-think the role of private companies in sub-Saharan Africa, the optimal way to involve them in health, and their collaboration with the public sector in the long term (Tallio 2015).

REFERENCES

Agamben, Giorgio. 2003. *Ce qui reste d'Auschwitz. Homo Sacer III*. Paris: Payot et Rivages.

Alice Desclaux, Odette Ky-Zerbo. 2014. "Ethical Considerations of Providers and Clients on HIV Testing Campaigns in Burkina Faso." *BMC International Health and Human Rights* 14 (1): 27. doi:10.1186/1472-698X-14-27.

Allender, Steven, Derek Colquhoun, and Peter Kelly. 2006. "Governing the Working Population through Workplace Health: Knowledge, Self and Power in Workplace Health Programs." *Critical Public Health* 16 (2): 131–142. doi:10.1080/09581590600828519.

Arimoto, Yutaka, Seiro Ito, Yuya Kudo, and Kazunari Tsukada. 2013. *Stigma, Social Relationship and HIV Testing in the Workplace: Evidence from South Africa*. IDE Discussion Paper 386. Institute of Developing Economies, Japan External Trade Organization(JETRO). http://econpapers.repec.org/paper/jetdpaper/dpaper386.htm.

Aventin, Laurent. 1997. "Discrimination à l'égard Des Employés Séropositifs Dans l'entreprise Abidjanaise : Dépistages Illicites Du VIH et Licenciements Abusifs (1995/1996)." *Sciences Sociales et Santé* 15 (3): 69–95.

Barnhart, Scott. 2016. "PEPFAR: Is 90-90-90 Magical Thinking?" *The Lancet* 387 (10022): 943–944. doi:10.1016/S0140-6736(16)00570-5.

Bekelynck, Anne. 2014. "Le rôle des entreprises privées dans la lutte contre le VIH/sida en Côte d'Ivoire : des vecteurs d'une utopie sociale aux partenaires d'une action publique." *Lien social et Politiques*, no. 72: 129–149. doi:10.7202/1027210ar.

Bekelynck, Anne. 2017. "Le rôle des entreprises privées dans le développement local en Afrique subsaharienne. L'exemple du VIH/sida en Côte d'Ivoire." *Revue internationale des études du développement*, no. 231 (September): 149–173. doi:10.3917/ried.231.0149.

Bhagwanjee, Anil, Inge Petersen, Olagoke Akintola, and Gavin George. 2008. "Bridging the Gap between VCT and HIV/AIDS Treatment Uptake: Perspectives from a Mining-Sector Workplace in South Africa." *African Journal of AIDS Research: AJAR* 7 (3): 271–279. doi:10.2989/AJAR.2008.7.3.4.651.

Brink, Brian, and Jan Pienaar. 2007. "Business and HIV/AIDS: The Case of Anglo American." *AIDS* 21 (Suppl 3): S79–S84. doi:10.1097/01.aids.0000279697.40568.fd.

Bryon-Portet, Céline. 2014. "Les rites de convivialité dans les escadrons de chasse de l'armée de l'air." *Communication & Organisation* 44 (2): 149–164.

Coates, Thomas J, Agnes Fiamma, Greg Szekeres, Shari Dworkin, Robert H Remien, Brent W Hanson, and Jean-Baptiste Rudatsikira. 2007. "Business' Role in Exercising Leadership, Promoting Equity, Embracing Accountability, and Developing Partnerships." *AIDS* 21 (Suppl 3): S3–S9. doi:10.1097/01.aids.0000279688.23535.04.

Day, J H, K Miyamura, A D Grant, A Leeuw, J Munsamy, R Baggaley, and G J Churchyard. 2003. "Attitudes to HIV Voluntary Counselling and Testing among Mineworkers in South Africa: Will Availability of Antiretroviral Therapy Encourage Testing?" *AIDS Care* 15 (5): 665–672.

Daykin, Norma. 1998. "Workplace Health Promotion: Benefit or Burden to Low-Paid Workers." *Critical Public Health* 8 (2): 153–166. doi:10.1080/09581599808402902.

Desgrées-du-Loû, Annabel, and Joanna Orne-Gliemann. 2008. "Couple-Centred Testing and Counselling for HIV Serodiscordant Heterosexual Couples in Sub-Saharan Africa." *Reproductive Health Matters* 16 (32): 151–161. doi:10.1016/S0968-8080(08)32407-0.

Feeley, Frank, Alizanne Collier, Sarah C Richards, Stefaan F Van der Borght, and Tobias F Rinke de Wit. 2007. "A Successful Workplace Program for Voluntary Counseling, Testing, and Treatment of HIV/AIDS at Heineken, Rwanda." *International Journal of Environmental Health* 13 (1).

Foucault, Michel. 1975. *Surveiller et Punir. Naissance de La Prison*. Gallimard. Paris.

Foucault, Michel. 1992. *The History of Sexuality, Vol. 2: The Use of Pleasure*. Translated by R Hurley. Reissue edition. New York: Harmondsworth, Middlesex:Penguin.

Foucault, Michel. 2004. *Naissance de la biopolitique: cours au Collège de France (1978-1979)*. Edited by François Ewald, Alessandro Fontana, and Michel Senellart. [Paris]: Gallimard : Seuil.

Gavin George, and Tim Quinlan. 2009. "'Health Management' in the Private Sector in the Context of HIV/AIDS: Progress and Challenges Faced by Company Programmes in South Africa." *Sustainable Development* 17 (1): 19–29. doi:10.1002/sd.366.

George, Gavin. 2006. "Workplace ART Programmes: Why Do Companies Invest in Them and Are They Working?" *African Journal of AIDS Research* 5 (2): 179–188. doi:10.2989/16085900609490378.

Guilbaud, Auriane. 2012. "Business and Global Governance." *Critique internationale* N° 55 (2): 173–176. doi:10.3917/crii.055.0173.

Hartwell, T. D., P. Steele, M. T. French, F. J. Potter, N. F. Rodman, and G. A. Zarkin. 1996. "Aiding Troubled Employees: The Prevalence, Cost, and Characteristics of Employee Assistance Programs in the United States." *American Journal of Public Health* 86 (6): 804–808.

Hommel, Thierry. 2006. "Paternalisme et RSE : Continuités et Discontinuités de Deux Modes d'organisation Industrielle." *Entreprises et Histoire* 45 (4): 20. doi:10.3917/eh.045.0020.

ILO. 2001. *The ILO Code of Practice on HIV/AIDS and the World of Work*. Geneva.

Le Texier, Thibault. 2012. "Foucault, le pouvoir et l'entreprise : pour une théorie de la gouvernementalité managériale." *Revue de philosophie économique* 12 (2): 53–85. doi:10.3917/rpec.122.0053.

London, L, and J E Myers. 1996. "HIV Testing in the Workplace." *South African Medical Journal = Suid-Afrikaanse Tydskrif Vir Geneeskunde* 86 (4): 329–330.

McCoy, David, Mickey Chopra, Rene Loewenson, Jean-Marion Aitken, Thabale Ngulube, Adamson Muula, Sunanda Ray, Tendayi Kureyi, Petrida Ijumba, and Mike Rowson. 2005. "Expanding Access to Antiretroviral Therapy in Sub-Saharan Africa: Avoiding the Pitfalls and Dangers, Capitalizing on the Opportunities." *American Journal of Public Health* 95 (1): 18–22. doi:10.2105/AJPH.2004.040121.

Moatti, Jean-Paul, and Fred Eboko. 2010. "Economic Research on HIV Prevention, Care and Treatment : Why It Is More than Ever Needed ?" *Current Opinion in Hiv and Aids* 5 (3): 201–203. doi:10.1097/COH.0b013e328338b960.

MSLS Côte d'Ivoire, Ministère de la Santé et de la Lutte contre le VIH/sida. 2013. *Enquête Démographique et de Santé et à Indicateurs Multiples (EDS-MICS) de Côte d'Ivoire. 2011 - 2012*. Abidjan.

Nguyen, Vinh-Kim, Cyriaque Yapo Ako, Pascal Niamba, Aliou Sylla, and Issoufou Tiendrébéogo. 2007. "Adherence as Therapeutic Citizenship: Impact of the History of Access to Antiretroviral Drugs on Adherence to Treatment." *AIDS (London, England)* 21 Suppl 5 (October): S31-35. doi:10.1097/01.aids.0000298100.48990.58.

Obermeyer, Carla Makhlouf, Sarah Bott, Ron Bayer, Alice Desclaux, Rachel Baggaley, and MATCH Study Group. 2013. "HIV Testing and Care in Burkina Faso, Kenya, Malawi and Uganda: Ethics on the Ground." *BMC International Health and Human Rights* 13: 6. doi:10.1186/1472-698X-13-6.

Olivier de Sardan, Jean-Pierre, and Yannick Jaffré. 2003. *Une Médecine Inhospitalière : Les Difficiles Relations Entre Soignants et Soignés Dans Cinq Capitales d'Afrique de l'Ouest*. Karthala.

Osty, Florence. 2003. *Le désir de métier : Engagement, identité et reconnaissance au travail*. Rennes, France: PU Rennes.

Paulin, Heather N, Meridith Blevins, John R Koethe, Nicole Hinton, Lara ME Vaz, Alfredo E Vergara, Abraham Mukolo, et al. 2015. "HIV Testing Service Awareness and Service Uptake among Female Heads of Household in Rural Mozambique: Results from a Province-Wide Survey." *BMC Public Health* 15 (February). doi:10.1186/s12889-015-1388-z.

Rajak, Dinah. 2010. "'HIV/AIDS Is Our Business': The Moral Economy of Treatment in a Transnational Mining Company." *Journal of the Royal Anthropological Institute* 16 (3): 551–571. doi:10.1111/j.1467-9655.2010.01639.x.

Revel, Judith. 2007. *Dictionnaire Foucault*. Paris: Ellipses Marketing.

Rosen, Sydney, Frank Feeley, Patrick Connelly, and Jonathon Simon. 2007. "The Private Sector and HIV/AIDS in Africa: Taking Stock of 6 Years of Applied Research." *AIDS* 21 (Suppl 3): S41–S51. doi:10.1097/01.aids.0000279693.61652.2d.

Rosen, Sydney, Jonathon Simon, Jeffrey R Vincent, William MacLeod, Matthew Fox, and Donald M Thea. 2003. "AIDS Is Your Business." *Harvard Business Review* 81 (2): 80–87, 125.

Roussel, Eric. 2007. *Vies de cadres : Vers un nouveau rapport au travail*. Rennes: PU Rennes.

Smith, Julia H., and Alan Whiteside. 2010. "The History of AIDS Exceptionalism." *Journal of the International AIDS Society* 13 (1): 47. doi:10.1186/1758-2652-13-47.

Tallio, Virginie. 2015. "The Corporate Social Responsibility Projects of the Oil Companies in Angola: Anecdotal Fact or Significant New Trend in Public Health Development Intervention?" *Journal of Southern African Studies* 41 (2): 389–404. doi:10.1080/03057070.2015.1015790.

United Nations. 2001. *Declaration of Commitment on HIV/AIDS*.

Weihs, Martin, and Anna Meyer-Weitz. 2014. "A Lottery Incentive System to Facilitate Dialogue and Social Support for Workplace HIV Counselling and Testing: A Qualitative Inquiry." *Sahara J* 11 (1): 116–125. doi:10.1080/17290376.2014.937739.