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REPORT AND RECOMMENDATIONS

PREVENTION EN

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REPORT ON PUBLIC POLICY FOR HIV PREVENTION IN MAINLAND FRANCE AND RECOMMENDATIONS FOR BETTER ENFORCEMENT OF PUBLIC POLICY ON PREVENTING HIV-TRANSMISSION

TABLE OF CONTENTS

TABLE OF CONTENTS 1

REPORT ON PUBLIC POLICY FOR HIV PREVENTION IN MAINLAND FRANCE 4

INTRODUCTION 4
PART I PREVENTION IN THE FACE OF INADEQUATE PUBLIC POWERS 6
1.1 INADEQUATE STATE COMMITMENT 6
1.1.1 HIV-Transmission Prevention: An Ill-Evaluated Issue 6
1.1.1.1 A Still-Unclear Position in Healthcare Policy 6
• Determining the objectives in the fight against the HIV-infection epidemic 7
• Poorly-identified powers at the central, decentralised and regional levels 7
• INPES: An uncomfortable role, unsteady missions 8
• The troubling development of funding structures 9
1.1.1.2 Slight Answers for an Active Epidemic 10
• High-risk transmission exposure groups lacking mobilisation 10
• The need to make better use of tools 11
1.1.2 Prevention in the National Education System: A Notable Absence 12
1.1.2.1 Insufficient Information to Teenagers in Schools 12
• Actions resulting from individual initiatives 13
• Associations challenged to fill in for the National Education system 13
1.1.2.2 Making Sex Education and Prevention Effective 13
• Circulars that are high in number yet low in effect 14
• A form of education that is lacking in the curricula 14
I.2 INADEQUACIES IN GOVERNMENT POLICY COORDINATION 15
1.2.1 Policies and Practices instituted by the Ministry of the Interior Hindering Prevention 15
1.2.1.1 Tighter Constraints for Migrants 15
• A vulnerable population with uncertain access to healthcare and information about prevention 15
• The quest for rights hinders healthcare 16
1.2.1.2 Access to prevention questioned 17
• The shaky successes of prevention amongst prostitutes 17
• The Negative Impact of the Domestic Security Act on Prevention 18
1.2.2 Persisting Difficulties in Prison 19
1.2.2.1 Inadequately Recognised Transmission Risks 19
• Inmate sexuality 19
• Declining risk inadequately reflected in prisons 19
1.2.2.2 Barriers to Prevention 20
• A dissatisfactory healthcare situation 20
• The Risks of Stigmatisation 21
PART II THE DIFFICULTIES INHERENT IN COLLABORATION BETWEEN THE STATE AND ASSOCIATIONS 21
2.1 THE RECIPROCAL CONSTRAINTS OF DELEGATION 22
2.1.1 The State's Duties with Respect to the Associative Community 22

2.1.1.1 Support: An Essential Ingredient 22
- The associations' uneasy task of day-to-day management 22
- Association contacts are inadequately mobilised 23

2.1.1.2 Monitoring: An Inevitable Part of the Process 23
- Maintaining the balance in the associative sector 24
- Accepting responsibility for the failings of delegation 25

2.1.2 The Requirement Placed on Associations 25

2.1.2.1 The Need to Overcome Controversy 25
- Messages about reducing sexual risk 25
- Issues at Stake in the Debate about Re-Contamination 26

2.1.2.2 Incorporation into National Policy 27
- Professionalizing action in prevention 27
- SNEG's gray areas 27

2.2 KNOWLEDGE-SHARING FOR BETTER PREVENTION: HIGH STAKES 28

2.2.1 A Better Understanding of the Epidemic 28

2.2.1.1 A Growing Scope of Understanding 28
- Epidemiology 29
- Research in the social sciences 29

2.2.1.2 An Epidemic that is Changing with Society 30
- Inadequately-studied exposure-risk groups 30
- Patchy Knowledge about Internet Use 31

2.2.2 Sharing Knowledge and Practices: A Vital Necessity 32

2.2.2.1 Exchanges about Field Actions 32
- Minimal experience-sharing 32
- Cooperation Programmes that Could be Reinforced 33

2.2.2.2 Disseminating Knowledge about Risks and Practices 33
- Inadequate reminders of the existence of risk 33
- Understanding current practices to disseminate messages 33

RECOMMENDATIONS FOR BETTER ENFORCEMENT OF PUBLIC POLICY ON PREVENTING HIV-TRANSMISSION 35

1 ENSURING PREVENTION POLICY THAT IS FULLY BORNE BY THE PUBLIC POWERS 35

1.1 THE STATE MUST CLARIFY THE ROLE OF PREVENTION IN THE HEALTH SYSTEM 35
- Making prevention of HIV-transmission a public health objective 35
- Clarifying funding sources 35
- Specifying and reasserting INPES' role 35
- Making full use of the Regional Anti-HIV Coordination Centres (COREVIH) 36

1.2 THE STATE MUST ASSERT ITS COMMITMENT IN FAVOUR OF PREVENTION 36
- Ensuring consistency in action at the decentralised level 36
- Giving even greater incentive for local authorities to contribute to prevention 36
- Supporting mobilisation for foreigners and migrants 36
- Requiring free provision of prevention materials by commercial sex establishments 36
- Guaranteeing access to post-exposure treatment everywhere in response to accidental sexual exposure 36

1.3 THE STATE MUST TAKE ON THE RESPONSIBILITIES ASSOCIATED WITH DELEGATION 36
- Ensuring that associations' actions are appropriate and consistent with regard to the 2005-2008 Anti-HIV Programme 36
- Fostering diversity in the associative sector 37
- Dealing with the lack of associations in a geographic area or with a target population 37

1.4 THE STATE MUST PROMOTE PREVENTION CAMPAIGNS TAILORED TO THE CHALLENGES AT HAND 37
- Giving a more accurate image of the infection's seriousness 37
- Devising distinct message for the HIV-positive and HIV-negative populations 37
- Increasing the frequency and diversity of messages 37

1.5 THE STATE MUST ENSURE THAT THE REQUIRED KNOWLEDGE IS AVAILABLE 37
- Funding behavioural studies 37
- Developing surveillance of emerging needs 37
- Activity reports need to be an analysis tool for public fund-providers 38
- Organising a consensus conference or public hearing about the risks associated with sexual practices 38
- Planning annual prevention conferences to share experiences 38

2 ENSURING CONSISTENCY ACROSS THE GOVERNMENT IN THE FIELD OF PREVENTION 38

I2.1 IMPLEMENTING AN INTERMINISTERIAL COORDINATION SYSTEM 38

2.2 THE MINISTRY OF NATIONAL EDUCATION MUST ESTABLISH PREVENTION FOR YOUNG PEOPLE 38
- The Ministry of National Education must revitalise education in sex and intimacy 38
- The Ministry of Youth, Sport and Associations needs to contribute to health education 38

2.3 THE MINISTRY OF THE INTERIOR'S POLICIES MUST NOT GO AGAINST PREVENTION POLICY 39
- The Domestic Security Act must not become an obstacle to prevention amongst prostitutes 39
- Foreigners' rights need to be fully upheld 39
- In administrative detainment centres, individuals need to be able to benefit from the rights guaranteed them by the law 39
- The fight against drug trafficking must not challenge the results achieved by risk reduction in intravenous drug users 39

2.4 THE MINISTRY OF JUSTICE MUST ADDRESS THE HIV-EPIDEMIC IN PRISON 39
- Creating the conditions for effective prevention 39
- Recognising the existence of high-risk sexual practices 39
- Completing risk-reduction policy in drug addiction amongst inmates 39

3 CLARIFYING THE PARTNERSHIP BETWEEN ASSOCIATIONS AND THE STATE 40

3.1 THE STATE MUST SECURE THE ENVIRONMENT IN WHICH ASSOCIATIONS OPERATE 40
- Paving the way for implementation of legislative developments affecting health or associative activities 40
- Keeping from weakening associations financially 40
- Fostering the diversification of funding sources 40

3.2 DELEGATION OF POWERS AND PUBLIC FINANCING ENTAIL RESPONSIBILITIES FOR ASSOCIATIONS 40
- All gay associations need to carry forth the prevention message 40
- SNEG needs to speak out publicly and unambiguously about prevention 40
- The associations need to be a driving force in assessing prevention actions 40
- Achieving a foundation for consensus-seeking amongst associations 40

APPENDICES 42

ACRONYMS USED 42

PERSONS HEARD BY CONSEIL NATIONAL DU SIDA'S PREVENTION COMMITTEE 45

BIBLIOGRAPHY 47

GREY LITERATURE 47
PUBLIC HEALTH, SEXUALITY, GENDER 48
HEALTH SURVEILLANCE 48
DRUG USE 49
PROSTITUTION 49
PRISON 49
HOMOSEXUALITY 50
FOREIGNERS, MIGRANTS, VULNERABLE POPULATIONS 50

REPORT ON PUBLIC POLICY FOR HIV PREVENTION IN MAINLAND FRANCE

INTRODUCTION

Upon its founding in 1989, Conseil National du Sida (CNS) was given the mission of "delivering its opinion on all issues raised in society in relation to AIDS". The decree signed by the President of the Republic states that it must be "consulted about information, prevention and education programmes on health, established by the Government and public organisations"[1]. Since then, CNS has consistently handed down its opinion on all aspects of the fight against HIV-infection, but has not looked at prevention programmes for several years. Considering how the epidemic is currently developing, it now feels it is vital to seize upon the topic of HIV-infection prevention policy in France.

Prevention with regard to HIV is carried out at three levels. Primary prevention aims to prevent the transmission of the virus through sexual intercourse, blood contact, during pregnancy or through nursing. Secondary prevention consists of preventing HIV-positive people from developing AIDS or other pathologies. Tertiary prevention aims to limit complications due to HIV infection. Secondary and tertiary prevention are in part based on treatment for infected persons by the healthcare system. Still today, and despite information campaigns and existing treatments, too many people come to hospital at the AIDS stage, unaware of their status or having been diagnosed yet still untreated. Screening and treatment are important issues in the fight against the epidemic, as is primary prevention, which occurs prior to transmission. As such, it limits propagation of the virus and makes the need for secondary and tertiary prevention all the lesser. At the same time, it makes use of special communication and action strategies targeting the population. In this report, the CNS' Prevention Committee decided to focus only on primary prevention. The other types of prevention also involve important issues, in particular regarding quality of living for people with HIV, and deserve separate efforts.

For several years now, the setting in which HIV-transmission prevention policy is conducted has been changing. Undeniably, the arrival of treatments has helped to considerably improve life expectancy for the HIV-positive individuals benefiting from them. The significant drop in number of deaths and the infection's lower visibility in society that has resulted from it, have lightened the epidemic's tragic dimension. At the same time, while prevalence amongst intravenous drug users has seen a spectacular drop thanks to risk reduction policy, new high-risk exposure groups have been attracting attention, primarily women and people from sub-Saharan Africa. Alongside this, a resurgence in high-risk behaviours can be seen and has reached worrisome levels in the gay population. The difficulties encountered in defining responses to these issues have been at the root of lasting controversy between associations. Whatever the case, the number of people living with HIV is constantly increasing and will continue to do so in the years to come, even as patient profiles change.

In 2003, according to *Institut de Veille Sanitaire* (IVS) estimate, around 6 000 people learned they were infected with HIV, and half of those lived in the Ile-de-France region[2]. Regardless of age group and sex, transmission between people having heterosexual intercourse is preponderant, accounting for 57% of newly-diagnosed cases; transmission amongst people having homosexual intercourse continues, at 21.4% of newly-diagnosed cases, a very high figure, considering the percentage of gays within the general population. The drop in contamination levels by drug injection was confirmed, with 2.2% of newly-diagnosed cases[3]. In those contaminated through heterosexual intercourse, 34% of the women and 16% of the men were nationals from countries in sub-Saharan Africa. In the 15-24 age group, around half the women involved were nationals of countries in sub-Saharan Africa. Also of note is the fact that HIV-infection rates vary according to sex and age. For instance, the virus is identified earlier in women, who account for 43% of newly-diagnosed cases, regardless of nationality, than in men. In 15- to 24-year-olds, 68% were women and 83% of those were contaminated through heterosexual intercourse[4]. In young men aged 15 to 24, 32% were contaminated through heterosexual contact and 52% through homosexual contact[5]. Yet looking at 20- to 24-year-olds, the percentage of people contaminated through homosexual contact reached 60%. The recent infection test shows that 51% of homosexuals who learn they

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[1] Article 1 of Decree 89-83, 8 February 1989, officialising the creation of a National Council on Acquired Immune Deficiency Syndrome was integrated into the Public Health Code, under Article D3121-1.

[2] IVS, *HIV-AIDS Surveillance in France. Report n° 2, Data as of 31 March 2004*, May 2005. All surveillance data on HIV and AIDS can be found at www.invs.sante.fr/surveillance/vih-sida/default.htm.

[3] This information was unavailable in 18.6% of those responding. *Idem.*, p. 4.

[4] IVS, *HIV and AIDS Infection in Young People Aged 15 to 24,* France, data as of 30 June 2004. Drug injection accounts for 1% of transmission. In 16% of those responding, information about the transmission method was not available.

[5] *Idem*. Drug injection accounts for 3% of transmission. In 13% of those responding, information about the transmission method was not available.

are HIV-positive were infected during the six months prior to the test, probably reflecting in part more frequent screening, as well as the persistently-high level of new contamination within this part of the population[6].

Clearly, the HIV-infection epidemic remains particularly active in France. It affects young people, women to a substantial extent and people from sub-Saharan Africa. Gays continue to be highly exposed to transmission risk, with the prevalence of HIV infection estimated at over 10% in the group[7]. This persisting transmission rate fully substantiates the need to devote specific attention to primary prevention. In addition, in a public health perspective, prevention policy must not be conceived of as a series of measures taken in response to an epidemic with the aim of eliminating it. Prevention policy consists, first and foremost, of preventing the occurrence of health problems and, thereby, the epidemic. In this case, the aim is to prevent HIV from being transmitted from one person to another. Therefore, epidemiological data should not be the only factors determining prevention action. The visibility of certain high-risk transmission groups must not lead people to neglect the importance of spreading prevention messages designed for the general population, in order to maintain the knowledge and practices necessary to prevent STDs. For instance, the decline of transmission levels in drug users is due to France's risk-reduction policy, not to the complete cessation of intravenous drug use. That policy therefore needs to be maintained. Likewise, only an effective care policy for pregnant women with HIV will make it possible to prevention mother-to-child transmission. Clearly, transmission prevention policy is more than necessary if the transmission chain is to be cut off, preventing both exposure to HIV transmission in uninfected people and transmission by those infected with HIV. This means ensuring that safe behaviours are adopted and providing information about risk. The number of people living with HIV can only grow with time and transmission exposure risks are here to stay. Transmission prevention policy must therefore be conceived of over the very long term.

Over the past few years, the CNS has publicised two reports followed by recommendations in connection with prevention, one on the risks due to drug use and the second on the HIV-infection epidemic's current situation in France's overseas administrative units[8]. For that reason, this report does not go into the latter's' specific situation, which remains of great concern. A number of noteworthy successes have been achieved in HIV-transmission prevention, specifically in preventing transmission during blood transfusions, preventing mother-to-child transmission and preventing transmission through needle-sharing amongst drug users. Those risks are not covered in this report, except to reiterate the need to maintain current actions and keep from hindering their implementation. Prevention in the workplace is governed by a specific approach and will not be covered either. The CNS' Prevention Committee based its work on analysis of existing policies and tools, and therefore does not go into the issue of microbicides either, as these are currently only in the research stage. Lastly, for several months now, in response to suits investigated by criminal law courts and a number of sentences, discussions as to whether HIV-transmission should be made a criminal offence have been in the forefront amongst prevention stakeholders. CNS has launched concurrent discussions on this issue, related to prevention policy and thus no more a focus of this paper than those listed above.

The Committee heard some forty prevention policy parties from France in a variety of positions and functions. Based on their contributions, it was able to take stock of prevention policy today, put together information from the field and see Government action and systems in a different light. The Committee wishes to thank the said individuals for their contribution to its work[9]. The information gathered during the hearings was supplemented by a study of existing publications about prevention or the groups at high risk of being exposed to HIV-transmission. Lastly, the Committee also used the "grey literature" published by associations or public bodies.

The *National Anti-HIV/AIDS Plan* for years 2001-2004 set out a number of objectives, including "to stop the resurgence of the epidemic in homosexual men" and "reduce the gap between the French population and foreign people living in France"[10]. The persisting transmission levels in this area show that HIV-infection prevention policy has not reached its targets. This report offers an analysis of the processes that are partially or fully hindering prevention action. In other words, its primary purpose is to study the overall structure of public policy on preventing HIV-transmission.

The first part of the report is devoted to the responsibilities of the State, which is in charge of the said policy. To begin with, the State's commitment in favour of preventing infection is not enough. From the standpoint of healthcare policy, the position of HIV-infection prevention in the new public health environment is unclear and the answers offered seem inadequate when compared to the issues at stake. The government's commitment is also inadequate in that the Ministry of National Education, which is a powerful tool for the State in shaping the citizens of tomorrow, is absent from the policy, despite its applying to French society as a whole. In

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[6] IVS, *HIV Infection in Homosexuals in France. Synopsis of Available Data*, June 2005. Risk-taking in homosexuals under age 25 can also be seen in the 2002 Gay Barometer Report put together by Velter A., Michel A., Semaille C., *Rapport Baromètre Gay 2002*, Saint Maurice, IVS, November 2005, pp. 32-33.

[7] IVS, *HIV Infection in Homosexuals in France, op. cit.*

[8] Conseil national du sida, *Risks due to drug use as a public health issue. Proposals for redesigning the legislative framework,* June 2001. Conseil national du sida, *Rethinking France's Anti-HIV/AIDS policy in the overseas administrative units,* March 2003.

[9] A list of the persons heard is available in the Appendix.

[10] *Plan national de lutte anti-HIV/SIDA* , p. 4.

addition, the failings of public authorities have led to the implementation of government policies that prevent prevention actions reputed effective from being successfully carried out. For instance, the Ministry of the Interior's policies with respect to prostitutes, drug users and migrants push those groups away from prevention associations and increase their exposure risk. Likewise, in prison, prevention policy remains incomplete, for lack of enough pragmatism and due to the more general issues faced by penitentiary establishments.

In Part II, the report focuses on the difficulties that can arise from choosing a prevention policy jointly managed by the national government and associations. Since the outset, the State has gradually passed the implementation of field actions in prevention to the associations, thus giving rise to mutual responsibilities. On the one hand, the State must fully take on the responsibilities inherent in choice, and provide its support to the associations, all the while working to ensure that the associative sector maintains its internal balance. Meanwhile, associations, through the major role they play, need to contribute to joint action by overcoming the controversies that can emerge and by designing their action fully in line with the objectives set out by the national government. In addition, significant issues with regard to knowledge-sharing exist in relation to the work jointly carried out by the State and associations. Knowledge on the epidemic needs to be constantly updated and field actions adjusted in response to the latest issues. Consequently, efforts to spread knowledge, whether about the epidemic or actions implemented, are of fundamental importance, as is regular assessment of all actions launched.

PART I PREVENTION IN THE FACE OF INADEQUATE PUBLIC POWERS

Policy on preventing HIV-transmission requires joint work on the part of a wide range of parties and intersects with many other forms of public policy, making constant adjustments and re-balancing necessary between the parties involved in prevention, but also those working in other areas of national government action. The lack of regulation has led to hesitation in defining the broad lines and difficulties for those working in field prevention. Regulation is the responsibility both of the administration in charge of healthcare and the governmental system as a whole, which must realise the exact importance of public health policy. Other public policies can interfere with public health, but it is fundamental that any action undertaken by a government department, regardless of its type, not go against public health objectives. Prevention policy needs to benefit from regulation at the highest level if it is to enable the implementation of effective action. To achieve this, the messages sent out by the State's highest authorities regarding the urgent need to fight HIV must not focus only on support for developing countries in this area, but also encourage the commitment of the State itself in preventing HIV transmission in France. Those involved in prevention must currently cope with two failings on the part of public authority: the inadequacy of the State's commitment to prevention and the inadequacy of government coordination of the said policies.

1.1 INADEQUATE STATE COMMITMENT

Whether during the elaboration, scheduling or implementation stage, anti-HIV policy requires joint work on the part of many parties from all State sectors or representing the full range of the associative sector and the various professions that make up the healthcare and social sectors. Despite that much-needed diversity, the public authority in charge of health needs to clearly set out the lines for prevention policy. Yet, today, the role given to HIV prevention in public health policy is still unclear and the Ministry of National Education, which should play a fundamental role in prevention education, is absent. While anti-HIV policy is the responsibility of the State[11] and the epidemic still active, there is no denying the fact that the State's commitment remains inadequate.

1.1.1 HIV-TRANSMISSION PREVENTION: AN ILL-EVALUATED ISSUE

1.1.1.1 A STILL-UNCLEAR POSITION IN HEALTHCARE POLICY

Since 2002, HIV-transmission prevention is part of the three-fold change that is witnessing the priority objectives in prevention multiply, financing methods radically change and powers in the field of healthcare reallocated. Adding onto to certain provisions in the so-called Patient Rights Act (March 2002)[12], the August 2004 Public Health Act[13] and the Local Freedoms Act, ratified at the same time, have changed the backdrop for HIV-prevention. Screening and anti-STD measures have been recentralised and regional bodies created, the associations having a place within them. With the change in decision-making frameworks and the participation of new parties, the structure of financing is being affected, as all three of the aforementioned have to fit into the new rules set out by the Framework Act on Finance (LOLF). The changes, poorly understood or explained, make it less easy to understand the role

[11] Public Health Code, Article L3121-1, Paragraph 1: "The fight on human immune deficiency virus and sexually transmitted diseases is the responsibility of the State".

[12] Law 2002-303 dated 4 March 2002 regarding patients' rights and the quality of the healthcare system, published in the 5 March 2002 *Official Journal*.

[13] Law 2004-806 dated 9 August 2004 regarding public health policy, published in the 11 August 2004 *Official Journal*.

ascribed to prevention policy in HIV-infection within healthcare policy[14]. The public authority needs to be able to clarify its objectives, the powers of the various parties involved and the rules according to which actions should be financed.

• Determining the objectives in the fight against the HIV-infection epidemic

The lack of precision as to the role ascribed to HIV prevention in healthcare policy can be seen, first and foremost, in the objectives in the fight against the HIV-epidemic and the indicators used to assess them. The Public Health Act calls for public health policy objectives to be set out every five years, alongside an objectives attainment report. Under the law currently in effect, the report sets forth a list of one hundred objectives, including HIV-infection. By targeting data about the infection's development, the objective selected is used for secondary prevention: lowering the occurrence of AIDS cases to 2.4 per 100 000 people by 2008. The primary prevention objective in transmission reduction, where the indicator is the number of newly-diagnosed cases, does not appear. As the bill was being drawn up, mandatory notification of HIV-infection was in the implementation stage, hence the decision to use a long-measured indicator like that of AIDS cases. Today, the inclusion of the primary prevention objective appears appropriate. In addition, there is a certain amount of confusion over the objectives of HIV-prevention policy, looking at the 2004 Programme "Public Health and Prevention" in the 2006 Finance Bill. The objective listed for HIV and, consequently, the related indicators, are different. Objective 6 in the programme is to "strengthen the adoption of behaviours preventing HIV/AIDS". The indicators used pertain to condom use and campaign recognition[15]. In other words, different objectives can be seen, all legitimate, but not related to HIV-infection transmission, or only related indirectly, with the adoption of prevention behaviours. Such differences between objectives and indicators, like the lack of HIV transmission, reveal the lack of precision in the role ascribed to transmission prevention in health policy. Greater consistency between HIV-related objectives in the Public Health Act's objectives attainment report and in the "Public Health and Prevention" programme are needed. Above all, the primary prevention objective of reducing HIV-transmission needs to be included.

• Poorly-identified powers at the central, decentralised and regional levels

The Ministry of Health, and the National Directorate on Healthcare established under it, is responsible for designing anti-HIV programmes. However, other participants in the healthcare system take part in implementing prevention policy, without their role always being very clear. The decentralised government services, as well as the local authorities, also contribute to both the design and implementation processes. The relations between different levels of national government or between national government and the local authorities are not always patent, due to a lack of clarity and consistency at the level of national government, or due to recent legislative developments for which support measures should be developed.

At the national government level, the Directorate on Healthcare is in charge of devising anti-HIV programmes and the various sub-versions of prevention programmes[16]. The relevant parties at the National Directorate on Health (DGS) or other Directorates such as DHOS (Directorate on Hospitalisation and Healthcare Organisation) are not always clearly identified and staffing levels appear too low. Such weaknesses denote disinterest in HIV at the national government level. It should be noted that, as is emphasised in the Planning Commission's Report[17], Bureau 6A "Anti-HIV" of the DGS have little staffing, but most importantly, do not show any person specifically in charge of prevention at the Health and Society under-directorate[18]. This means that problems are likely, whether in devising the programme or incorporating whatever proposals may be set forth by those involved in prevention.

The previous anti-HIV programme covered 2001-2004 and enjoyed broad consensus. Its main lines were to maintain prevention in the general population and extend access to prevention and screening. In other words, for the first time, people of foreign descent were included as a target population and priority regions identified[19]. More recently, for 2004-2006, the DGS published a programme

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[14] IGAS, 2003 Annual Report. *Santé, pour une politique de prévention durable*, Paris, La Documentation française, 2003, p. 123. These remarks can be applied to the entire prevention policy, making them "the sign of an inadequately disseminated public health culture".

[15] Indicator 1: percentage of young people aged 15 to 26 having used a condom during their first sexual experience. Indicator 2: percentage of young people aged 18 to 24 having used a condom during their most recent sexual experience. Indicator 3: recognition rate for AIDS prevention campaigns by target populations.

[16] French National Health Directorate, *Programme d'actions de prévention de l'infection VIH/sida et M.S.T. en France pour les hommes ayant des rapports avec les hommes pour les années 2001-2004*, November 2001. French National Health Directorate, *Programme national de lutte contre le VIH/sida en direction des étrangers/migrants vivant en France, 2004/2006*.

[17] National Evaluation Council, National Planning Commission, *La politique de lutte contre le sida 1994-2000*, Report by the Anti-AIDS Policy Evaluation Authority 1994-2000, November 2002.

[18] CNS Hearing.

[19] This applies to the following regions: Ile-de-France; Provence-Alpes-Côte d'Azur; Rhône-Alpes; Aquitaine; Midi-Pyrénées; Languedoc-Roussillon; Guadeloupe; Martinique; Guyana.

focusing on foreigners[20]. The section devoted to prevention laid emphasis on communication campaigns, and dealt with care during pregnancy and prevention in HIV-positive patients.

In contrast, in designing the 2005-2008 programme, the DGS launched the consensus-seeking efforts later on in the process, making it difficult to incorporate remarks, as they could only be voiced as criticism of a nearly-completed document. DGS takes action in steering, but has not yet fully integrated certain concepts brought out by changes in the healthcare system, in particular the participation of HIV patients. That lack of precision in designing the programme reinforces the impression that less attention is devoted to anti-HIV efforts.

At the decentralised level, the perception of powers attributed to regional offices and those befalling the departments is hindered by recent changes in remit. The decentralised powers have successfully adapted the national programmes. Certain DDASS have proven innovative and developed specific programmes themselves, like the Paris[21] office, which worked with associations to implement the various actions. The PACA DRASS also managed to put together regional versions of national programmes. In other local governments, where the epidemiological situation is very different, similar efforts to bring the parties in contact with one another have also been identified[22]. In the aforementioned cases, the State's commitment can be clearly seen. However, in many other departments or regions, public health inspecting physicians (MISPs) are expected to deal with a workload so large that such efforts cannot be made, or the resulting choices end up different. For instance, condoms can be distributed by the MISPs, but depending on the geographic region, the rationale behind this can be very different ranging from a response to issues identified at the local level, to a desire to fulfil demand alone. Condom distribution is sometimes seen as a burden to be dealt with, rather than a means of communicating about prevention. On the issue of condoms, the chain of command involves the INPES and DDASS offices and has predictably stirred questions as to the responsibilities of the various parties involved in the system's shortcomings.

The Public Health Act provided a regional framework for public health policy. A regional health plan is set to be determined by the State, once the Regional Conference on Health, responsible for assessing regional public health objectives, has handed down its opinion[23]. The regional health plan will be implemented by a Regional Public Health Grouping, which will involve all of the national and regional parties involved in healthcare[24]. The Regional prefect sets out the implementation procedures "taking into account the features specific to each region"[25]. This means that the objectives set out at the national level will benefit from planning and implementation specifically suited to the regional level. The fight against HIV-infection, except in top-priority regions, will in other words give rise to arbitration, just like other objectives do. The objectives attainment report under the Public Health Act sets out a series of five strategic plans for 2004-2008, the most widely-known being the fight against cancer (the others deal with violence and addictive behaviours, health and the environment, chronic illnesses and care for rare diseases)[26]. In other words, HIV-infection prevention at the regional level competes with the aforementioned programmes.

Ratified in August 2004, the law is being implemented gradually, but its implications at the local level are still not clearly visible, whether to associations, aside from those with powers to monitor the changes, or sometimes State civil servants. The roles and powers of the regional powers are stated in the law, but those of healthcare or prevention advocates can be set out in other legislation, without necessarily being seen, recognised or understood. For this reason, the rules and requirements need to be clarified in order for prevention advocates to re-fit their action into the new setting.

- INPES: An uncomfortable role, unsteady missions

Founded in 2002, INPES is responsible for implementing prevention policy, but the role and missions of what is a public government establishment have turned out inadequate with regard to almost all of the parties in healthcare, as its independence and position are

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[20] French National Health Directorate, *Programme national de lutte contre le VIH/sida en direction des étrangers/migrants vivant en France, 2004/2006*.

[21] Paris Directorate on Health and Social Affairs, *Programme d'actions de prévention de l'infection VIH/sida pour les hommes ayant des rapports avec les hommes*, December 2001.

[22] CNS Hearing.

[23] Article L 1411-11 and L 1411-12, Public Health Code.

[24] Article L 1411-14, Public Health Code. Article L 1411-15 lists the organisations involved as: the State, IVS, INPES, ARH, the regional government (or local governments, in Corsica and Saint Pierre et Miquelon), the departmental governments, townships or town groups, URCAM, CRAM, and Public Health Insurance.

[25] Article L 1411-10, Public Health Code.

[26] Public Health Objective Attainment Report, appendix to Law 2004-806, dated 9 August 2004. The exact headings are, for each national plan: the fight against cancer, the fight to limit the impact of violence on health, risk-inducing behaviours and addictive behaviours; the fight to limit the impact of environmental factors on healthcare; the fight to improve quality of living for chronic illness victims; the fight to improve care for rare diseases.

poorly defined, as are its strategy and role in financing actions[27]. INPES has changed the face of prevention in France by breaking away from the previously existing pyramid-shaped structure. The French Committee on Health Education, an association, was at the top of a structure in which the regional health education committees and departmental committees formed the base. By turning an associative structure into a governmental structure, France replaced a highly responsive association with a public establishment with more cumbersome operating rules. This is particularly true of the requirements placed upon the organisation with regard to public procurement and calls for tender. The promotion of regional powers, as called for by the Public Health Act, did not bring about the creation of formal ties between a national institute and regional or departmental relay institutions.

INPES also changed the face of prevention through the roles attributed to it (programme implementation, appraisal and consulting, developing education in health, training in health education, managing emergency situations) making it a partner to the DGS. Initially, INPES' missions were defined by the law on patients' rights[28], and were later revised to be presented in a slightly different form, in the 2004 law on public health policy[29]. It should be noted that the public health programme implementation mission is the top priority amongst the missions set out in the 2004 Act, unlike what was stated in 2002. INPES' missions were later extended, when the institute was asked to manage automatic syringe dispensers, for instance. The series of efforts made to define each mission, under two distinct laws and, later, in non-legislative texts, probably contribute to making this public health institute less recognised by the other participating parties. The IGAS report on prevention[30] emphasises that certain INPES powers should not be assigned to it and that it should remain a mission-based administration, taking on a role as an appraiser. For instance, the report states that the DGS' decision to entrust INPES with responsible for paying subsidies to associations is an error[31], even though it is difficult to see how programmes could be implemented without any financing capacity. The other component making INPES' situation more unwieldy is the authority that the Ministry of Health has over it, while the majority of its budget – 75% – is provided by CNAM[32].

This muddles up its position in the healthcare institution landscape, and the confusion over the ties between INPES and government offices or healthcare system institutions is heightened by the fact that it takes orders not only from the Ministry of Health, but also the Ministries of National Education, Labour and National Infrastructures. INPES is assigned duties, but does not have the independence required to perform them successfully, as its governing institutions do not allow it control over its internal schedule or the right to set out a strategic framework document. The institute's duties need to be specified in order to clarify its relations with other institutions in the healthcare system.

• The troubling development of funding structures

Changes in public healthcare policy affect the way in which prevention is funded. Today, the lack of clarity around prevention policy is heightened by the wide range of financing possible. The said diversity is necessary, but makes the situation difficult to understand. Funding methods for HIV-infection prevention have regularly changed with the epidemic and in accordance with what was deemed to be the most appropriate response at the time. When AFLS was founded in 1989, it was designed to clearly show the State's commitment to fighting the epidemic, and the agency put together calls for tenders to fund the actions of associations. Once the State's shortcomings have been overcome, responsibility for funding will go to DGS, which has since become a means of overseeing the activities of associations[33]. The founding of INPES marks a new stage in this development, with the DGS making INPES responsible for managing subsidies to associations on all prevention actions, in addition to its work exchanging syringes and providing condoms. At the national government level, this means that there are two "backers" providing subsidies. The two sources of financing, though resulting from different rationale, contribute to maintaining the confusion.

The DRASS offices currently receive subsidies to finance the associations previously operating under DDASS leadership. The DDASS offices are now in charge of issuing an opinion on projects, which can be helpful in that they are familiar with the field reality and perform follow-up, while not being involved in execution. The decision to move powers up from the DDASS to the DRASS is consistent with the transfer of public health policy to the regional powers and the creation of regional authorities. However, whereas the relevant workers were able to follow in the move from the department to the regions, the local associations can sometimes lose

[27] Article L. 1417-1 of the Public Health Code: "A public State establishment named the National Institute of Prevention and Education for Health is responsible for: implementing, on behalf of the national government, and the establishments operating under it, the public health programmes called for in Article L. 1411-6". INPES is also responsible for acting as appraiser and consultant and ensure that education on healthcare and therapeutic education are offered.

[28] Article 79, Law 2002-303, 4 March 2002 regarding patients' rights and the quality of the healthcare system.

[29] Article 7, Law 2004-806, 9 August 2004 regarding public healthcare policy.

[30] IGAS, *Rapport annuel 2003, op. cit.*

[31] *Idem*, p. 314. Calls for project proposals include those dealing with: reducing HIV occurrence in top-priority populations; reducing delays in screening; STD prevention and identification.

[32] CNS Hearing. Regarding the balance of power on prevention between CNAM and INPES, see IGAS, *Rapport annuel 2003*, pp. 119-120.

[33] Pinell P., *Une épidémie politique. La lutte contre le sida en France, 1981-1996*, Paris, PUF, coll. Science, histoire et société, 2002, pp. 197-199.

sight of their contacts. Its presence on the field provided a guarantee that the DDASS offices would properly track the prevention programmes funded. The tie between the DRASS offices and local parties needs to be kept up.

Within the new regional framework, competition will be encouraged between the associations as regards choosing between the various healthcare programmes. At the same time, the arrival of the Framework Finance Act profoundly changes the funding procedures by instituting binding objectives contracts, under which the renewal of subsidies is dependent on performance. In other words, the rules determining how funding shall be allocated will change the negotiation procedures at the regional level or with respect to the legal framework. For this reason, it is necessary that any information that can help understand the implications of the law be provided, not only with regard to funding for associations, but also with regard to how associations are managed internally.

1.1.1.2 SLIGHT ANSWERS FOR AN ACTIVE EPIDEMIC

The HIV-epidemic is active in France and, while the State has implemented prevention campaigns and funding for field programmes, it has failed to show real determination to take action to slow down HIV-transmission. Whether with regard to the actions targeting people or the campaigns, its responses have appeared weak and intended to bide time, when compared to the epidemiological data. For instance, mobilisation in favour of people originating from sub-Saharan Africa needs to receive strong support. Likewise, the concerns stirred by persisting transmission levels amongst gays needs to give rise to regulatory measures guaranteeing access to prevention materials in all public places. Lastly, in the countryside, there is an absence of outright and consistent determination to deal, in a distinct manner, with those living with HIV and those exposed to high transmission risk.

- **High-risk transmission exposure groups lacking mobilisation**

The prevalence of HIV-infection in France is low. UNAIDS has published an estimate of 0.4% of people living with HIV[34]. Aside from the fact that it is difficult to evaluate the prevalence of HIV[35], finer detailed information needs to be provided about transmission groups. Prevalence is far higher amongst men having had sexual intercourse with men, and the results from mandatory HIV-infection notification show that people from sub-Saharan Africa account for a major portion of those who have been recently diagnosed as HIV-positive for the first time. For this reason, it is important to look both at the mobilisation capacity of migrants and the opportunity for mobilising the gay community, taking into account the current sexual and risk-taking cultures.

The latest results from HIV-infection monitoring show that 50% women and 20% of men diagnosed for the first time are sub-Saharan Africa nationals[36]. Considering how high transmission levels are in the group, active mobilisation on the part of associations will be needed in order to deal with the epidemic. Existing AIDS organizations recognise the difficulties they encounter with this population, whether as regards the ability of association proponents to fulfil current requirements, or the existence of mobilisation opportunities for foreigners[37]. This is why associations founded by peers stand out as one of the means to be favoured for informing the groups. Nonetheless, while there are many associations made up of people from Africa, with a variety of aims, in culture, sport or development aid, very few of them become involved in prevention work itself.

For instance, with regard to action targeting North Africans, there are very few associations specifically working in anti-HIV. Officially, only the Committee for Families, which refuses to fall within the category of State-funded activities, offers support to infected people and their loved ones[38]. Another player identified is the FTCR, which has established itself near Mediterranean ports and works with North African families leaving France for their holidays. Some associations target populations from sub-Saharan Africa, contributing to prevention actions, by making it possible, for instance, to circulate information during parties and special event. Some of them, founded to target Central African nationals, operate in bars. Others deal primarily with women, or are composed of African physicians working in hostel for workers. That handful of clearly-identified associations fulfils only part of current need, at a time when a wide range of programmes would be needed, whether targeting prostitutes or men living alone in homes, and would need to be suited to different lifestyles, depending on country of origin and living conditions that are not the same for all parties. The diversity of these few associations that have recently gained visibility clearly show the need for varied action. That action needs to receive support, even though it automatically involves a large number of parties. Such support is possible in particular in partnership with major associations which, by virtue of their skills either in developing, managing or funding programmes, are valuable backers. One example is a major Comorian association in Marseilles, which has developed a remarkable anti-HIV programme, supported by AIDES.

[34] Onusida, *Report on the global Aids epidemic, 4th global report*, June 2004, p. 197.

[35] Desenclos J.-C., Costagliola D., Commenges D., Lellouch J., "La prévalence de la séropositivité VIH en France", *BEH*¸ n° 11/2005, 15 March 2005.

[36] IVS, *Surveillance du VIH – Données au 31 December 2004*, www.invs.sante.fr/surveillance/vih-sida/default.htm.

[37] AIDES, *Etat des lieux migrants 2004*, undated.

[38] CNS hearing.

Migrants live and work in our society. The association ARCAT has developed prevention and information programmes in companies, but they are mainly one-time efforts, intended primarily to raise awareness about discrimination[39]. Migrant workers are highly present in certain sectors of activity, such as maintenance, cleaning or construction. The State needs to encourage companies in those areas or the organisations representing the interests of the said economic sectors to take part in spreading information to the high-risk transmission exposure population. This is especially true given that many tools exist, and that they were developed in connection with the Labour Relations Department under the Ministry of Health, whereas the State has never taken responsibility for circulating the tools[40].

The prevalence of HIV in the gay population is estimated at 12 to 14%[41], and the spread of HIV through homosexual intercourse accounts for a large proportion of newly-diagnosed cases. Behavioural data from the "Gay Press Survey" show that risky behaviour is more frequent amongst homosexuals than in the past. The number of people declaring unprotected anal penetration is constantly on the rise, by nearly 70% between 1997 and 2004[42]. The risk-taking is the greatest amongst HIV-positive men (49% of them) and those who do not know their status (45% of them). In other words, transmission is continuing amongst homosexual, risk-taking is increasing and HIV-infections are joining other STDs or co-infections, for instance with VHC[43]. In a press released dated 26 June 2005, the inter-LGBT announced new responsibility-allocation in the fight against HIV[44]. It appears important that all gay associations mobilise more clearly in favour of the fight, alongside efforts to fight the persisting discrimination that gays must face in France.

The notable increase in risk-taking and the emergence of STDs such as lymphogranuloma Venereum (LGV) require that the State provide a clear response in favour of prevention amongst gays. The State must show its dedication to the fight against HIV by implementing a recommendation set forth in the national anti-HIV plan for 2001-2004. It pertains to the use of the Consumer Code and the Public Health Code, making it mandatory to provide prevention materials in commercial sex establishments[45]. The notable increase in risk-taking and the emergence of STDs such as LGV require that the State provide a clear response in favour of prevention amongst gays. Ensuring universal access to prevention materials in such establishments would make it possible to deal with persisting transmission levels, yet without jeopardising freedoms. Concurrently, encounters in outside pick-up sites still occur. It is therefore important to also take those into account and support actions targeting those who frequent them.

Likewise, such measures need to apply to the commercial sex establishments that target heterosexuals or bisexuals. It is particularly regrettable that the heads of such establishments targeting heterosexuals, barring local exceptions, do not show the same interest in prevention as some gay establishments. A regulatory framework needs to be set up to ensure that prevention materials are available in all sites offering the opportunity to have sexual intercourse.

• The need to make better use of tools

The State has tools which it does not use to their fullest, such as information and prevention campaigns, or the healthcare system itself. As regards the so-called "general public", the Ministry's prevention messages are conveyed mainly by television on the 1st of December, World AIDS Day. Yet awareness-raising efforts of this kind can also be carried out through messages sent out during Sidaction's calls for donations. The campaigns, produced by INPES, nonetheless remain limited in timeframe and target a variety of groups, from heterosexuals, homosexuals and migrants. In 2004, one notable innovation was an ad showing the many undesired effects of treatment. Some media make it possible to send out the messages to specific populations. For instance, Radio France

[39] The partner companies belong to very different business sectors, from Axa, to Lafarge, Sony, La Poste, Total or Monoprix. See www.arcat-sida.org/actions/entreprise.php.

[40] AIDES, AGEFIPH, Ministère de l'Emploi et de la solidarité, *Guide de sensibilisation VIH et milieu de travail* et *Savoir pour agir : VIH et milieu de travail*, 2001.

[41] IVS, *Infection par le VIH chez les homosexuels en France, op. cit.*.

[42] National Institute for Public Health Surveillance, National Agency for Research on AIDS and Viral Hepatitis, *Premiers résultats de l'Enquête Presse Gay 2004*, 22 June 2005, pp. 17-18: "The percentage of respondents having experienced at least one unprotected anal penetration in the past 12 months with occasional partners was 19.5% in 1997, amounted to 25.9% in 2000 and reached 33.2% in 2004".

[43] Gambotti L., "Acute hepatitis C infection in HIV positive men who have sex with men in Paris, France, 2001-2004", *Eurosurveillance*, 10 (4-6), 2005, pp. 115-117. van de Laar M.J.W., Fenton K.A., Ison C., "Update on the European mymphogranuloma venereum epidemic among men who have sex with men", *Eurosurveillance*, 10 (4-6), 2005, pp. 134-135.

[44] 26 June 2005 Press Release from Inter-LGBT, "La Marche des fiertés lesbiennes, gaies, bi et trans rassemble 700 000 personnes - L'Inter-LGBT demande au Premier ministre d'agir pour l'égalité".

[45] *Plan national de lutte contre le VIH/sida*, 2001-2004, p. 11: "Establishment directors will be asked to comply with hygiene regulations, ensure that condoms and gel are made easily, widely and freely accessible, in line with the Consumer Code (Article L 221-1) and will accept the contribution of prevention associations. France's Higher Council on Public Health will be asked about possible emergency measures to be taken or enforce, in line with Article L 1311-4 of the Health Code; in Paris, a working group comprising DDASS, the Prefecture, DGCCRF, the Prefecture of Police and the Town Hygiene Department will come together to plan enforcement measures on existing regulations and measures recommended by CSHPF; the commitment charter around prevnetion and hygiene applying to establishment directors and drafted by SNEG, will incorporate the recommendations".

International, TV5, local radio populations in the overseas departments, or those intended for African populations in mainland France, can carry prevention messages, or messages with contributions from prominent figures and artists[46]. Other media also exist, like videos, though which short clips intended for the sub-Saharan Africa population (Mussa the Cab Driver) or North African (Huria) can be sent out. Such media are used by associations, which draw on them as a starting point for discussion. The posters and brochures published and distributed are also many in number and style: posters, pamphlets, postcards and, for DFA target populations, men with homosexual practices or sub-Saharan Africa migrants. The documents can also be made available in many languages and developed in conjunction with the associations[47]. The tools available can be highly varied, but it is rare that information be sent out through mass media. Communications campaigns launched by other parties, such as the City of Paris or associations can make a useful contribution to government-produced documents. It is regrettable that, in publications such as *Têtu*, prevention messages from INPES are not regularly included.

Moreover, despite the wide range of materials and messages existing, the lack of distinct messages for HIV-positive and HIV-negative populations is regrettable. Yet different approaches are a necessity, depending on whether the target population already lives with HIV or is rather at risk of being exposed to transmission. Likewise, the decision to do away with prevention practices, whether temporary or long-lasting, results from different rationale. The perceived seriousness of HIV-infection has changed due to the impact of treatments and the analogy drawn with chronic illnesses. However, it seems helpful to give a more realistic vision of what life with HIV is, the first factor being a decline in self-sufficiency, not only because of the life-long treatment required, but also because HIV-infection changes relations with friends, family and co-workers.

Hospital establishments also need to take part in primary HIV-infection prevention, as part of an overall treatment approach. The role that the care provision team can play in prevention was emphasised in the 2002 version of the Delfraissy Report. Prevention is portrayed as a duty for caregivers and a variety of strategies are suggested as to how to broach the issue with infected people[48]. There has, seemingly, been little compliance with the recommendations and outpatient physicians seem particularly absent from prevention actions. The lack of prevention for infected persons is underscored by the fact that the circular on prevention and education duties to maintain health in patients treated for HIV-infection in healthcare establishments came out very late, at the end of 2005, when compared to the epidemic's age – over twenty years. The newly-established COREVIHs are responsible for prevention and thus offer an opportunity to support prevention work targeting infected persons. The experiences observed in support groups about self-esteem or on sexual issues show that such exchanges foster the emergence of discussions about prevention[49]. In light of that experience, the wards dedicated to infected persons can contribute to primary prevention as part of a broader care approach, rather than in a prevention medical visit.

Alongside that, hospital establishments provide emergency treatments in the event of accidental sexual exposure. Aside from the fact that such treatment needs to be easy to access and not give rise to an objectionable attitude on the part of the medical staff with regard to the person, it is important that information and guidance be prepared for associations. When post-exposure treatment is prescribed, following accidental sexual exposure, this should be the opportunity to offer support, especially if the person requesting it has trouble finding protection. Lastly, some treatment establishments, such as psychiatric establishments, need to set out a specific prevention policy. The efforts made by certain physicians for many years now have made it possible to both emphasise the importance of prevention policy in a psychiatric setting, and the issues this may raise on the part of healthcare personnel and supervisory staff. Internal rules and regulations prohibit sexual relations and drug use both, yet this cannot be considered a prevention policy. The heads of such establishments can but have trouble concluding that such practices are adopted by people living in them. For this reason, the experiments currently carried out in psychiatric establishments should be extended to all establishments[50].

1.1.2 PREVENTION IN THE NATIONAL EDUCATION SYSTEM: A NOTABLE ABSENCE

Alongside its missions in disciplinary education, the Ministry of Education, along with public and contracted establishments is one of the tools that contributes to training for future citizens. As such, the State's withdrawing commitment in the field of prevention is blatant insofar as education in sex and intimacy is either dealt with as the establishment heads see fit, and to whatever extent the staff and associations are willing to look into it, or limited to well-designed but unenforced circulars.

1.1.2.1 INSUFFICIENT INFORMATION TO TEENAGERS IN SCHOOLS

[46] Examples include Jocelyne Beroard, Rokia Traoré, Firmine Richard or Sonia Rolland and Christine Kelly.

[47] Instructions for using the male condom, for instance, are available in 21 languages, including: Arabic, Spanish, Bulgarian, Polish, Mandarin and Haitian Creole.

[48] Delfraissy J.-F., dir., *Prise en charge des personnes infectées par le VIH. Recommandations du groupe d'experts*, Paris, Ministry of Health, Families and the Disabled, Flammarion Coll. Médecine-Sciences, 2002, see p. 292 in particular.

[49] Georges Pompidou Hospital support groups.

[50] CNS hearing.

Aside from the few exceptions where it is organised at the regional level, information about HIV-infection prevention is reliant on a few people mobilised in the establishments. The said parties call upon associations that are not capable of fulfilling all the requests they receive and whose job requires that they provide information about a difficult topic – sexuality – under sometimes poorly-suited circumstances.

• Actions resulting from individual initiatives

Prevention or information programmes are often organised in schools thanks to personal dedication on the part of the school nurse, sometimes an establishment head or an instructor. They take the initiative to invite associations into the picture, and in some cases, have done so for many years now. In such cases, if prevention programmes exist within the establishment, a one-day or half-day event on prevention is held, through the commitment of a handful of people. Aside from such exceptional situations, even when the proposal comes from a member of the national education administration, it can be rejected by the establishment head or parent representatives. When it occurs, refusal results from fears regarding the content of the messages spread, even though these can easily be alleviated by informing establishment heads and parents in advance of both the objectives and content of the action.

Such action, based on personal initiative, contrasts with the training efforts funded by the Ministry of National Education for instructors, based on association skills transfer programmes[51]. Until now, 10 500 people have been trained, specifically physicians, nurses and school nurses, life and earth sciences (SVT) teachers, and primary education advisors (CPEs). More resources need to be made available at the national level, but there is also a need for real support from the school systems. For example, out of France's 30 school districts, only 22 steering teams have been established and have organised prevention actions. The latest review in the lower secondary system goes back to 2001 and shows that only 50% of lower secondary schools are in this situation. A review carried out in 1997 show that demand from instructors, in particular for supplementary training in sex education methodology and scientific teaching. Since that time, 250 people have been trained[52], but are no better equipped than the associations in terms of setting in which students can benefit from their knowledge. Teaching missions do not always match those of prevention, though the two can be complementary. Referral to lessons on biology and reproduction in life sciences courses are not enough. Despite the training and efforts made today, there is no review of the actions carried out, but only a summary on the people trained from 1997 to 2000. In addition, while INPES does have an agreement with the Ministry of National Education, implementation of prevention in the establishments is based on the determination of the latter or the national administration.

• Associations challenged to fill in for the National Education system

Campaigns targeting the general population are carried on through direct contact with adolescents and young adults. Action in the upper secondary schools stands out as the easiest way to spread prevention and health education messages. Action in secondary schools depends, as we have seen, on individual commitment, but the handful of actions currently underway remain very unevenly spread across the regions and are difficult to implement for several reasons.

First of all, when they are not called for by an establishment, action proposals are not always well received, including when they come from associations approved by the Ministry of Education to do such work. It is surprising to see that the approval for associative action from the Ministry does not allow access to establishments. In other words, the barriers can exist at several levels. Action is difficult to carry out as, when it does take place, those involved must sometimes run several information sessions in a row in order to see all of the classes at a given level within a day, thereby preventing effective exchange.

The associations do not have enough proponents trained or willing to carry out such action. In some cases, the said parties have to fill in gaps in the students' education in biology and that they broach issues in sexuality, with which instructors can sometimes be uneasy. Lastly, their action needs to be suited to the wide range of students addressed.

The National Education system must not only open up to the associations to which it issues approval, but action on the part of prevention advocates need to be seen as an integral part of the curricula. These will mean consistently planning action over time, rather than providing or one-shot actions during which an association representatives speaks to dozens of students for an entire day. At the least, sex education and prevention need to be listed as part of each establishment's mission plan, thus implying work with the principals, upstream.

1.1.2.2 MAKING SEX EDUCATION AND PREVENTION EFFECTIVE

Despite the landscape just described, the Ministry of National Education has put out circulars on education in sex and intimacy, but they have not been effectively implemented. HIV-infection prevention needs to be made part of health education including education on sex. It needs to be supervised and validated and, to make this possible, included in the curricula, the only effective way to

[51] CNS Hearing.

[52] CNS Hearing.

enforce it. This would make it possible to better prepare establishments to receive the circulars sent out the day before 1 December, reminding them of the importance of continuing to properly inform students[53].

• Circulars that are high in number yet low in effect

HIV-infection prevention is integrated into sex education programmes that also include prevention of sexual violence. The Ministry of National Education, at the national level, has continuing think-tank efforts on health and sex education and the way in which they should be incorporated into educational work or combined with other issues, whether interpersonal relations or sexual violence. The results of those discussions are the foundation for circulars designed to explain or offer a reminder of how an article of law should be integrated into teaching. Unfortunately, the impact of the circulars appears to be nil, considering what was said above. The circulars go into sex education in a broad sense, for instance that of 19 November 1998[54]. The relationship dimension of sexuality is dealt with extensively and includes specific objectives with regard to self-image, dealing with others, the right to sexuality and education in responsibility. All of these points are essential in prevention. The decision to incorporate sex education into a broader setting was extended through reflections that ultimately led to suggesting sex education throughout the school years, with adjustments made as students rise through the educational system. The 1998 circular, for instance, was replaced by the February 2003 version on sex education in primary, lower secondary and upper secondary schools[55]. Sex education needs to make it possible to combine scientific knowledge with thinking about individual, family and social responsibility. The circular recalls the terms of the 4 July 2001 Act, Article 22[56] on voluntary termination of pregnancy, which provides that students shall take part in three mandatory sessions per year on sex education. It sets out the procedures by which the sessions shall be implemented, with the most frequent topics including: diversity, mutual respect and AIDS-prevention. The inclusion of health education in a broader setting was restated with the 1 December 2003 circular[57] on the five-year prevention and education programme, which states in its preamble: "consideration for student health cannot be limited to a handful of specialists, but relates to the whole of the educational community. For that reason, promotion for student health cannot be separated from overall educational policy". Point 3.2 "Developing Sex Education" draws upon the 17 February 2003 circular and the July 2001 Act. It states that supporting documents for discussions will be updated and, indeed, the brochure for upper secondary schools entitled *Ten Questions about HIV-AIDS*, drafted in conjunction with the National Directorate on Healthcare, was updated in 2004[58]. Despite the updating of those documents, circulars and brochure, which reflect real thinking about the place of health in educational work, the impact of providing information in school establishments remains minimal.

• A form of education that is lacking in the curricula

In other countries, similar concerns have given rise to different responses. For instance, instructors in Canada have been given training in health-related prevention, but this did not make it possible to show any greater involvement on their part in health education for student. Such awareness-raising efforts are probably necessary, but not sufficient, for students to effectively receive information. In France, efforts to establish standards exist through circulars, but the funding required is lacking and the desire to verify enforcement is not clear. Consequently, in order to make sex education effective as part of a broader health education effort, it needs to become part of the curricula, as they are the only means today for information to be conveyed to students. Such education needs to see prevention in its broadest sense and contribute to preventing STDs and unwanted pregnancies, improve boy-girl relations, respect for others and different sexual orientations, as stated in the aforementioned circulars. Today, there exists an Information Technology and Internet Certification earned upon completing lower secondary school and for which a set number of course hours has been determined, with adjustments over each year of lower secondary school. A certificate designed according to the same model needs to be considered for health education and the sex education dimension.

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[53] Circular n° 2004-206 dated 12 November 2004, *Journée mondiale de lutte contre le sida: 1er December 2004*. Circular n° 2003-202 dated 17 November 2003, *Journée mondiale de lutte contre le sida: 1er December 2003*. Circular 2002-262 dated 22 November 2002, *Journée mondiale de lutte contre le sida: 1er December 2002*.

[54] Circular n° 98-234,19 November 1998, Sex education and AIDS prevention.

[55] Circular n° 2003-027 17 February 2003.

[56] Article 22 of Act 2001-588 dated 4 July 2001 on voluntary termination of pregnancy and contraception is a supplement to the Educational Code, with Article L312-16: "Information and education about sex shall be provided in primary, lower and upper secondary schools through at least three annual sessions and by uniform age group. The sessions may bring in personnel contributing to schools' health mission and staff from establishments mentioned in Paragraph 1 of Article L. 2212-4 of the Public Health Code, as well as other outside advocates, in line with Article 9, Decree 85-924, 30 August 1985 on local public teaching establishments. Students trained in organisations accredited by the Ministry of Health may also be brought in."

[57] Circular n° 2003-210, 1 December 2003, *La santé des élèves: programme quinquennal de prévention et d'éducation*.

[58] Available at the following address: http://eduscol.education.fr/D0060/sida2004.pdf.

By making sex education, as part of health education, a full-fledge form of education, the State would clearly display its commitment to preventing STDs and health in general.

I.2 INADEQUACIES IN GOVERNMENT POLICY COORDINATION

The action conducted by field advocates need to not only overcome issues in spreading information required for prevention, but also deal with the inadequacies of government coordination for policies implemented in areas other than health. Whereas prevention policy should make the most vulnerable populations their priority[59], prostitutes, drug-users, migrants and the incarcerated are not able to fully benefit from them. The inconsistencies of governmental policies can either heighten exposure risks or deprive the said parties from some of the tools required to protect them.

1.2.1 POLICIES AND PRACTICES INSTITUTED BY THE MINISTRY OF THE INTERIOR HINDERING PREVENTION

Since 2002, a range of legal measures has made life more difficult for both those most exposed to transmission risk (migrants, prostitutes and drug users) and the associations that help them keep up their efforts as regards prevention behaviours. The prevention actions funded using public money are, in other words, hurt by policies that are actually obstacles to them. In addition to those obstacles, arbitrary administrative practices and variations in the extent to which regulations are enforced across the nation can also be noted.

1.2.1.1 TIGHTER CONSTRAINTS FOR MIGRANTS

Preventing HIV-transmission in migrants living in France means overcoming the obstacles specific to that population as it aims to access healthcare. Those obstacles are heightened by a quest for rights that too often pushes health to the bottom of the list of everyday priorities.

- **A vulnerable population with uncertain access to healthcare and information about prevention**

Many factors make migrant access to prevention difficult, starting with social inequality in healthcare. This population's living conditions, level of education and proficiency in French have a negative impact on their health, reflecting the fact that inequalities in healthcare "are *also* social inequalities, and also does not mean exclusively"[60]. Moreover, their income level influences their tendency to make use of health services and social instability has an effect on health[61].

Looking at an active segment at Delafontaine Hospital in Saint-Denis, it is easy to see the link between living conditions and HIV-infection[62]. For instance, the data on precarious living conditions in sub-Saharan Africa nationals treated for HIV-infection are well-known: 52% of those living in the greater Paris region are in precarious housing. The same population also has low income and reports being either jobless (47% of those active) or employed as a "clerk" or "manufacturing worker" (77% of those active)[63]. The problems arising from that diminished access to healthcare are heightened by still inadequate prevention actions. Those that exist cannot all reach the targeted populations. In addition, it is still not possible to set up information stands at the sites frequented by vulnerable populations. For instance, the association Afrique Avenir was refused approval by the Prefecture of Police to set up a stand on Chateau Rouge Market, Paris' African market.

Clearly, the foreign and migrant population that lives in France must cope with a combination of negative social factors with regard to health. Prevention of HIV-infection transmission needs to integrate that dimension, especially as "the measures that are effective in this area are unevenly distributed"[64]. It is difficult to establish contact with certain groups, for instance with Chinese migrants,

[59] Article L1411-1-1, Public Health Code: access to prevention and healthcare for vulnerable populations is a priority objective for healthcare policy. The public health programmes implemented by the State and local authorities and public health insurance offices take into account the difficulties specific to vulnerable populations.

[60] Leclerc A., Fassin D., Grandjean H., Kaminski M., Lang T., dir., *Les Inégalités sociales de santé*, Paris, Inserm, La Découverte, 2000, p. 14.

[61] Auvray L., Dumesnil S., Le Fur P., *Santé, soins et protection sociale en 2000*, CREDES, Report n° 1364, December 2001. *Questions d'économie de la santé*, « Santé, soins et protection sociale en 2002 », n° 78, December 2003. « Précarités, risques et santé », n° 68 January 2003.

[62] Study available at: www.popinter.org/article.php3?id_article=108.

[63] Valin N., Lot F., Larsen C., Gouëzel P., Blanchon T., Laporte A., *Parcours sociomédical des personnes originaires d'Afrique subsaharienne atteintes par le VIH, prises en charge dans les hôpitaux d'Ile de France, 2002*, Saint Maurice, National Institute for Health Surveillance, 2004, pp. 13-14.

[64] Leclerc A., Fassin D., *et alii*, *op. cit.*, p. 432: "Moreover, social differentiation with regard to prevention deserves greater interest on the part of researchers, especially considering that such action is known to have a potentially significant contribution to reducing certain risks and pathologies, and that the measures that are effective in this area often have unevenly-distributed effects".

and prevention actions targeting them need to be encouraged[65]. For the population originating from sub-Saharan Africa, the wide range of prevention actions, in bars, individual homes, festivals and homes, show how diverse the migrant population is and how diversified the various messages need to be. Debate exists between those promoting a culture-based approach to prevention and those who feel that no one wishes to be locked up in an ancestral culture that they have rejected. Likewise, while actions in homes can be useful, some note that 80% of migrants from sub-Saharan Africa have individual housing[66]. Those various viewpoints show it is important to maintain a great deal of diversity in action methods.

• **The quest for rights hinders healthcare**

The aforementioned factors, which deter information from being spread and taken on by those for which it is intended, are magnified by the administrative issues with which foreigners and migrants must cope. The uncertainties surrounding their ability to stay in France and restrictions on healthcare are as many constraints making prevention unsteady. The prerequisites for being granted the right to stay in France are, like the prerequisites for access to healthcare when dealing with illegal residents, all hinder access to prevention. CNS has spoken out on these issues repeatedly[67]. For infected people and HIV-negative people alike, living as a clandestine immigrant in poverty-stricken conditions while awaiting a temporary stay permit does not offer the opportunity to consider health or prevention methods.

Whether the individuals legally reside in France and are awaiting renewal of their stay permit, or have just filed a first-time request, application processing times are an issue. Even those who have been legal residents for many years must go through a long renewal application process, sometimes due to the excessive workload with which personnel in prefectures must deal. The process can also be painstaking insofar as the legitimacy of each party's stay and associated right to work can give rise to issues, in particular for student. The stay permit is a pre-requisite for those wishing to be granted health benefits. Yet, a reciprocally poor understanding of the paperwork required on the part of applicants and of health benefits by the civil servants in prefectures and health insurance offices make the process tedious. In certain situations, such as when foreigners do not have a stay permit and file a temporary residency application to receive healthcare, the difficulties are heightened by the sometimes imaginative or illegal requests made by the prefectures. For example, it is sometimes asked that the applicant write a letter of intent to go along with his application, which no legal text requires[68]. Moreover, even when approval is given, the stay permit is not always officially granted. Instead of a one-year stay permit entitling its bearer to work in France, as provided by the law, the person often receives a temporary stay permit that does not entitle the holder to work[69]. This heightens social precariousness. Such issues occur in a setting where the right to healthcare is challenged. No secret is made about the suspicions over the quality of the work performed by physician-inspectors from the public health services, in charge of writing up opinions on each application. This led to the creation of regional medical committees, but these are not always implemented and their value has not been substantiated[70]. Generally speaking, false portrayals of access to healthcare on the part of foreigners in France persist[71].

In addition, preventing transmission implies providing care and psychological support for HIV-positive individuals. The reform of State-funded medical aid or the prospect of implementing a regional medical commission are as many obstacles to preventing HIV-infection, in that they dilute access to information. Those living with HIV need to have quick access to healthcare and are entitled, under the law, to stable residency conditions. The fight against the HIV-infection epidemic requires preventing the virus from being transmitted from an HIV-positive individual to one who is HIV-negative. If the former sees he/she is denied existence and the opportunity to be informed of his status, thus ending up condemned to a life of a utilitarian life, he/she cannot be expected to contribute to preventing infection. If the latter is confined to the same ignorance, how can he/she consider protection? The public health system's two provisions – State-funded medical aid and the right to temporary stay for health reasons – are regularly threatened for reasons that obstruct public health objectives. Yet they need to be maintained, as they are some of the tools vital to preventing HIV.

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[65] Arcat, *Les Chinois d'Ile de France et l'infection à VIH. Savoirs, vulnérabilités, risques et soins*, Cramif/Arcat, December 2003.

[66] CNS hearing.

67 CNS, *Position paper on the medical assessment procedure for aliens applying for residence permits on medical grounds*, 26 February 2004.

[68] AIDES, *Enquête AIDES sur l'accès au séjour, aux soins et à l'hébergement des étrangers séropositifs au VIH en 2004*, Pantin, AIDES, 2005, p. 6.

[69] The issuance of a temporary stay permit entitling its holder to work in France is governed by Articles L 313-11 and L 313-12 of the Code on Foreigners' Entry and Stay and on Right of Asylum. Article L313-11: "Unless the individual's presence is a threat to public order, a temporary stay permit bearing the specification 'private and family life' is automatically issued: 11° A foreigner usually residing in France whose health condition requires medical care without which exceptionally serious consequences would arise, and provided that the person actually cannot receive the appropriate treatment in the country from which he/she comes […]"; Article L313-12: "The permit issued under Article L. 313-11 allows it bearer to work in France".

[70] See CNS opinion dated 26 February 2004.

[71] This is why the Ministry of the Interior can be quoted as having said: "Today, an illegal alien is entitled to more free healthcare than a minimum-wage recipient who pays taxes – unacceptable!", *Le Figaro*, 30 June 2005, p. 6.

Lastly, questions need to be raised about the actual possibility for foreigners detained or kept in detainment centres to gain access to the resources needed to apply for temporary residency for medical reasons. The information available about living conditions in detainment centres or holding areas in airports give reason to believe not only that such risks do exist but that, moreover, healthcare in general and prevention are reduced to their simplest form or are not taken into account at all. For people illegally residing on French soil and housed in detainment centres, access to healthcare and information about prevention is a real issue. The fact that such sites are relatively closed-off make them areas from which prevention is absent, even as they take in people likely to have been exposed to the virus[72].

1.2.1.2 ACCESS TO PREVENTION QUESTIONED

Whereas prostitutes and intravenous drug users have been effective prevention advocates for many years, the articles listed in the Domestic Security Act (LSI)[73] on prostitution and rising police pressure on certain sites have worsened these groups' health situation and made the work of healthcare personnel harder. Prostitution is repeatedly the focus of debate in France, relaunched by the implementation of LSI. Two debates have been carried out side by side, one on the attitude to be adopted with regard to sexual workers and their activities, alternating between legalisation and prohibition, the other focusing more specifically on the impact of the Domestic Security Act on the health of prostitutes and working conditions of prevention agents. We will focus on the latter here.

• The shaky successes of prevention amongst prostitutes

Debate as to the framework to develop around prostitution does not always properly assess the extent of the healthcare actions that have developed from community associations and their diversity. Community associations have been performing effective health education for many years. For instance, the operating mode for the Women's Bus in Paris has been reproduced by Cabiria in Lyons and PASTT, which works with transgenders. The founding principle for the action is to provide training in prevention to prostitutes, who can later protect themselves and educate their clients. Faced with the growing precariousness of this group, this specifically health-focused work required the development of social programmes, in particular those regarding access to rights for foreigners. This change in community work calls for an all-encompassing approach to healthcare, which itself requires new skills. The presence of foreign prostitutes has also made it necessary to provide greater support for health-related actions, for instance screening. In the medium term, those who use Cabiria's services come for screening, then are guided to hospital care when necessary. One example is people whose income has decreased, hence also making their living conditions more difficult.

However, some prostitution practices cannot be helped through community work. Prostitution covers a broad range of practices, put to work by different people in a wide range of locations. The diversity of those practices is such that no single form of prevention can be applied. Street prostitution, in a variety of forms, remains the most accessible, whereas that organised via the Internet, through ads in specialised magazines or in bars is less so, just like that organised in workers' hostels. People working as prostitutes also have differing and changing profiles. One example is the development of prostitution amongst Chinese women who are relatively old when compared to the usual criteria; their migratory history and background are different from those of women from Africa or Europe[74]. Some people do not necessarily recognise themselves as prostitutes. This is true, for instance, of those who work occasionally or in closed places, like hostels. Lastly, the conditions in which this type of work is carried out leave healthcare personnel very differing degrees of room for manoeuvre, insofar as certain prostitutes are kept under close watch by their procurers, who allow them only the briefest of breaks when the prevention buses pass. For this reason, while it is still possible to hand out condoms, exchange with the bus team, possibly leading to improvements in prevention capacity for prostitutes, is kept to a bare minimum. The language barrier is another major obstacle, even though some associations have prevention workers who speak foreign languages[75].

HIV-transmission prevention therefore requires additional investments so that, materially speaking, it is possible to provide information to those who are not covered by road associations. This prospect is all the more necessary as the LSI's provisions on solicitation contribute to the development of clandestine practices. Approaches to prevention therefore need to be adjusted in accordance with the origins of the prostitutes and what brought them to migrate or work as prostitutes. For instance, migrant or foreign transgenders often do not have any choice but to work as prostitutes to earn a living. The places where prostitution takes place also require adjustments and, in some cases, innovations. For instance, action targeting street prostitutes or those operating in mini-vans cannot be similar to that conducted in the outskirts that can only be reached by train or road, whether the forested areas around Paris or cities in the provinces.

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[72] Médecins du Monde, *La zone d'attente de Roissy, une zone de non-droit, Rapport 2002*, March 2003. National Association for Border Assistance to Foreigners, *Zones d'attente: 10 ans après, les difficultés persistent. Visites quotidiennes à Roissy en Mai 2002*, March 2003. National Association for Border Assistance to Foreigners, *La frontière et le droit: la zone d'attente de Roissy sous le regard de l'Anafé. bilan de six mois d'observation associative (April-October 2004)*, November 2004.

[73] Loi 2003-239, March 18. 2003 for domestic security, *Journal Officiel*, March 19, 2003.

[74] Arcat, o*p. cit*. Handman M.-E., Mossuz-Lavau J., *La prostitution à Paris*, Paris, Editions de la Martinière, 2005.

[75] For instance, Altaïr and PASTT.

• The Negative Impact of the Domestic Security Act on Prevention

There is no reason to believe that the Domestic Security Act was intended to counter the field work performed by associations in charge of preventing HIV-infection with prostitutes or drug users. Yet it has, first, led to a decline in relations between the police forces and the said parties and associations and, secondly, hindered some field prevention work and made the target populations more difficult to access.

The Domestic Security Act contains an article modifying solicitation as a criminal offence, as well as provisions intended to fight those who are "victims of the exploitation of prostitution". The law was designed as a response to the visibility of prostitution and the complaints of residents in neighbourhoods where it takes place, and to clearly state the Ministry of the Interior's heightened security policy. It changed the conditions under which prostitution is practiced in order to put an end to what is currently portrayed as skyrocketing prostitution[76]. Passive solicitation has become an offence, making it possible to take action against prostitutes under all circumstances[77]. The law has also provided means for preventing prostitution from being carried out in mini-vans[78]. As the law is enforced, prostitutes have been pushed out of downtown areas – the original aim – and tend to operate now in industrial wastelands, as is the case in Lyons, for instance. The distance has made it more difficult to negotiate condom-wearing by the client, both because some feel freer when dealing with a group of people officially designated as being responsible for public unrest and because the decline in business has left prostitutes with less negotiating power. The latter have thus sought refuge at city outskirts, or in remote areas, such as forests or roads. They have gradually seen their exposure risk increase, in particular with the decline in contact with community associations whose presence used to be able to discourage attacks. The same is true of clients' changing behaviours and a declining ability to negotiate with them.

Government policy with regard to prostitutes has also impacted France's prevention associations, making their work difficult insofar as it has become socially less acceptable. Proof of this can be found in the verbal or physical attacks from passers-by to which field advocates are subject[79]. Relations between prostitutes and health workers have faded due to the geographic distance between them or the "extinction" of prostitutes. The rounds made by prevention buses have thus become less effective, sometimes because fewer people are reached, and sometimes because those present limited their contact to providing prevention kits (condoms, gel)[80].

This means that, initially, it is the contact between prevention workers and the target population itself that is limited, partially due to fears that the latter will be subject to police checks when in contact with prevention teams. True to form, and as is the case with drug users, the police often park near the buses with the aim of arresting people illegally residing in the country. Action has been attempted in some cases, but with little success, in associations or prevention buses[81]. The decline in contact is such that it is no longer possible to hand out prevention materials as in the past, or under poor conditions[82]. Later in the process, the prevention and treatment materials are sometimes confiscated by the police forces. Most frequently, health training for prostitutes, like information distribution to clients, no longer occurs. Consequently, the health concerns displayed by the Minister of the Interior with regard to HIV-infection amongst prostitutes is totally invalidated[83]. Lastly, the staff in associations have seen their work hampered by the behaviour of the police following the prevention buses, and thereby discouraging any contact with prostitutes. This is an example of

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[76] *J.O., Débat Assemblée nationale*, 15 January 2003, 2nd sitting on 14 January 2003, Minister of the Interior, Domestic Security and Local Freedoms. "...And because we let prostitutes operate on the sidewalk without any obstacles or checks. Over the last ten years, prostitution has taken off in our country. Two-thirds of prostitutes today are foreigners, having come from a variety of channels: some come from the East, in particular Albania, Bulgaria and Russia ; from Africa ; and transgenders, from South America. On painful topics such as these, we need to stop being hypocritical, because hypocrisy currently reigns supreme. Prostitutes are victims, it is said. Fine, but let's not forget the other victims: the people living in the surrounding areas, where life has become impossible." http://www.assemblee-nationale.fr/12/cri/2002-2003/20030114.asp#PG15>

[77] Article 225-10-1 Criminal Code: "Publicly soliciting, by any means, including bearing, even passive, another person, with the intent to incite sexual relations with the person in exchange for compensation or promised compensation is subject to two months imprisonment and EUR 3 750 in fines".

[78] Article 225-10, Criminal Code: "Subject to ten years' imprisonment and EUR 750 000 in fines, whether through direct action or via another person: 4) Selling, renting or making available, regardless of the means, to one or more people, vehicles of any kind with the knowledge that they will be used for prostitution".

[79] CNS hearings.

[80] CNS hearing.

[81] CNS hearing.

[82] CNS hearing.

[83] *J.O., Débat Assemblée nationale*, 15 January 2003, 2nd sitting, 14 January 2003, Ministry of the Interior, Domestic Security and Local Freedoms. "We need zero tolerance on this matter, and what takes place in certain areas of our capital city is an honour to no one! *(Applause from the ranks of the Union for the Presidential Majority and Union for French Democracy groupings)* Let me add that universal mobilisation against the horrendous disease that AIDS has become, though much-needed, including within the National Assembly's ranks, is of little use if we overlook what goes on in the Bois de Boulogne and Bois de Vincennes parks, where the epidemic is ravaging those unfortunate transvestites and prostitutes. Is it because they are in the woods that we don't talk about them, and that we are afraid to look this painful truth in the eye?" < http://www.assemblee-nationale.fr/12/cri/2002-2003/20030114.asp#PG15>

how a legal measure, distinct from any public health concern, can become a definite obstacle to prevention policy. The Domestic Security Act smothers out the work performed by prevention associations and leads prostitutes to adopt practices that carry them further from associations and make them vulnerable to clients.

For this reason, the Domestic Security Act's provisions on prostitution need to be reviewed so that prostitutes can once again enjoy maximal security prior to accessing support and prevention systems.

The pressure from the police to make undesirable populations less visible also applies to drug users. There too, gradually, the associations that operate on the field have less contact with the people whom their actions target. The users live in more scattered squats, seek refuge in parking lots or electrical cabinets (EDF or RATP), making them unreachable. Relations between prevention workers and the police depend on the type of action carried out; for this reason, the Medecins du Monde methadone bus is better accepted than needle exchanges[84].

1.2.2 PERSISTING DIFFICULTIES IN PRISON

The 1994 Act, by establishing the UCSAs, helped bring hospitals into prisons, thus guaranteeing greater confidentiality in physicians' work with regard to patients and making it possible to better track patients[85]. Prevention in prisons has also progressed along as screening opportunities, condoms and access to the chlorine used to clean injection materials in drug users have become more widespread[86]. Despite those improvements, health continues to be left on the wayside of penitentiary administration. The HIV-transmission risks to which prisoners are exposed are still too often denied and the conditions specific to incarceration continue to make it difficult to provide health education to a population that consumes a large amount of psychoactive substances and relies upon psychiatric care far more frequently than the population as a whole[87]. The age of the buildings, the overpopulation in the penitentiary environment, the lack of staffing – even though there exist a variety of situations – and sometimes the attitude of care providers toward prisoners, are as many barriers to prevention[88].

1.2.2.1 INADEQUATELY RECOGNISED TRANSMISSION RISKS

HIV-transmission prevention needs to entail recognition for risk-inducing practices. However, sexual relations or needle-exchanging are prohibited in prison. It is therefore difficult to spread information about the risks related to denied practices and, more generally, ensure that the institution cooperates. There is a need for experimentation with family visits and needle exchanges, based on what has been done abroad, in France.

- **Inmate sexuality**

Today still, and despite recent parliamentary reports, prisons are often wrongly portrayed, wavering between *Midnight Express* and a four-star hotel[89]. For instance, the image of sexuality in prison is generally based on the most violent accounts communicated to the public. Rape and sexual attack do exist in prison and carry transmission risk. But there also exist other forms of sexuality between inmates, referred to as *ad hoc* or during visits. The role of sexuality in relations between inmates is complex[90]. Generally speaking, sexuality is denied during incarceration and disciplinary action can be taken against inmates found masturbating. Likewise, prison wardens are not supposed to be exposed to the private act of masturbation or intercourse during visits. However, considering the risk of HIV-transmission during sexual intercourse, it is necessary that adjustments be made. Family living units, for instance, offer a number of benefits. Furtive sexual intercourse in the visitors' room is not suited to prevention where it involves detainees and their spouses. Under other circumstances, such as rape, access to post-exposure treatment needs to be possible, and this assumes the option for the detainee to discuss the violence with the wards and, later, care providers, without running any risk.

- **Declining risk inadequately reflected in prisons**

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[84] CNS hearing.

[85] Law n° 94-43 dated 18 January 1994 regarding public health and social protection. Chapter II is dedicated to "Healthcare in the penitentiary environment and social protection for the incarcerated".

[86] DGS/DH/DAP Circular, 5 December 1996 regarding the fight against HIV.

[87] *Etudes et résultats*, "La santé des personnes entrées en prison en 2003", n° 386, March 2005. *Etudes et résultats*, "La prise en charge de la santé mentale des détenus en 2003", n° 427, September 2005.

[88] OIP, *Les conditions de détention en France*, Paris, La Découverte, 2005. Regarding overpopulation p. 47 and p. 272. The incarceration rate in France increased from 78.6 prisoners per 100 000 inhabitants in 2001 to 94.9 per 100 000 in 2005. On caregiver-patient relations, see p. 118, in particular.

[89] CNS hearing.

[90] Welzer-Lang D., Mathieu L., Faure M., S*exualités et violences en prison*, Lyon, International Observatory of Prisons, Aléas Editeur, 1996.

The prevalence of viral infections during detainment, whether HCV or HIV, is significant, in particular among drug users, even though it is on the decline[91]. In the open world, risk reduction for intravenous drug users is based on the concept of substitution and needle exchange. The policy aims at best to prevent injection and, where not possible, enable an injection that will reduce damage and transmission risks by providing high-quality sterile equipment. In the best-case scenario, prison offers only substitution, and even this is not always implemented uniformly[92]. Where it is not available, inmates suffering from addiction find the way to compensate for their dependency. The drugs become an ordinary medium for exchange in the penitentiary environment, and drug injection or injection of deviated drugs, is a reality. It would be unthinkable for a penitentiary institution to make use of them. Recognising them and taking them into account would mean admitting it is impossible to design completely drug-resistant prisons. However, effective prevention requires a pragmatic approach and thus means accepting the existence of such practices in order to manage the risks involved. For the penitentiary authorities and State to take a different stance would mean they are indifferent to inmate health – yet the latter is responsible for persons it feels need to be locked up in order to protect society. By contributing to risk exposure, denial of sexual risks or risks arising from the injection of drugs puts the inmates in a lawless situation. One need only remember that deprived an individual of freedom is not supposed to deprive him/her of healthcare and prevention.

Needle-exchanging experiences are implemented, often successfully, in Western Europe, Germany, Spain and Switzerland, but also in penitentiary systems less similar to that of France, like those of Moldavia, Kirghizistan and Byelorussia, using a range of procedures[93]. Yet violence has not risen because of this and the cooperation of prison wardens is certain. Yet, documents published in France about needle exchange show contradictory remarks. It is supposedly urgent to wait, yet neither reasons nor a timeframe are provided; it is stated that inmates most often fail to comply with decontamination procedures using chlorine, but that the procedures themselves are sufficient; it is stated that there are few injecting drug users, yet at the same time emphasise that injection as a practice resumes when there is a lack of substitution product, not an infrequent occurrence[94]. In light of the experiments carried out abroad, and to ensure true equality in access to healthcare between the outside world and prisons, needle exchange needs to be experimented with in order to be later extended, if it proves effective, as is the case in other countries.

1.2.2.2 BARRIERS TO PREVENTION

It is difficult to disseminate information about transmission risks due to the constraints specific to living in a penitentiary institution and because of the portrayal of HIV in the penitentiary environment. Better health education in prisons, possibly run by trained inmates, might help overcome some of these issues.

• A dissatisfactory healthcare situation

The constraints involved in managing prisons are the leading barrier to spreading information about health in general and, more specifically, on HIV-infection risks. Penitentiary establishments are hurt by overpopulation and a lack of prison wardens. These two factors combine to complicate access to healthcare and make it difficult to implement any prevention actions whatsoever. Though lacking, the staff is required to accompany the inmates on their UCSA appointments or during information meetings. Information sessions about prevention are thus dependent on the availability of personnel. Organising movement within the prisons is another obstacle to prevention. The wards can "forget" to bring inmates to information sessions or refuse to take them there as a means of implicit disciplinary action. Likewise, the lack of available ward staff can sometimes be arranged by establishment heads to discourage the work performed by associations. More generally speaking, wards carry out their work as part of a set of missions, in which prevention or health come far behind security. In any case, prisons are notoriously understaffed, hence it is impossible to envision frequent, regular sessions, in small groups.

In addition to those specific issues on prevention, there are more general problems with health in prisons. With a few rare exceptions, there are no physicians available at night. The low staffing levels are also a reality amongst healthcare providers. The two-fold deficiency, in wards and caregivers, make treatment provision – for instance, emergency treatment – a purely theoretical concept. The wards do not have the time to make unplanned visits and the physician accredited to provide medication is not always on site. Prison does not offer an opportunity to choose one's physician either, and this is a problem for those who wish to benefit form a substitution programme, which they are refused by an UCSA physician.

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[91] *Etudes et résultats*, n° 386, *op. cit.*

[92] Michel L., Maguet O., *L'Organisation des soins en matière de traitements de substitution en milieu carcéral*, Report for the National Advisory Committee on Substitution Treatments, April 2003. International Observatory of Prisons, *Les conditions de détention en France*, Paris, La Découverte, 2005.

[93] Canadian HIV/AIDS Legal Network, *Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience*, 2004.

[94] Ministry of Solidarity, Health and Family, INPES, Ministry of Jusice, *Proceedings from "Health in Prison" Conference. Dix ans après la loi: quelle évolution dans la prise en charge des personnes détenues*, 7 December 2004. Stankoff S., Dhérot J., *Rapport de la mission santé-justice sur la réduction des risques de transmission du VIH et des hépatites virales en milieu carcéral*, National Directorate on Penitentiary Administration, National Health Directorate, December 2000.

Insofar as substitution is an integral part of risk reduction, it is important that the remaining obstacles to treatment are overcome, in particular unequal access.

• The Risks of Stigmatisation

The above stumbling blocks to information and emergency or substitute treatment are magnified by the stigmatisation and discrimination that HIV-positive people must face. It is difficult for them to envision requesting emergency treatment for this reason. With regard to both the other inmates and the wardens, it can be likened to recognising sexual relations and thus risking stigmatisation, or recognising having injected drugs, at the risk of being inflicted the relevant disciplinary action. More implicitly, participation in information sessions on health can be discouraged by the way things are portrayed in the penitentiary environment. Promoting them, as is done in the places where such sessions are arranged, implies that there are coalitions between outside speakers, wardens and the more influential inmates, and attending the sessions becomes likened to allying with religious leaders or "mob heads". Disseminating information about health in general and HIV-transmission risks in particular means accepting a form of "community-wide health action" on the part of the inmates, as is the case in other groups with a high risk of transmission in the outside world.

PART II THE DIFFICULTIES INHERENT IN COLLABORATION BETWEEN THE STATE AND ASSOCIATIONS

HIV-transmission prevention policy is a public policy jointly produced by the State, associations and researchers. As advocates they do not, starting with the State administrations, take action in a uniform, harmonised manner. The prevention landscape is, to a large extent, diverse. Nonetheless, the constant interaction between all of the parties builds a dynamic by which decisions are made and action programmes determined, thereby lending objectivity to the way in which shared issues are handled. It is important to recall that the normative guidelines in prevention policy are never the result of a command "from nowhere", but the outcome of exchanges between parties from different backgrounds working together to determine the possible responses. In France, the said parties, "reality decoders", who turn knowledge into field actions, belong to State department, whether central or decentralised, from the research community and associative sector. Through their ongoing contacts, discussions and incessant negotiations, they determine the appropriate objectives and resources to be implemented, and are sometimes required to perform assessments. One specific point needs to be emphasised here: the essential role played by parties with multiple stances, which belong to both the research community and the associative sector. The jointly-designed outcomes remain imperfect, however, as they require those participating to deal with certain constraints, and this can be difficult.

Anti-AIDS policy has been designed around the alliance between the public powers, physicians and associations[95]. The latter have gradually gained powers and legitimacy in a variety of fields and developed unit-based dynamics[96]. As regards physicians, their role in prevention is contrasted at this time, but generally inadequate. General practitioners are absent, except in a handful of cases. The outpatient-hospital networks, meanwhile, deal in healthcare, but very little with prevention, and prevention in hospitals is rare. The State, using varied and varying means, has provided the necessary funding to associations so that they take direct responsibility for managing field actions. The public funding is generally supplemented using funds collected and redistributed by SIDACTION, founded for this purpose, or using funds collected directly from associations. In other words, the percentage of public funding in the associations' resources can vary[97], but reflects the reciprocal dependency that exists between associations that need public funding to take action and the State, which needs associations to reach the objectives it sets out. For this reason, it is easier for the State to entrust telephone services to Sida Info Service, or to have field actions targeting prostitutes or drug users handled by associations. This is because the latter stir greater trust in the target population, something that would not be easy to gain with civil servants. Other public parties make an important contribution as well. This is true, for instance, of the General Councils, which fund buildings and technical platforms for CDAGs or local public health insurance offices, which in turn fund local campaigns with FNPEIS and the social care with FNASS. Lastly, the French Mutual Fund network also contributes to implementing prevention policy.

In other words, the State relies on AIDS organizations a for a substantial portion of its field action, whereas, in the field of healthcare, the tradition is rather for the government to keep control over the action. Over the years, the State has fallen into a *de facto* delegation policy, not to be taken here in its legal sense: it has put the associations in charge of part of its duty to fight HIV, in this case, action targeting the most exposed populations. Going back to what was said with regard to relations between the State and prostitute associations, which can be applied to all participants in prevention: "relations between the prevention partners are neither mutually-consenting, egalitarian, nor based on standards, interests or necessarily common objectives"[98]. In reality, they

[95] Pinell P., *op. cit.*, p. 151.

[96] Idem., p. 309 and thereafter.

[97] For AIDES, this accounts for around 60% of resources (2003 Financial Report), arond 65% for Sida info service (Yves Ferrarini testimony, SIS Director), or 54% for ARCAT (Thibault Tenailleau testimony, ARCAT Director).

[98] Mathieu L., *Prostitution et sida. Sociologie d'une épidémie et de sa prévention*, Paris, L'Harmattan, Coll. Logiques sociales, 2000, p. 227.

evolve constantly and are not based on a network of unbending relations, but rather on a constantly-changing process[99]. The shift to a *de facto* joint management system can be seen, for instance, in the action tracking indicators selected for the 2005-2008 National Anti-HIV/AIDS Programme, which include the number of AIDES volunteers involved in local actions or barmen having been involved in SNEG-organised awareness-raising programmes[100]. Despite the wide variety of parties involved, the success of their cooperation is generally a certainty thanks, in part, to an operating mode that serves everyone's interests through *de facto* delegation and, at the same time, mutual dependency combined with reciprocal skills recognition, above and beyond the criticism voiced on either side. Based on the hearings held by the CNS Prevention Committee, relations between association representatives and State civil servants are generally good.

However, the work carried out jointly between the State and the associations is not problem-free. The State's decision to entrust field action management to the associations creates constraints for the parties involved in the process: the associations, for instance, can be accused of carrying forward State initiatives whose legitimacy is questioned. More broadly speaking, the cooperation concept needs to be able to meet the challenges of knowledge-sharing so that each party can continue to jointly produce prevention policy. The aim here is just as much to ensure that knowledge about the epidemic constantly grows as to share knowledge and practices.

2.1 THE RECIPROCAL CONSTRAINTS OF DELEGATION

The interdependency resulting from the joint work between the State and the associations entails constraints for all those taking part in prevention. However, it is not so much the constraint in itself that is an issue, but rather the failure to recognise it. For instance, the State does not go all the way in its *de facto* delegation, failing to assume certain responsibilities associated with it, and prevention policy can appear to be "on hold" when the associations have trouble playing their part as "reality decoders". The State needs to shoulder the responsibilities that result from delegation, while the associations need to reconcile their internal schedules with their public addresses and the imperatives of a public policy which they contribute to building.

2.1.1 THE STATE'S DUTIES WITH RESPECT TO THE ASSOCIATIVE COMMUNITY

By choosing more or less voluntarily to rely on the associations to implement part of its prevention programme, the State is not shirking its responsibilities, but does create duties for itself. The *de facto* delegation of prevention actions to the associations has proved itself both appropriate and effective, but it cannot be based on the use of funds alone. The Minister of Health needs to guarantee the quality of the operational framework in which associations work so that they enjoy optimal conditions. The *de facto* delegation is not a way of giving up. It is a means for the government to bring its rationale on health policy full circle, by acting as a regulator, in other words by monitoring the associations' actions and ensuring that they are able to sustain themselves.

2.1.1.1 SUPPORT: AN ESSENTIAL INGREDIENT

The associations responsible for implementing the field actions sometimes face issues that can be solved by State action. In order for them to optimally fulfil their role, the health authorities need to ensure that the environment in which prevention advocates take action is of the highest quality, while also ensuring the best-suited framework for the associations.

• The associations' uneasy task of day-to-day management

The State requests that, in exchange for its subsidies, the associations implement field actions. It seems to be content to act as sponsor, without looking into the constraints of how they are managed on a day-to-day basis. Yet the associations' financial fragility is due in part to the State's late subsidy disbursal schedule. In other words, it is more than necessary to ensure greater consistency between the choice of associative actions to be funded and the way in which the said funding is paid out. The first measure for making management easier would be to implement swift pay-outs, rather than requiring the financially fragile structures to bear the brunt of the State's delays in delivering on its commitments[101]. By virtue of the same need for consistency, it is unacceptable that the national programme be triennial, when the financing agreements are still concluded on an annual basis. The decision to operate on a triennial basis needs to be based on rationale suited to the actual activities of the parties involved, as stated, moreover, by a circular from the Prime Minister dated 1 December 2000[102]. In addition to providing clear and simple information about the new

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[99] With regard to the implementation of prevention actions targeting the prostitute community, here is what is said: "In other words, there is no policy (or model as to the appropriate response to HIV) set out in advance and ready to be applied concretely. Here, policy has been determined gradually, at the same time as it was designed, and as a result, it has been subject to redefinition and improvisation, as the enforcemnet process proceeded. Mathieu L., "Genèse d'une politique publique: la prévention du VIH dans l'espace de la prostitution", *in* Welzer-Lang D., Schutz Samson M., dir., *Prostitution et santé communautaire. Essai critique sur la parité*, Lyon, Le Dragon Lune Cabiria Editions, 1999, p. 71.

[100] *Programme national de lutte contre le VIH/sida et les IST 2005-2008*, p. 31.

[101] This constraint is shared by all associations in France and is sometimes heightened by funding freezes. *Libération*, 26 July 2005, « Associations, le grand gâchis ».

[102] 1 December 2000 Circular regarding multi-year objective attainment agreements between the State and associations.

funding arbitration procedures and legal framework in which they are to be designed, it would be helpful if the State's offices could inform prevention advocates about the European programmes capable of providing them with additional resources. This would, however, require additional efforts to achieve consistency, insofar as the said European funding, in order to be granted, requires a financial soundness that the associations do not always have, due to the very fact that their subsidies are paid late. Lastly, as is already the case in the Provence-Alpes-Côte d'Azur region for instance, closer ties with the social departments of the DDASS need to be considered in order to gain greater benefit from the funding of social programmes that may have a health component, such as the Departmental Employment Assistance Programmes (PDAE), Regional Prevention and Healthcare Access Programmes (PRAPS) or Regional Immigrant Mainstreaming Programmes (PRIPI).

The associations' internal management can also be upended due to inadequate consideration for their human resources management. Career development for association personnel needs to be given as much bearing as programme development. An employee, or even a volunteer worker, who gradually gains professional skills needs to be able to receive recognition accordingly, for instance in the form of university credit for experience in associative work. At another level, the use of government-facilitated jobs or fixed-term contracts cannot be an acceptable human resource management method over the long term. Reflection needs to begin as to how to give consideration to pay scales. Some employees, physicians in particular, have not seen any pay increase for many years[103]. The quality of the vocational training provided also deserves thought. Some association representatives feel that real skills assessment is needed. Hiring health workers based on their community or career background alone cannot be enough. They need to receive training and actual supervision, especially as they can be vulnerable and as weekly work time can exceed the legal limit[104]. In addition, participation in European projects requires specific skills, which call for training that could also be funded[105].

- **Association contacts are inadequately mobilised**

To consolidate the operational framework in which associations operate means also improving their political environment. Associations are active in very different locales and with very different groups, and must deal if not with hostility, then at least with poor understanding of the purpose of their actions.

First and foremost, the issues appear at the level of the State agencies, whether involving social workers or prefecture staff with little awareness of the difficulties faced by people living with HIV. There are a number of tools to help better understand the disease, including *Parcours de VIH. 24 minutes pour comprendre* [*Following the Course of HIV. 24 Minutes to a Better Understanding*] developed by AIDES. Designed as a role-playing game, it raises participant awareness about the issues faced by people living with HIV, and reproduces a model developed by Amnesty International and MSF to raise awareness about the difficulties specific to those cared for by the organisations.

Secondly, the same obstacles can emerge in private organisations dedicated to spreading information, like certain hostels for foreign workers. The organisations' leaders can refuse subsidies intended for awareness-raising about health, which could lead residents to wonder about the hygiene in their shared housing. At the same time, faith-based associations can have access to the sites, thus demonstrating that the door is not closed to outside action. There too, the State needs to ensure that diversity in information-sharing is upheld for the populations that most need it.

Better State support for associative action also implies more appropriate use of the tools it promotes. Those who work with drug addicts, for example, find their messages discounted through communication techniques that are unanimously deemed unsuited to the situation. One example is the brochure designed by France's Interministerial Task Force Against Drugs and Drug Addiction (MILDT) about marijuana, which makes it difficult to discuss drug use and the risks associated with them by immediately putting marijuana on the same level as other products.

The mobilisation can involve regional players, in particular in areas where associations have low presence. This aspect of *de facto* delegation can be adjusted in accordance with the local capacity of prevention advocates. In the Ile-de-France and Provence-Alpes-Cote d'Azur regions, such efforts appear less necessary than elsewhere, due to generally satisfactory associative coverage levels. Better understanding of the issues by the local authorities would help improve acceptance of the information stands set up.

2.1.1.2 MONITORING: AN INEVITABLE PART OF THE PROCESS

While it is true that associations' requirements need to be taken into account in order to make their action more effective, the associations themselves also need to be assessed with a critical eye. To effectively monitor them, government agencies need to watch over the associative landscape so as to preserve, over time, the experience gained and the room required to devise responses

[103] CNS hearing.

[104] CNS hearing.

[105] For example, PASTT takes part in TAMPEP, the Transnational AIDS/STD Prevention Amongst Migrant Prostitutes in Europe Project.

to challenges to come. At the same time, the State must not have qualms about dealing with the shortcomings of *de facto* delegation, including the lack of associations in a specific region, or responding to the needs of a particularly exposed group.

• Maintaining the balance in the associative sector

Founded at different times and for different reasons, France's AIDS organizations have different approaches to prevention, in part influenced by the circumstances surrounding their creation. The models used in the field of HIV respond to a variety of requirements. The largest association in terms of paid staff, volunteers and geographic network, AIDES, implements a highly-varied set of prevention actions[106]. Serving different objectives, the association Act Up does not claim to conduct prevention policy, but rather to point out dysfunctioning and make institutional players face up to their responsibilities[107]. Alongside them, Sidaction, which was established with the aim of funding research and associations, contributes to prevention by providing financial support, hand in hand with decentralised government agencies, and a large number of AIDS organizations. Sida Info Service works to spread information and provides social telephone services.

In certain groups at high risk of being exposed to transmission, the community and peer approach was the key to success and has proved effective, in particular amongst drug users. Their risk reduction policies, which are based on teaching injection techniques and using sterilised and substitution equipment, have attracted the cooperation of physicians and drug-users' self-support associations. The latter have enabled regular contact without the distance that sometimes existed in the past between the medical community and the drug-user community. The resulting familiarity with the latter group's living conditions has clearly been instrumental in bringing out well-designed messages. Community associations for sex workers have also proved themselves effective, making it possible to better identify health-related expectations and keep prevention education from being limited to a single concept by refusing to confuse it with normative guidelines, for example, doing away with a paid activity that allows individuals to earn a living. The concept of peer education has also been used by certain prevention associations targeting the migrant community. The epidemic affects populations that are far-removed from the most central associations, and thus forced to follow the epidemic's development pattern in society. However, the community-based associations or those specialised in health education for immigrant populations are not spared any difficulties, having to choose between an approach that emphasises ethnic descent or refusal of the culture-based model. In addition, the presence of health mediators who are proficient in foreign languages cannot suffice, considering the large number of languages that need to be used in prevention.

The other way to adapt prevention to its target group is to take action at the sites where sexual risk-taking occurs. It has become common to place volunteers or paid staff, even temporary, at meeting places or commercial sex sites, for instance. Such action is used both in commercial establishment and exterior sites, via a wide range of approaches. The action itself can take on a variety of shapes: a hut on the beach (Var Region EMIPS or Roving Health Information and Prevention Team); messages targeting the partner-swapping community in Grau-du-Roi; or what can be likened to "rounds" at motorway rest stops in the Loire Region. Alongside the actions of associations specialising in the fight against HIV, other associations take action in the field of health for inmates, women or migrants and conduct part of it as prevention or contribute to general reflection on the process[108].

Insofar as the associative sector is one of the major components of prevention policy, the State cannot lose interest in balancing out its members. Associations have become increasingly specialised, forming a set of bodies within which national-level associative work is carried out alongside other more local actions or actions in response to the needs of a specific population. The State must also successfully keep open the option for associations not specialised in anti-HIV to enter the picture and take part in such work. Lastly, the balance between players in the associative sector would not be complete without the State's allowing new associations to emerge or existing associations to transform themselves. For instance, the association Afrique Avenir has gradually extended its scope of action and diversified its targets.

In other words, the State cannot become unconcerned with associations and needs to preserve their innovation capacity, all the while ensuring that their action and the skills of their agents are of high quality. The emergence of new target populations, migrants or new psychoactive product users, for instance, have uncovered difficulties for the organisations, whatever their kind, in following society's changes. Improving delegation will therefore mean finding ways to develop appropriate responses to emerging phenomena. It is difficult to adjust to new audiences. In delegating powers to associations, the State needs to keep from creating a situation that would limit the range of new emerging associative responses or limit its own ability to steer the said delegation. Dividing subsidies up between a large number of associations can be a regrettable decision if, in the end, non-productive actions are funded. However, the State's choice to ask associations to implement its policy assumes that it will keep its action steering capacity and that it actively strives to keep room for innovation. The major AIDS organizations can bring greater innovation in their area, but cannot provide a response to all of the epidemic's developments alone.

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[106] See association Web site, section « AIDES en bref ».

[107] CNS hearing.

[108] Examples include the French Movement for Family Planning, Migration Santé, the International Prison Observatory and COMEDE.

The best-known associations have skills that can be helpful to other associations, but cannot become central players under which other associations would come together.

• **Accepting responsibility for the failings of delegation**

De facto delegation of field actions to associations offers benefits, but is not free of failings. It does not cover the entire country and population. This means that the State needs to monitor the field accordingly to identify the areas of the country where associations may be lacking or identify the groups that do not have a suitable outlet. Moreover, the State's agencies need to ascertain that the actions completed under the national programme are effective.

The first issue raised by delegation of powers can reside in a lack of associations, or certain associations' holding a position by default. In certain regions, the receiving associations themselves, though recognised for their skills, admit that they have no trouble securing financing as they are the only ones requesting it. Yet where State action depends on the presence of associations, the principle of delegation implies that the central authority will have to plan the measures necessary should associative structures turn out to be missing. Even the associations with the best structure across the country cover the land unevenly, from region to region. Any mismatches between a geographic area where needs are apparent and the coverage provided by associations need to be identified by State agencies. The said agencies need to provide answers, either by calling upon a national associative network, or mobilising other health players that are present at the local level. The second problem raised by delegation has to do with the existence of associations that are both present and active, but cannot fulfil all of the demands placed upon them. For instance, whereas in Lyon, prevention action in heterosexual swapping clubs has existed for several years, such action toward multi-partner heterosexuals is rare. Likewise, the diversity of action targeting migrants appears inadequate or too limited in timescale.

In order to determine how effective implementation has been, it is thus necessary to assess how suitable certain actions, considered effective and accepted, actually are. For instance, while INPES is distributing an increasing number of condoms, the associations are saying that they still have trouble finding supply, especially with regard to the female condom. Some say that DDASS hands out condoms too widely, to associations whose prime mission is not prevention.

Regulating the balance of the associative community does not mean organising resource-sharing, as has seemingly been the case in the past. For example, in Marseilles, needle exchange systems have been jointly managed by the associations on site, without regard for the specifics of automatic dispenser management and associative powers in the field. Achieving that balance will require, first and foremost, identifying deficiencies and maintaining the diversity of responses available.

2.1.2 THE REQUIREMENT PLACED ON ASSOCIATIONS

Because they take part in developing and implementing prevention policy, associations are also expected to meet certain work standards. Insofar as they are essential players in prevention policy, they must find ways to overcome the controversy and friction in the associative sector, which slows down the joint production process. Moreover, those that implement actions using public funding have to adjust their practices in line with collective issues.

2.1.2.1 THE NEED TO OVERCOME CONTROVERSY

At the time when there was much discussion over "bareback" sex, initially understood as an appeal for unprotected sexual relations, and promoted in the media, the government did not speak out once. The impression that the infection had become commonplace was reinforced and messages about risk appeared outdated. At the same time, controversy about a sexual risk-reduction strategy dominated exchanges between the associations. More recently, another discussion emerged about possible re-contamination of people living with HIV with a second virus. The controversy over prevention dealt mainly with the sexual practices of gays, but their impact on the associative sector is important in that they have made it difficult to achieve a consensus on a common core of group preferences in the field of prevention.

• **Messages about reducing sexual risk**

Since the late 1990s and the first debates about bareback in France[109], sharp tension has been running through the anti-HIV associative community. Starting at the end of the 1990s, it has been clear to anti-AIDS players that safe sex practices have been slackening, a phenomenon known as relapse, as would be confirmed the STD epidemics amongst gays[110]. At the same type, two very different types of messages came out, one pleading in defence of so-called bareback practices, meaning the appeal for unprotected relations for people with HIV, and the other highlighting sexual risk reduction as a response to relapse. During field actions, as has been true since the beginning of the epidemic, the concept of risk reduction has been developed during face-to-face encounters.

[109] Le Tallec J.-Y., *Bareback et pratiques sexuelles à risque chez les hommes gais. La visibilité gaie au temps du sida*, Rapport final de recherche à l'ANRS, May 2004, p. 83 and thereafter.

[110] D. Lestrade, *The End*, Paris, Denoël, 2004, p. 125 and thereafter.

Prevention advocates who embark on discussions with people at meeting places explain that there is a scale of transmission risk, varying by type of practice. They use this type of message with people who have trouble using condoms with the aim of giving them the means to adapt their practices to their risk levels. Based on existing practices, the association AIDES has put together an experiment in risk reduction promotion, using flyers[111] handed out in saunas by the people working on the programme. In other words, the aim was to create a written medium for an already-existing message. The concept adopted by AIDES was that it was no longer enough to urge people to use condoms, and that one option would be to inform about the different ways of protecting oneself, by showing a risk scale, listing all of the practices and their respective risks, depending on whether a condom was used or not[112]. The choice stirred a great deal of criticism, of varying types, above and beyond the methodological aspect: dissemination of a written medium[113], dissemination of questionable information, uncontrolled dissemination, impact on so-called "safe" practices. The flyers were available for reproduction via Web sites or copied and handed out in bars[114]. This gave rise to heated exchange between AIDES and Act Up in the press[115]. While it is true that the two associations faced off to a significant extent, it is also important to remember that Sida Info Service, SNEG and AIDES Ile-de-France also came out against the action. In July 2004, a letter from Act Up was sent out to a variety of recipients, asking them to stand up against sexual risk reduction, thereby stirring a reaction from AIDES, which justified its choices, citing in particular the need to be realistic in terms of prevention and recalling the fact that risk reduction is part of a broader set of prevention techniques, but is not the only one[116].

The face-off between the associations has gave rise to lasting difficulties in exchanging about prevention amongst gays and discussing prevention in general. A workshop about prevention amongst gays held during the National Sidaction Convention in June 2004 offered the opportunity to open debate, going back over the concepts that were unclear and describing poorly-identified practices, such as bareback. The campaign on sexual risk reduction was seen as unwise, considering the environment, and capable of lending legitimacy to a line of thought in which risky practices would be promoted. At the very start of the new millennium the authors enjoyed the forthcoming attention of the medias in spreading a message that came out in defence of unprotected sexual practices amongst gay people. HIV-infection was portrayed as a minor factor and a well-identified risk that should in no way hinder individual freedoms. In response to that, a series of studies[117] made it possible to set aside the above portrayals of bareback to move toward greater familiarity with their diversity, helping mitigate the conflicts in analysis and interpretation that separated the associations. Bareback can be seen differently depending on individuals and unprotected practices explained by factors very different from the mere barebacker position itself. That clarification was undoubtedly behind a decline in tension on the issue of risk reduction. At the same time public debate about making HIV-transmission a criminal offence substantially contributed to rebuilding a part of the associative front about prevention. Nonetheless, debate seems more on hold than overcome and clarified.

• Issues at Stake in the Debate about Re-Contamination

In 2005, and despite the break in associative face-offs about prevention, the issue of re-contamination, or double infection with HIV, has come out more clearly in debate. It has become a recurring concern in the associations for several years now. More commonly known as cross-contamination, it is defined as the risk, for a person already infected with HIV, to become reinfected with the virus, under a different sub-type[118]. The way in which AIDS advocates have seized upon the issue to draw diverging conclusions reveals how debate is departing from the topic of prevention amongst gays itself. Some maintain that cross-contamination risk is another argument in favour of wearing condoms in all situations. Other associations, however, feel that cross-contamination is virtually impossible in a transmission group sharing the same sub-type and thus advocate unprotected sexual relations between HIV-positive partners. This practice is known as serosorting.

In other words, from an attempt to address relapse via risk reduction, we have moved to a situation where the absence of risk in sexual relations between HIV-positive individuals is used to justify it. This stance on what can be a form of prevention – unprotected relations between HIV-positive individuals – coincides with the emergence of a message on pre-exposure prophylaxis. The latter consists of an HIV-negative person's taking an anti-retroviral prior to sexual intercourse to prevent any risk of contamination in the

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[111] Available at http://rita.spi.france.free.fr/rdr/pages_rdr/flyers.html. The slogans, accompanied by a few lines of specifications and explanations, included: No rubber? Better withdraw before ejaculating; Sucking without a rubber? Watch out for the sperm!; Fucking for hours – real hardcore! And even riskier without a rubber; Without a rubber, a high viral load increases HIV-contamination risk; No rubber? The more the guys, the more the risk; Sexually-transmitted diseases increase HIV-contamination risk; Without a rubber, you've got an even bigger chance of getting screwed; Do you fuck without a rubber? At least use some gel!

[112] *RemAIDES*, June 2002, n° 44 and September 2002, n° 45.

[113] *Lettre d'Information du CRIPS*, n° 64, December 2002.

[114] CNS hearing.

[115] Saout C., « Repenser la prévention du sida », *Libération*, 30 August 2002 ; J. Devemy « La capote, rien que la capote », *Libération*, 6 September 2002.

[116] Act Up letter, 8 July 2004, addressed to parties such as CNS, ANRS, DGS, INVS and INPES; reply from AIDES, dated 27 November 2004.

[117] Recent research by Alain Léobon, Jean-Yves Le Tallec, Philippe Adam or the hypotheses advanced by Olivier de Busscher.

[118] See report on « Surinfection », *Protocoles*, n° 37, May 2005 and RéPI Report by Act Up on the matter: www.actupparis.org/IMG/pdf/CR-Repi54-Surcontamination.pdf. *RemAIDES*, n° 57, September 2005, « La surcontamination. Mythes et réalités », pp. 22-23.

event of unprotected sex. Studies conducted by NIH about the benefits of tenofovir in this case are underway in San Francisco. Some people would like to see the stabilisation of new infection cases in San Francisco as the result of serosorting. Yet there is no evidence supporting that hypothesis. Others feel that the distorted use of tenofovir as pre-exposure prophylaxis needs to be accepted, despite the fact that there is no data about the effects of such monodose use on the body, in particular the possible resistance mutations. Even if the effectiveness of prophylaxis were to be demonstrated in trials, it would have to be used with caution. Currently clandestine use of antiretrovirals to this end often occurs alongside the ingestion of many psychoactive products, which interact with medication in yet unknown ways.

Though it may be difficult to wear a condom in all situations, this should not lead to messages implying that condom use can be discontinued, as this would keep alive false portrayals that there is less danger and, thereby, encourage risk-taking. Today, such ideas are widely relayed by Web sites used to find partners for unprotected sexual intercourse, as well as by the dissemination of so-called bareback pornographic films in which there is no condom use. More broadly speaking, messages about sexual risk disrupt the prevention-seeking movement, as they can easily be changed into controversies between associations. Such controversies hearken back to more fundamental debate that is still not yet fully discussed as such, regarding the interaction between individual and group conceptions or, in other words, the impact of public collective discourse and portrayals of the sex culture on individual behaviour.

It is vital to overcome that type of controversy through research that reasserts or specifies the risks related to practices, while also clarifying the different types of meanings ascribed to often unclear concepts, with a view toward determining a minimum common vocabulary.

2.1.2.2 INCORPORATION INTO NATIONAL POLICY

Through their participation in prevention policy, associations are mechanically part of national policy. This implies that they must adopt practices allowing them to compare their work and guarantee the quality of the services they perform. At the same time, their incorporation into national policy requires that SNEG do away with the ambiguity associated with its position as a federation of prevention advocates.

• Professionalizing action in prevention

Part of the action carried out by associations relies on public funding for actions that fit in to a broader national programme to fight HIV-infection. Sometimes, associations get a head start on national guidelines and, in so doing, become experimenters. Where such ties exist with prevention policy, they justify that associations professionalize their actions. The oldest of them already offer models dealing with organisation, internal continuing training and adaptation of work methods to meet changing responsibilities. Yet professionalization relies first and foremost on the skills of the association leaders, who can but struggle to combine their commitment to associative work with an outside career.

It is regrettable that the only tools that exist at the level of the national government for tracking associations are financial reviews of how funding is used – in other words, purely descriptive accounting statements[119]. Better tracking of prevention policy implementation clearly requires better assessment policy based on association activity reports, making it possible to perform cross-analysis and emphasising the qualitative aspect of the work carried out. The associations' activity reports shall have to be harmonised to whatever extent possible, in order to be useable as analysis and assessment tools. Still today, the State often requires only figures, which keep the reports within the purely financial domain, without any qualitative outlook. Factors as varied as employee and volunteer qualifications, developments observed in the field, management or implementation issues encountered and developments in actions under consideration all need to be shown in the activity reports so as to put together a database used to constantly adjust practices in accordance with public expectations.

• SNEG's gray areas

SNEG illustrates a special form of gay mobilisation in favour of prevention. A federation of enterprises, it is composed to two branches: SNEG Prevention and SNEG Federation. The federation was first established to make condoms available in bars. However, since 1990, when it was founded, gays' consumption methods and its service offering have both changed considerably. SNEG remains a vital prevention material distributor[120], but has many members whose turnover comes primarily from sex consumed in commercial sites[121]. A first response to this development was set forth in 1995 with the first Charter on Sex Establishments' Responsibilities. Renewed in 2002, the charter, jointly signed by AIDES, Act Up-Paris and Sida Info Service, guarantees that

[119] DGS, SD6-A, Budget Unit, *Bilan de l'utilisation des crédits 2003 au titre du VIH/sida chapitre 47.11 articles 60 et 70*, October 2004.

[120] Condoms and gel, as well as brochures, posters and cards.

[121] SNEG membership includes the following business sectors: 23% bars; 14% saunas; 10% liberal professions, craftsmen, services; 10% discos; 9% associations; 9% restaurants; 9% shops, beauty parlours; 8% sex clubs, sex shops, video clubs; 5% press publications, Internet; 3% tourism.

prevention material shall be accessible, free-of-charge and visible in all signing establishments[122]. Through its prevention branch, SNEG has adapted and developed prevention in gay establishments, in particular those that offer a place for sexual activity. For instance, the presence of condom and gel distributors has grown, as has the range of posters and brochures used. Poster campaigns have been implemented, in response to the growing trend of consuming multiple psychoactive products amongst gays[123]. The prevention charter provides not only that material should be made available, but also that prevention workers should receive training. The signing establishment receive monthly visits during which monitoring for prevention actions takes place. The prevention action, covering all of France, is funded in part by the usual prevention sponsors: DGS, INPES and the decentralised agencies. At the same time, SNEG Prevention recently contributed to research about risk-taking (Sex Drive Survey) and took part in developing a prevention pamphlet distributed with pornographic DVDs. That work and skill deserve to be recognised, as does their contribution to current knowledge through the sex drive survey.

Nonetheless, considering the prevalence of the infection in gays, the number of establishments and current risk-taking levels, a number of grey areas need to be pointed out. First of all, while it is certainly positive that SNEG Prevention was able to have the prevention charter signed by establishments that are not amongst its members, it is surprising to note that not all of its members signed. The self-regulation in play here could be perfectly legitimate, if it nonetheless allowed almost complete coverage of the establishments. Yet, as the situation stands, only around 50% of the member establishments actually signed. SNEG Prevention's firm commitment does not seem to be shared by all of its members. To wit, in 2000, when public funding was delayed, SNEG's prevention branch had to close down, reopening a few months later. The decision was a disturbing one, as it implies that prevention is not essential to the union, when its members owe their subsistence, in one way or another, to the sex business.

In other words, the federation walks a thin line between its operations as a trade organisation, offering leisure activities, and that of an association that needs to keep the excesses of those leisure activities in rein. SNEG members promote sexual intercourse and it is thus natural that they should bear the cost of preventing the risks they have their clients take. SNEG initiated condom supply in bars and contributed to changing the law in this area. Over the years, it has succeeded in adapting to the development of the sex business. It is now legitimate that the federation be expected to (re-)gain a full grip on the epidemic amongst gays and the place of the sex business in the epidemic, as well as behavioural trends. In line with the public authorities, it needs to contribute to making the charter mandatory. It is important that awareness-raising efforts be implemented for its members and that its position with regard to prevention in members that distribute unsafe porn videos. Considering the development of various Internet-based uses, SNEG's members from the sector need to continue their prevention efforts.

The stakes are high as regards ensuring consistency between funding, prevention actions initiated in SNEG's name and the activities of SNEG members.

2.2 KNOWLEDGE-SHARING FOR BETTER PREVENTION: HIGH STAKES

Determining and implementing prevention policies requires an ever-growing understanding of the epidemic. To achieve this, the State's cooperation with associations is necessary, both to produce knowledge and subsequently decode them in terms of field action, and to share knowledge and practices. They need to be shared with associations so that the latter can gain benefit from successful experiences and have the required knowledge on the risks associated with the said practices.

2.2.1 A BETTER UNDERSTANDING OF THE EPIDEMIC

The knowledge required to design prevention policy encompasses a whole range of components, from virus transmission methods to epidemiology, health monitoring and social sciences. Over time, the range of topics relating to the epidemic has grown constantly and benefited from cooperation between associations and researchers, in particular in the social sciences. Nonetheless, in many areas, knowledge is still lacking, due to constant changes in the epidemic and in society.

2.2.1.1 A GROWING SCOPE OF UNDERSTANDING

Prevention actions are devised according to what is known about high-risk practices and transmission groups. Because this epidemic is deeply tied to the unending changes that occur in a society, the scope of knowledge is continually expanding. That knowledge is produced mainly by government institutions, but can also result from joint production programmes. For instance, while epidemiology or health monitoring remain the responsibility of research organisations or agencies, the associations are very much present in

[122] The seven points developed in the Charter are: prevention material, documents and information, health check-ups, prevention action, hygiene and building upkeep, staff training, guarantees to personnel, charter compliance and assessment.

[123] ORS Ile de France, OFDT, *Tendances récentes sur la toxicomanie et phénomènes émergents liés aux drogues à Paris en 2004*, ORS, OFDT, Ile de France Prefecture, Ile de France Region, April 2005.

producing knowledge in the fields of social sciences, whether data or constructed knowledge[124]. Today, we know how the disease is transmitted. That understanding is the foundation for current recommendations in favour of condom use, needle exchanges and safe practices during blood donation. Prevention cannot be limited to putting out recommendations about protection techniques; the said recommendations also need to be targeted to those who need them and be suited to those parties. In other words, it is necessary to have data about the social characteristics of newly-infected individuals. On that basis, the most affected geographic areas and population groups can be identified. Such knowledge also makes it possible to assess the degree to which prevention policy is successful, for instance, needle exchanges in intravenous drug users, and identify changes in the epidemic, in women for example. Yet understanding the populations alone is not enough; it is also important to be familiar with current practices and knowledge, which should be able to enable messages to be adjusted and targets to be redefined.

• Epidemiology

Epidemiology is the study of a disease's breakdown, frequency and determinants. In the specific area of HIV, it is based on such factors as the statistical data used both to gain information about the epidemic's dynamic as the population's understanding of HIV or sexual practices. It is the result of constant data collection, as well as enquiries that are more limited over time. Research organisations keep in constant contact, either collaborating or supporting one another, both technically and financially. The first data available are provided by IVS, one of the responsibilities of which is to track the HIV-infection epidemic, making it possible to have information about the people affected (sex, age, geographic area, social group) and the way in which they were infected. After a long period during which the only measurement tool was mandatory AIDS infection reporting, the Institute gained access, in 2003, to data from mandatory HIV-infection reporting and virological monitoring. Thanks to this, the second HIV and AIDS Monitoring Report came out, in May 2005[125]. Under its HIV-infection monitoring efforts, IVS has to secure the collaboration not only of physicians and biologists, but also laboratories, CDGAs and DDASS workers. In other words, to collect monitoring data, coordinated efforts are required on the part of a variety of players. At the same time, the hospital database on HIV-infection, though not designed for population monitoring, offers important epidemiological information about those infected, and for medical and economic research.

• Research in the social sciences

ANRS finances and coordinates research on HIV-infection, and is thus a prime contributor to understanding the epidemic, along with Action Coordonnée 18 "Behaviour and Prevention", which works to coordinate and choose financing targets, including large-scale surveys like VESPA[126] and research on anthropology and sociology. The surveys also help better understand infected persons' sexual behaviours and, in particular, monitor trends in high-risk practices. IVS has also contributed through a partnership with SNEG on the Gay Barometer. Questionnaire results from that effort have been made available on Web sites and by AIDES volunteers[127]. ANRS finances large-scale surveys, including the Gay Press Survey (EPG), with IVS, dealing with lifestyles and prevention.

The first results of EPG 2004[128] show an increase in risk-taking in gays and confirmed the hypotheses from the 2000 Survey, in particular with regard to the individuals' ages, and their serological status[129]. It should be noted that, in both cases, the Gay Barometer and EPG, Web sites and the oriented press both lent their support. Social science research can also receive funding from multiple sources, like a study about the psychological determinants of risk-taking, which was granted funding from DGS and SNEG[130]. Knowledge about heterosexual practices is not as abundant insofar as the surveys are less frequent. A few examples include the studies funded by ANRS, like Analysis of Sexual Behaviours in France (ACSF) in 1992, and Analysis of Sexual Behaviours in the Caribbean and Guyana (AGSAG) in 1994, and currently under renewal. Studies like these, dealing with practices, are vital.

Lastly, going beyond behaviour, the KAPB Surveys (Knowledge, Attitudes, Practices, Beliefs) were an opportunity to better measure knowledge and risk perception. Conducted since 1987 at the request of the Ile-de-France Regional Council by ORS, they make it possible to understand, for instance, how condom use is portrayed in society. To wit, the latest data available, dating back to 2001, show that there are more people who believe that condoms lessen sexual pleasure, and that fewer people consider it

[124] In France, it is produced by organisations with differing objectives, such as IVS and ANRS, as well as by associations like ARCAT or SIDA Info Service. One example is Arcat, *op. cit.* or M. Lefranc, X. Bertin, H. Freundlich, S*ida Info Service à l'écoute des femmes*, Sida Info service, Special Topic Study, Assessment and Quality Department, March 2005.

[125] IVS, *Rapport n° 2. op. cit.*. Reports on CDAG and outpatient laboratory check-ups are also used.

[126] The VESPA survey deals with the lives of infected people, which it is important to understand insofar as their living conditions affect their attitudes toward prevention.

[127] Velter A., Michel A., Semaille C., *Rapport Baromètre Gay 2002*, Saint Maurice, IVS, November 2005.

[128] IVS, ANRS, *Premiers résultats de l'Enquête Presse Gay 2004*, June 2005.

[129] Adam P., Hauet E., Caron C., *Recrudescence des prises de risque et des MST parmi les gays. Résultats préliminaires de l'Enquête Presse Gay 2000*, Direction générale de la Santé, ABNRS, InVS, undated.

[130] This relates to the survey on psycho-social determinants in risk-taking, known as "Sex Drive", by Adam P. and De Wit J. The survey was presented to the press by a DGS civil servants, assisted by researchers and SNEG.

commonplace[131]. ORS has also looked at the risks taken by individuals following a marital break-up, thereby shedding light on certain special risk-taking circumstances amongst heterosexual individuals[132]. However, it has been pointed out that the AIDS epidemic, all the while contributing to their development, has considerably influenced the direction taken by research on sexual behaviours. When HIV is no longer the focus of the studies, it turns out that concerns over prevention are relatively rare in those surveyed[133].

Funding for research in social sciences helps not only better understand practices, but also raise questions as to the categories used to describe the social realities resulting from HIV. Whether Jean-Yves Le Tallec's work on high-risk sexual practices or that of Alain Léobon on Internet-based social and sexual customs, studies of this kind help raise issues about the value of research on categories, like bareback or bug-chasing[134]. Such questions about how analysis categories are designed are important in that they determine what we know or wish to know. In other words, the understanding necessary to design prevention policy cannot do without reflexive studies such as those carried out by Didier Fassin, on epidemiology amongst migrants. They show the need to design "sociologically suitable categories, meaning categories designed according to the issue considered"[135]. Defining a "target" to which a "message" is to be delivered first requires identifying the relevant players and realities in society. For instance, the recent studies recently carried out about prostitution, describing and analysing its various forms[136], like those that offer genre-based approaches[137], make it possible to fine-tune general understanding of data, or better prepare major surveys. Consequently, understanding the HIV-infection epidemic with a view toward designing prevention policy requires meshing a large number of research areas and cannot rely on a single funding source, as the existing cooperation projects between State agencies, private players and research centres have shown. However, AIDS is not a field that rallies a high level of mobilisation for research in social sciences, even though ANRS funding does attract new researchers and new generations[138]. For this reason, the development of cross-funding needs to be encouraged, in order to support such research at a time when the State has very markedly stepped back from committing to social science research. In addition, with regard to the major surveys that have gradually become recurring, funding needs to come from sources other than ANRS, which is a research agency and whose funds should be used only for research and not for supporting monitoring work.

2.2.1.2 AN EPIDEMIC THAT IS CHANGING WITH SOCIETY

Those contributing to prevention must deal with a constantly-changing society and individual or group behaviours, without always having access to the knowledge required to build up a prevention strategy. While they can call attention to certain trends, many fields remain poorly-grasped or completely unfamiliar.

• Inadequately-studied exposure-risk groups

As in society as a whole, portrayals and practices in groups exposed to transmission-risk change. For instance, while drug-addition risk-reduction has yielded good results, it is important to keep prevention efforts at the same level, in order to keep up those results and monitor developments in practices. This will help adjust risk reduction to possible new users or short-lived trends that can lead to certain already-existing products' being used differently. The importance of such changes is difficult to assess, and requires constant monitoring on the part of prevention advocates. The latest TREND report[139] highlighted the use of injection by young users and injections being performed in different groups, such as travelers or partiers, using a variety of products. Lastly, also notable is

[131] ORS Ile de France, *Les Connaissances, attitudes, croyances et comportements face au VIH/sida en Ile de France*, Ile de France Region, Ile de France Region Prefecture, December 2001.

[132] National Planning Commission, ORS Ile de France, ANRS, *La Gestion du risque VIH-sida après une rupture conjugale*, Ile de France Region, Ile de France Region Prefecture, December 2002.

[133] Giami A., Schiltz M.-A., dir., *L'expérience de la sexualité chez de jeunes adultes. Entre errance et conjugalité*, Paris, Inserm, coll. Question en santé publique, 2004.

[134] Le Tallec J.-Y., *op. cit.*. Léobon A., Frigtault L.-R., Levy J., *Les usages sociosexuels d'Internet dans la population homo et bisexuelle française : résultats de l'enquête "Net Gai baromètre"*, ANRS, Fond Québécois de recherche sur la société et la culture, Association Com'on west.

[135] Fassin D., "L'indicible et l'impensé: la « question immigrée » dans les politiques du sida", *Sciences sociales et santé*, 17 (4), December 1999, p. 29. On page 16, the article states that: "For this reason, far more than the sociological reality of AIDS in immigrants, it is the epidemiological design of the categories used to approach the disease that is an issue, as it puts labels on reality and, thereby, impoverishes their meaning. What hinders knowledge, and the dissemination and use thereof, is the exclusive use of certain definitions in passing on knowledge, without any reference to the social conditions surrounding the epidemic. In other words, the unspeakable is the result of something unthought. We do not allow discussion about AIDS in immigrants because we have not given ourselves the tools needed to approach it as anything other than a contamination hazard, even though it would be unfair and inappropriate to blame epidemiologists alone for this."

[136] Handman M.-E., Mossuz-Lavau J., *op. cit.*

[137] Cabiria, Guillemaut F., dir., *Femmes et migrations en Europe. Stratégies et empowerment*, Lyon, Le dragon Lune Editions, 2004.

[138] Fassin D., "A quels défis la recherche en sciences sociales sur le sida est-elle confrontée ?", *ANRS Information*, n° 41, July-August 2005.

[139] ORS Ile de France, OFDT, *op. cit.*

the exchange of practices between different groups, such as hitch-hikers and drug addicts from Eastern Europe. The spread of drug use practices and the emergence of new user groups less inclined to work on risk reduction changes the job of prevention advocates.

Many practices are still poorly grasped. For instance, the use of narcotics during gay parties is often mentioned in the press or in specialised publications[140], yet the said method of consumption does not seem to be the focus of very steady prevention actions. The use of drugs in a party setting is a longstanding reality in the gay community, but the development of multiple-substance consumption is recent. In addition, due to its impact in the United States, it is feared that crystal meth consumption will progress in France[141] and is now the focus of attention, after a period of relative indifference[142]. It is yet unclear how the trend toward psychoactive substance consumption, a challenge for prevention advocates, should be handled. "Gay clubbing" probably deserves to be the focus of research, in particular to determine the frequency of individual movement between European countries, as reflected in the dissemination of LGV between Amsterdam, Paris and London. This would require exchange between national authorities similar to those organised by the associations[143].

In addition, the development of heterosexual swapping clubs is sometimes highlighted to condemn the absence of prevention measures targeting this group, contrary to what occurs in gay establishments. The mot recent work shows that prevention does not occur in all cases[144]. Moreover, there is not a single assessment as to the number of people frequenting the said swapping establishments. The issue of prevention amongst women does not seem to have been the focus of any joint thinking. Several publications offer the opportunity to have a fragmented view of the said problems, but prevention amongst women as a research topic is more or less missing from the scene[145].

Migrant populations, too, are asking for more diverse research. Nothing is known about the effects of exposure risks in gay migrants or foreigners from North Africa or Africa, despite the fact that data from foreign countries show higher prevalence in those groups[146]. Groups such as migrants from China or Eastern Europe seem to receive less attention as well. The forms of prostitution in which migrants engage are also varied, whether they come from Africa or Eastern Europe, and require responses that are specifically suited to the social structures through which they will be disseminated.

• Patchy Knowledge about Internet Use

The Internet is one of the tools that has most changed social practices these past few years. The use of Web sites dedicated to gays are relatively well-known thanks to Alain Léobon's recent work, which helped differentiate between the various common practices, places and users. Research indicates that Internet users also adopt the most unsafe practices and are generally younger[147]. Other studies specify that online encounters generally lead to relations between people with matching status[148]. Comparative studies on groups of people who have unprotected sex and meet, in the first instance, online and in the second, in society, conclude that there is no reason to believe that the Internet is a factor in risk-taking[149]. At the least, the findings encourage further research to delve into the hypotheses used in the studies with regard to comparable groups. The new practices described above raise the issue of how to convey a message to people whose meeting ground is the Internet and who are relatively insensitive

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[140] *Idem*.

[141] M. Specter, "Higher risk. Crystal meth, the Internet, and dangerous choices about AIDS", *The New Yorker*, 23 May 2005, pp. 38-45.

[142] *Têtu*, n° 95, December 2004, dossier "Drogue. Alerte au crystal", pp. 110-116. *Têtu* n° 105, November 2005, "Crystal: bientôt une brochure", p. 172.

[143] Shorer Gay Lesbian Health, *European expert meeting. Addressing the Rise in HIV and STI Rates among MSM in Western Europe*, Bregen aan Zee, The Netherlands, 6-8 October 2004.

[144] Welzer-Lang D., *La planète échangiste. Les sexualités collectives en France.*, Paris, Payot, 2005.

[145] Mossuz-Lavau J., *Une politique de réduction des risques sexuels pour les femmes en difficulté de prévention*, Report drawn up for The National Health Directorate, AIDS Division, May 2000. Sida Info Services, *Sida Info Service à l'écoute des femmes*, 2005. *Femmes et sida, Etats généraux*, 7 March 2004, www.planning-familial.org/documentation/femmesEtSida.pdf. Val de Marne General Council, *Etude sur l'acceptabilité du préservatif féminin*, Val de Marne General Council, Department on Prevention and Social Action, Department on Health Action, Department on Children and Families, July 2004.

[146] *Morbidity and Mortality Weekly Report*, 2005, 54 (24), "HIV Prevalence, Unrecognized Infection, and HIV Testing Among Men Who Have Sex with Men. Five U.S. Cities, June 2004-April 2005".

[147] Léobon A., Frigtault L.-R., Levy J., *Les usages sociosexuels d'Internet dans la population homo et bisexuelle française: résultats de l'enquête "Net Gai baromètre"*, ANRS, Fond Québécois de recherche sur la société et la culture, Association Com » on west, p. 17. See summaries in *Transversal*, September October 2005, n° 26, « Internet: un nouvel enjeu pour la prévention » and *Le Journal du Sida*, September October 2005, n° 179, « Gays: les défis de la prévention ».

[148] Bolding G., *et al.*, "Gay men who look for sex on the internet: is there more HIV/STI risk with on-line partners ?", *AIDS*, 19(9), 2005, pp. 961-968.

[149] Hospers H. J. *et al.*, "A new meeting place: chatting on the internet, e-dating and sexual risk behaviour among Dutch men who have sex with men", *AIDS*, 19 (10), 2005, pp. 1097-1101.

to prevention. In addition, the development of the Internet has brought about changes in forms of sociability, by shifting encounters from bars to private locations and thereby offering a wider range of options. However, it is important that the heightened interest shown in Internet-based practices, as well as the efforts to provide information in places of commercial sex, not lead to neglect for research on outside meeting places.

Less is known about Internet-based practices involving heterosexuals. Interest is lower due to the very low prevalence rates in the said users. However, it is striking to note the lack of messages on prevention or STIs at meeting places, unlike what can be observed on sites intended for men having sex with men. The sites offer services which, in some cases, can be likened to those of marital agencies, while others offer explicitly opportunities for sexual encounters. Information about STIs is totally lacking on these sites, which is not the case with sites dedicated to multiple sexual orientations[150], but are part of a reflection on sexuality.

The Internet as a tool for prostitution is also little known. It would offer prostitutes a way to work more safely, but would also keep prevention advocates and clients away.

2.2.2 SHARING KNOWLEDGE AND PRACTICES: A VITAL NECESSITY

The activities of associations are sometimes hindered or slowed down by the difficulties inherent in making choices or for lack of technical support. There exist a large number of inadequately publicised actions, which would deserve to be extended or which offer lessons that could be helpful to other parties. At the same time, as discussions about reducing sexual risks show, it is necessary to better share knowledge about risks. Through its central position, the State needs to act as a vehicle for spreading knowledge about risks and foster skills transfer, or determine the conditions needed for effective knowledge dissemination. It should also be pointed out that parties playing several roles with respect to the gay community, whether advocates or researchers, are if not numerous, at least sufficient in number. The same cannot be said about prevention policy targeting migrants. Researcher-advocates do exist, and have in some cases founded associations that are highly visible today, but do not yet hold a position as an intermediary that would make them pivotal players.

2.2.2.1 EXCHANGES ABOUT FIELD ACTIONS

The wide range of players involved in prevention allows a large number of innovations or arrangements that are not always brought to the forefront. It appears important to develop such exchange that might build the capacities of associations by giving them validated field action models or enabling cooperation between associations.

• Minimal experience-sharing

Field actions or reflection about the issues of today do not stand out at the national level. The actions carried out in prisons exist and are recognised, but are not able to benefit from the capitalisation and redistribution that come with experience-sharing. They remain isolated from one another. Generally speaking, information sharing seems relatively rare, more due to lack of information vectors than a desire to withhold knowledge.

The lack of publicity around certain actions is not a limit specific to associations. Research or actions conducted by other players would also deserve to be disseminated, just like prevention actions in psychiatric establishment or adjustments specific to DDASS or DRASS services. Reponses to specific situations can always be helpful to a certain extent for other departments or regions, like Alsace, where prevention in the gay community needs to take into account the fact that gays there also frequent establishments located in Germany. The local versions of national programmes also offer helpful indications, like those of the Provence-Alpes-Côte d'Azur DRASS[151]. For this reason, it is necessary to look at how information can be regularly disseminated. In that regard, despite the criticism expressed and the fact that it is temporary, the AIDS Major National Cause 2005 makes it possible to innovate, for instance, with the prevention action map. The methods used during that process can be the foundation for a more lasting development. The Ile-de-France Region's CRIPS already offers a wide range of services, such as a daily electronic press review or an association directory. The development of an online database also needs to be considered, but not only in a specifically gay perspective or to disseminate news, like the Warning site[152]. The Internet still seems underexploited as a tool for disseminating knowledge that can be likened to information made accessible by associations on their Web sites, incidentally very diverse in terms of access and offering. It is regrettable that there is no French equivalent of the AIDSMAP[153] or more general support sites about

[150] Site www.multisexualites-et-sida.org.

[151] Paris Directorate on Health and Social Affairs, *Programme d'actions de prévention de l'infection VIH/sida pour les homes ayant des rapports avec les hommes*, December 2001. Provence Alpes Côte d'Azur Regional Directorate on Social Affairs, Departmental Directorate on Health and Social Affairs, *Prévention de l'infection à VIH en Provence Alpes Côte d'Azur, 2004-2007*, undated.

[152] www.thewarning.info.

[153] www.aidsmap.com

health[154]. The experiments implemented in foreign countries, like Checkpoint[155] in Amsterdam or Geneva, could be presented and discussed, thereby offering associations a more regular lead-up to reflections conducted outside France. In simpler terms, efforts need to be made to identify risk-reduction experiments, like the report on the KitBase set up by Espoir Goutte d'Or for crack users [156], or centres for drug injection[157].

• Cooperation Programmes that Could be Reinforced

Knowledge-sharing like that described above would make it possible to strengthen the least equipped associations. Some of them develop original actions, like providing information, implemented by Afrique Avenir, but recognise they have trouble meeting the assessment criteria on their actions, which are not necessarily suited to their practices. Training for association members would thus benefit from skills transfer from older organisations to the most recent. However, successful cooperation experiences stand out, for instance between AIDES and a Comorian association in Marseilles. It should be noted that the skills transfer here, goes both ways: expertise in the fight against HIV, in exchange for familiarity with Comorian migrant community. The State cannot decide to establish associations, but can foster their emergence, as was the case with associations working for prostitute communities, and guides their action through its advisory services. Some of the associations that are now independent have benefited from support from the administration during their earliest years. That support which was, at the time, provided in part by Ministry of Health agents, can now come from the employees at major associations. Cross-comparisons between the experiments need to be made the rule in order to build them further.

2.2.2.2 DISSEMINATING KNOWLEDGE ABOUT RISKS AND PRACTICES

The considerable understanding of the epidemic today is not enough to keep controversy such as that described above from occurring. It is therefore necessary to restate the various risks, by type of practice, and to share knowledge in order to devise clear and differentiated messages.

• Inadequate reminders of the existence of risk

The perception of risk has changed as treatments have developed, making the disease comparable in the minds of many to chronic illness. The analogy can be helpful in reassuring patients and the medical community, all things considered, but it can lead to misunderstanding as to the seriousness of HIV-infection. What is true from the individual's standpoint, if the person is diagnosed early enough, does not apply should the diagnosis come later in the process. Moreover, a chronic illness like diabetes is not transmitted between sexual partners, a risk that does exist with HIV. In addition, the treatment is particularly heavy and associated with a large number of undesirable effects. For this reason, a more realistic image of the infection needs to be given in order to put an end to its portrayal as something ordinary, and contribute to a better understanding of risk. If infected people were to speak out in public, this could help give a more accurate image of how life really is for them[158]. HIV-infection has a huge impact on day-to-day life and leads to a loss of freedom in relations with others: it is difficult to tell others – partners, family and friends, co-workers – about one's infection.

Risks during sexual intercourse vary depending on types of practices and STIs. For instance, it has been clearly established that syphilis is easily transmitted through oral sex. The risk of HIV-infection during unprotected oral sex is now well-documented, but little-known. Other infections such as LGV or HVC transmission appear tied to specific so-called "hardcore" sexual practices. Consequently, consideration needs to be given to organising a consensus conference or public hearing, followed by the publication of a document taking stock of the risks. In light of current knowledge, and since the topic at hand is HIV-transmission, messages targeting the public need to reaffirm condom use as the only effective and proven prevention method.

• Understanding current practices to disseminate messages

For many people heard by the Prevention Commission, the wariness that can result from years of fighting AIDS can be summarised in an often-heard phrase, "Everything has already been said". The views expressed by associations can sometimes be influenced by the fact that prevention has been underway for a long time, is difficult, and sometimes yields discouraging results. Associations' portrayals of the actions to be carried out need to be taken into account in order to support innovations, while those designed to reject older practices need to be considered cautiously.

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[154] www.healthnet.org

[155] The option to perform, based on an initial pre-counseling encounter, a quick monitoring test followed by a second meeting. www.thewarning.info/article.php3?id_article=73&var_recherche=dialogai.

[156] Espoir Goutte d'Or, *Rapport d'évaluation du "Kit-Base"*, Paris, EGO, STEP, November 2004.

[157] B. Bertrand, *Structures d'accueil avec possibilité de consommer à moindre risque des drogues*, September 2005, www.ludic-mulhouse.org/On_peut_franchir_le_pas_faire_un_essai.pdf.

[158] CNS Hearing. Lestrade D., « Septième ligne », *Le Journal du Sida*, n° 177, July 2005, p. 34.

In order to effectively adjust messages and plan distinct messages for HIV-positive and HIV-negative individuals, it is important to understand their respective practices. The vast majority of people infected with HIV protect their partners, and their efforts need to be supported and encouraged despite current trends, which are more conducive to serosorting or the development of pre-exposure prophylaxis. Recent research has also focused on the psychological determinants of risk-taking and self-esteem, others show that suicide is more frequent in homosexuals. Those factors give reason to believe that risk-taking in gays can be owed to the position granted to them in society and that less discrimination would make it possible for gays to lead fuller lives and take better care of their health. For this reason, there is a need for messages targeting men living with HIV for many years. The development of prevention approaches included in an all-encompassing health approach also appears a useful option.

Above and beyond HIV-transmission amongst gays, it is vital that efforts be made to understand the facts to the same extent in other transmission groups. Specific knowledge about the relations between people, by sub-group, would make it possible to develop better-suited messages or prevention actions. A greater understanding of developments in narcotic consumptions methods is also important, as injection practices change and are adopted by new target populations.

This report underscores, with particular emphasis, on the ties between public authorities and AIDS organizations. However, to overcome the epidemic at hand, virtuous developments in those ties will not suffice. Rather, civil society as a whole must be fully mobilised, if we are to bring the fight on AIDS to the next level. Recommended at the international scale, the multi-sector approach to the fight on AIDS is also the clear answer for our country.

RECOMMENDATIONS FOR BETTER ENFORCEMENT OF PUBLIC POLICY ON PREVENTING HIV-TRANSMISSION

Pursuant to Article L3121-1 of the Code on Public Health, defining public policy on HIV-infection transmission is the State's responsibility. This health policy's organisational methods must be fully borne by the national authorities responsible for health. Other public policies may interfere with public health, but it is vital that any action undertaken by an agency, regardless, be in line with the concepts of public health.

Since the beginning of the epidemic, anti-AIDS associations, along with those working with those most exposed to transmission risk, are essential players whose place in prevention policy needs to be specified.

HIV-infection transmission has been successful in three areas: blood transfusions, mother-to-child transmission and intravenous transmission amongst drug users. In order to keep up the same performance, the policies underlying therefore needs to be at least maintained, otherwise it is feared that transmission could resume in groups such as drug users and pregnant women living with HIV.

It is also important to remember that non-discrimination against people living with HIV is vital for prevention. Being able to speak more easily about being HIV-positive with family members, friends or co-workers maintains ties with society and also provides means for protecting others.

It is essential that more messages are delivered publicly, at the highest level, in favour of prevention and against discrimination.

1 ENSURING PREVENTION POLICY THAT IS FULLY BORNE BY THE PUBLIC POWERS

From when it is first drafted through to the planning and implementation processes, prevention policy requires the collaboration of many players from all sectors of State administration, the professions that make up the health and social sectors, the business community and the associative sector. Despite that need for diversity, the public powers in charge of health need to reassert its place at the heart of prevention policy. To achieve this, the role of prevention in the healthcare system needs to be clarified, the State's commitment reasserted, the delegation of powers to associations fully carried out, campaigns adapted to meet the challenges at hand, and the production of the required knowledge secured.

1.1 THE STATE MUST CLARIFY THE ROLE OF PREVENTION IN THE HEALTH SYSTEM

• Making prevention of HIV-transmission a public health objective

The Public Health Act's objective attainment report sets out 100 objectives and tracking indicators. With regard to HIV-infection, the stated objective is lowering the number of AIDS cases. It is significant, but must come along with a primary prevention objective: reducing HIV-transmission.

• Clarifying funding sources

There exist a large number of funding sources and all of them claim to be suitable to the various action and implementation levels at which prevention takes place. The funding matches the various functions fulfilled by the organisations issuing them. However, the said functions are allocated in a way that is not always clear. In order to clarify each party's role under the new architecture resulting from the Public Health Act, it is therefore necessary to make the place of national government agencies, decentralised services, the public health insurance system and INPES with regard to public funding and prevention easier to understand.

• Specifying and reasserting INPES' role

Though defined by the law (programme implementation, expertise and consulting, health education development, training in health education, emergency situation management), the actual connection between INPES functions with the rest of the healthcare system is still interpreted in different and sometimes contradictory ways, by other player in the healthcare system. The missions set out in the law need to be accepted by all of the players, or a request made for them to be revised.

• **Making full use of the Regional Anti-HIV Coordination Centres (COREVIH)**

As part of a broader coordination effort with all of the parties contributing to prevention the COREVIHs need to make prevention amongst people living with HIV their top priority, in order to give them the means to protect their partners and tell them about their status. At the same time, they need to offer information about the epidemic's situation in a specific region.

2.2 THE STATE MUST ASSERT ITS COMMITMENT IN FAVOUR OF PREVENTION

• **Ensuring consistency in action at the decentralised level**

Local implementation of the national programme and distribution of prevention materials to high-priority populations lacks consistency across the nation. Considering the changes underway with the Public Health Act, and all the while maintaining the independence of the decentralised agencies, the national administration needs to ensure that prevention actions are consistent at the local level, first in the high-priority regions, but just as much across the country.

• **Giving even greater incentive for local authorities to contribute to prevention**

The regional public health groupings give the local authorities an active role in implementing regional health programmes, elaborated in part with the contribution of the Regional Health Conferences. Representatives at the State level need to give incentive for the local governments involved in both bodies to fully take into account the issues inherent in preventing HIV-transmission. Wherever necessary, the national associations representing the local authorities (Association of French Mayors, Assembly of French Departments, Association of French Regions), should mobilise to support prevention actions.

• **Supporting mobilisation for foreigners and migrants**

People of sub-Saharan African origin living in France are currently amongst the most exposed to HIV-transmission risk. The African associations that take action in prevention are still too few and far between to deal, alone, with their community's needs. Alongside that, other categories of foreigners or migrants, from North Africa, Asia, Eastern Europe or Latin America, can also be particularly exposed. In other words, all of the vehicles used to reach those individuals need to be mobilised or activated in favour of prevention: medical and social services, in particular mother and child prevention (PMI), departmental health education committees, existing associations, occupational medicine services, and companies employing a substantial number of migrants or people of foreign descent.

• **Requiring free provision of prevention materials by commercial sex establishments**

Prevention in commercial sex establishments is entirely up to their owners and the commitment of a handful of associations. Using Articles L 221-1 of the Consumer Code and L 1311-4 of the Public Health Code as a foundation, a regulatory framework guaranteeing those who frequent such establishments access to prevention materials and information needs to be determined quickly and implemented.

• **Guaranteeing access to post-exposure treatment everywhere in response to accidental sexual exposure**

The post-exposure treatments made available in the event of sexual exposure accidents have a prophylactic dimension, but can also make it possible to provide support to people dealing with prevention-related issues. Access to such treatment needs to be guaranteed across the country and the provision conditions suited to the preventive issue at stake.

1.3 THE STATE MUST TAKE ON THE RESPONSIBILITIES ASSOCIATED WITH DELEGATION

The decision to delegate field actions in prevention to associations has proved itself appropriate and effective. However, the National Health Directorate needs to shoulder the responsibilities that result from it. To do so, the fight against HIV and STIs needs to be able to rely on adequate staffing with recognised skills, particularly in government agencies.

• **Ensuring that associations' actions are appropriate and consistent with regard to the 2005-2008 Anti-HIV Programme**

Though detailed, the reports on funding use do not give a full picture on the basis of which the quality and suitability of the actions funded can be appraised and assessed. Inspections must not be financial alone. Delegation gives the State the responsibility of checking that all actions are relevant and effective. It must shoulder that responsibility.

• Fostering diversity in the associative sector

Peer-performed prevention guarantees effectiveness and is a source of innovation and responsiveness when dealing with a constantly-changing epidemic. To effectively steer prevention, the State must recognise this and support diversity in the associative sector in order to foster the development of complementary actions.

At the same time, the model, based on community health and prevention action run by peers, makes it necessary to consider the training and skills that might be required for such action.

In order to ensure that each action is best suited to the population in need, and considering the diversity of the populations making up certain groups, it is also necessary that the State's agencies provide technical support to the small associations. This support can also come from the large national associations whose powers allow them to make a helpful contribution or the network of Regional Health Education Committees, provided that the State delegates them resources for this purpose.

• Dealing with the lack of associations in a geographic area or with a target population

Delegating powers to associations does not mean that the entire nation or all of its population will be covered. The State must know how to deal, here and there, with a lack of associations, whether in terms of quality or quantity. Where associations are lacking, those that make up the healthcare and social sector (physicians, pharmacists, educators, etc.) and the Departmental Health Education Committees need to be mobilised. Likewise, the Departmental Federations of Family Associations and family movements contributing to health education can develop actions in the field of HIV. The French Movement for Family Planning's network also needs to be better put to work. The response can also come through the implementation of roving action and AIDS prevention teams, combining association members and public health workers.

1.4 THE STATE MUST PROMOTE PREVENTION CAMPAIGNS TAILORED TO THE CHALLENGES AT HAND

• Giving a more accurate image of the infection's seriousness

Perceptions of HIV-related risks have changed as treatment has developed, making the disease comparable in the minds of many to chronic illness. The analogy can be helpful in reassuring patients and the medical community, all things considered, but it can lead to misunderstanding as to the seriousness of HIV-infection and hinder prevention. For this reason, a more realistic image of the infection needs to be given in order to put an end to its portrayal as something ordinary, and contribute to a better understanding of risk.

• Devising distinct message for the HIV-positive and HIV-negative populations

Preventing HIV exposure or transmission requires implementing specific individual strategies to protect others and protect oneself, and is based on different mechanisms. The differences inherent in the two groups need to be the foundation for adapting the messages and plan distinct communication for HIV-positive and HIV-negative individuals. The INPES services, COREVIHs and associations will need to work on devising those differentiated messages.

• Increasing the frequency and diversity of messages

The campaigns implemented during the summer or on December 1st are not enough. There are not enough messages targeting gays, particularly in the specialised press, whereas exposure risk in that group is the highest. In contrast, migrants are the focus of many messages, even though the "migrant" category has not been specifically defined. Campaigns conducted on a more regular basis and better focused on specific audiences will make it possible for the prevention messages put out to be better received on the ground. Real consensus-seeking and better-supervised design need to go into the process by which the target populations are selected and campaign content determined.

1.5 THE STATE MUST ENSURE THAT THE REQUIRED KNOWLEDGE IS AVAILABLE

• Funding behavioural studies

The major surveys about behaviours and portrayals of HIV are funded mainly by ANRS. The agency's funds are intended to finance research and should not be used for surveys of this kind, which fall into the assessment indicator collection category.

• Developing surveillance of emerging needs

The State should not only provide funding for prevention actions and their renewal year on year, but also ensure that emerging needs are covered by its grants. To this end, it needs to establish a surveillance system, relying on its network of agencies and on all prevention parties. The system should focus on developments in the epidemic and changes in resource levels, so as to constantly adjust actions to meet field requirements, based on experiments, research programmes, assessment and, possibly, observation of what is done outside France.

- **Activity reports need to be an analysis tool for public fund-providers**

The activity reports issued by associations need to be harmonised in order to be usable as analysis and assessment tools. Still today, they show only figures, thus remaining inside the purely financial domain, without any qualitative outlook. Factors as diverse as employee and volunteer qualifications, developments observed in the field, management or implementation issues encountered and developments in actions under consideration all need to be shown in the activity reports so as to put together a database and enable real comparative assessment. INPES has the skills required to perform such assessment, and the related costs should be provided for in its budget.

- **Organising a consensus conference or public hearing about the risks associated with sexual practices**

The lack of specificity in message about risks has been at the root of sometimes major friction and misunderstanding between associations. A better understanding of the risks associated with the various practices and potential risks tied to recontamination is thus needed. To achieve this, a consensus conference or public hearing involving scientists and prevention partners needs to be organised in order to clarify risk levels. Their work will serve as a foundation for drafting a reference document.

- **Planning annual prevention conferences to share experiences**

Information-sharing about action in prevention and the assessment thereof has not been adequately developed. This is due more to a lack of vectors for information than a desire to withhold knowledge. Therefore, the procedures by which experiments underway can be consistently shared, for instance though an online database updated every half-year. Alongside that, an annual prevention conference on prevention, necessarily relating to mobilization of HIV-positive individuals, would be held to assess what is being done, share experiences and prepare, continually and in a coordinate fashion, programmes to fight HIV.

2 ENSURING CONSISTENCY ACROSS THE GOVERNMENT IN THE FIELD OF PREVENTION

I2.1 IMPLEMENTING AN INTERMINISTERIAL COORDINATION SYSTEM

To be successful, prevention policy needs to take into account all of the issues at hand. In other words, its premise is effective, efficient interministerial coordination. Achieving this requires that the policy launched needs to benefit from recognition at the highest level and have a designated contact person in each relevant ministry and a level of responsibility that enables real participation in decision-making.

2.2 THE MINISTRY OF NATIONAL EDUCATION MUST ESTABLISH PREVENTION FOR YOUNG PEOPLE

- **The Ministry of National Education must revitalise education in sex and intimacy**

As part of health education, the Ministry of National Education needs to implement a full-fledged education plan in sex and intimacy, one that broaches such issues as preventing unwanted pregnancy, STIs and, in particular, HIV-transmission.

The prevention policy in the establishment needs to be supported by specific budgetary funds, be allocated a set number of hours in students' schedules and be planned by a specially-designated individual.

The staff in charge of school health needs to be in sufficient numbers and receive the training required to know and respond to teenagers' requests.

- **The Ministry of Youth, Sport and Associations needs to contribute to health education**

Sporting association leaders and instructors need to be able to inform or guide the children and teenagers they educate if asked questions about education in sex and intimacy by them. To make this a reality, the Ministry of Youth, Sports and Associations needs to offer them the required training.

2.3 THE MINISTRY OF THE INTERIOR'S POLICIES MUST NOT GO AGAINST PREVENTION POLICY

The police's behaviour greatly influences the quality of field actions targeting the most exposed populations: drug addicts, prostitutes or illegal aliens. The same understanding that gave rise to the needle exchange system, at the time, needs to be revived now.

• The Domestic Security Act must not become an obstacle to prevention amongst prostitutes

Since the Domestic Security Act came into effect, the conditions under which prostitution is conducted and has caused people to move away from the associations that are supposed to help them. Prostitutes have become more vulnerable and their exposure to transmission risk has grown. The articles contained in the Domestic Security Act on prostitution need to be reviewed according to their undeniably negative impact on prevention in the group.

• Foreigners' rights need to be fully upheld

Before considering applications for temporary stay for health reasons, prefectures sometimes request papers that the law does not require and overstep the bounds of their prerogatives. In so doing, they delay the implementation of care for the said individuals and, therefore, transmission prevention work. More generally speaking, the difficulties that foreigners face in having their rights recognised contributes to increasing precariousness, meaning greater risk of being exposed to the virus. The law needs to be enforced in a disciplined manner and within a short timeframe.

• In administrative detainment centres, individuals need to be able to benefit from the rights guaranteed them by the law

The foreigners placed in detainment centres must have access to a physician and be able to file temporary stay applications and be issued the required application receipts.

• The fight against drug trafficking must not challenge the results achieved by risk reduction in intravenous drug users

Whereas, for many years, the interest in risk reduction was clearly understood by all of the parties involved in the fight against narcotic use, drug users have once again become forced to spread out and are harder to reach for prevention players. Users need to once again have easy access to the prevention actions that are designed for them.

2.4 THE MINISTRY OF JUSTICE MUST ADDRESS THE HIV-EPIDEMIC IN PRISON

Effective prevention needs pragmatism and requires recognising the existence of certain practices, in order to deal with the risks associated with them. For instance, failure to recognise needle use or sexual intercourse amongst inmates makes it difficult to spread the required information to inmates and workers, and also hinders the cooperation of the penitentiary administration.

• Creating the conditions for effective prevention

Prisons experience a large number of difficulties due to their condition, overpopulation and undeniable dearth of medical or warden staff. These issues are all obstacles to prevention and must be overcome. There and elsewhere, the priority needs to be given to public health and HIV-transmission prevention, by improving the dissemination of information and reducing the discrimination which HIV-infected inmates must face.

• Recognising the existence of high-risk sexual practices

The sexual practices of inmates are a reality and give risk to HIV-transmission risks. Condoms need to be accessible to all in all penitentiary establishments. That accessibility cannot be subject to the willingness of medical or warden staff. Likewise, the efforts made to create family living units for couples need to be extended.

• Completing risk-reduction policy in drug addiction amongst inmates

Access to substitution products involves opiates is an integral part of risk reduction and needs to be a reality in all establishments. In light of what occurs in certain countries, and in connection with the administration at the penitentiary establishment, experiment with needle-exchanges need to be implemented in order to complete the range of risk reduction tools used for inmates. Should the assessments yield positive results, the assessments will need to be extended to all penitentiary establishments.

3 CLARIFYING THE PARTNERSHIP BETWEEN ASSOCIATIONS AND THE STATE

3.1 THE STATE MUST SECURE THE ENVIRONMENT IN WHICH ASSOCIATIONS OPERATE

In order for the associations to fulfil their responsibilities as effectively as possible, the State needs to promote a framework that is better suited to the associations to which it delegates prevention, and contribute to building their skills. In return, the associations need to serve the shared objectives for which they are funded.

• **Paving the way for implementation of legislative developments affecting health or associative activities**

The Framework Law on the Finance Act (LOLF) modifies the rules by which associations develop contractual relations with the State by setting up objective attainment contracts, where performance is a condition for renewed financing.

The Public Health Policy Act created new arenas for negotiating funding and prevention programmes: regional health conferences contributing to the definition of regional health objectives; regional public health groupings that implement healthcare programmes, health programmes set out by the State's representative and encompassing a range of programmes, including one on access to prevention for the underprivileged and programmes for health in schools and health education.

Together, these major developments make the situation more complex. The State needs to support them technically and financially.

• **Keeping from weakening associations financially**

The subsidies paid out need to come as early as possible in the year in progress, so that the associations' treasuries do not have to deal with delays in public disbursements. The national prevention programme is designed on a three-year basis. The agreements signed with the associations should have the same foundation in order to guarantee better financial standing, as recommended in a circular from the Prime Minister, dated 1 December 2000. This will make it all the easier to gain access to the European funds provided only to financially sound recipients. They need to take into account changes in skills and salary levels.

• **Fostering the diversification of funding sources**

There exists a wide range of possible funding sources, including those instituted by the Public Health Act, the social programmes that can include a health component, or the European funds. The associations need to be provided with clear information about them. The subsidy applications need to be simplified and harmonised.

3.2 DELEGATION OF POWERS AND PUBLIC FINANCING ENTAIL RESPONSIBILITIES FOR ASSOCIATIONS

• **All gay associations need to carry forth the prevention message**

Considering the major prevalence of HIV-infection in men having sex with men, gay associations need to make the fight against HIV-infection a top priority and mobilise in favour of prevention, in particular in regions where the associative networks are inadequate. They can also be vectors for prevention messages and contribute to mobilising people who do not recognise themselves in anti-AIDS associations. For this to happen, the State needs to grant them special funding.

• **SNEG needs to speak out publicly and unambiguously about prevention**

Despite its long-standing commitment in prevention, the National Federation of Gay Enterprises (SNEG) plays an unclear role, between trade association and prevention advocate. That lack of clarity is heightened by the activities of some of its members, which derive their income from commercial sex establishments in which risk-taking occurs. Considering the level of HIV-infection prevalence amongst gays, it is essential to assert the full responsibility of SNEG's member companies in prevention. Only an unambiguous public stance about prevention on the part of SNEG can justify the continuation of public funding for its activities.

• **The associations need to be a driving force in assessing prevention actions**

The associations are the best equipped to come up with the most appropriate indicators in assessing field actions and the means by which information should be collected. They therefore need to put forth an effort to self-assess, based on criteria determined in connection with the public powers.

• **Achieving a foundation for consensus-seeking amongst associations**

The controversy over prevention actions make it difficult for associations to exchange in this area. The stumbling blocks hurt the entire prevention process, as they hinder innovation and the emergence of new practices. Anti-HIV associations must now give themselves the means for creating areas for exchange and suggest innovative solutions to the problems emerging in the field of prevention.

APPENDICES

ACRONYMS USED

AAH: Allocation adulte handicapé (Disabled adult subsidy)

AC: Action concertée (Concerted action)

ACCES: Action pour la citoyenneté et l'éducation à la santé (Action for Citizenship and Health Education)

ACSAG: Analyse des comportements sexuels aux Antilles et en Guyane (Analysis of Sexual Behaviours in the Caribbean and Guyana)

ACSF: Analyse des comportements sexuels en France (Analysis of Sexual Behaviours in France)

ACT: Appartements de coordination thérapeutique (Therapeutic coordination apartments)

AFLS: Agence française de lutte contre le sida (French Anti-AIDS Agency)

AFSSAPS: Agence française de sécurité sanitaire et des produits de santé (French Health-Products Safety Agency)

AME: Aide médicale d'Etat (State-granted medical assistance)

AMM: Autorisation de mise sur le marché (Marketing approval)

AMPT: Association méditerranéenne des toxicomanies (Mediterranean Drug Users' Association)

ANAES: Agence nationale d'accréditation des établissements de santé (National Agency for the Accreditation of Healthcare Establishments)

ANPAA: Association nationale de prévention en alcoologie et addictologie (National Prevention Association in Alcohology and Addictology)

ANRS: Agence nationale de recherche sur le sida (National AIDS Research Agency)

ARCAT: Association de recherche, de communication et d'action pour l'accès aux traitements (Research, Communication and Action Association for Access to Treatment)

ARH: Agence régionale d'hospitalisation (Regional Hospitalisation Agency)

ASUD: Auto-support des usagers de drogues (Drug users' self-support)

BIP: Bulletin d'information professionnel (Professional Newsletter)

CAC: Centre d'accueil de crise (Crisis Centre)

CASO: Centre d'accueil et de soins (Healthcare and Assistance Centre)

CATTP: Centre d'accueil thérapeutique à temps partiel (Part-Time Therapeutic Assistance Centre)

CDAG: Centre de dépistage anonyme et gratuit (Anonymous and Free Screening Centre)

CFA: Centre de formation des apprentis (Apprentice Training Centre)

CFES: Comité français d'éducation à la santé (French Committee on Health Education)

CGL: Centre gai et lesbien (Gay and Lesbian Centre)

CHR: Centre hospitalier régional (Regional Hospital Centre)

CISIH: Centre d'information et de soins de l'immunodéficience humaine (Information and Healthcare Centre in Human Immune Deficiency)

CMP: Centres médicaux psychologiques (Psychological Medical Centres)

CMU: Couverture maladie universelle (Universal Medical Coverage)

CNAM: Caisse nationale d'assurance maladie (National Public Health Insurance Centre)

CNRS: Centre national de la recherche scientifique (National Scientific Research Centre)

CODES: Comités départementaux d'éducation à la santé (Departmental Health Education Centres)

COREVIH: Coordination régionale de lutte contre l'infection due au virus de l'immunodéficience humaine (Regional Coordination on the Fight Against Human Immune Deficiency Virus Infection)

CPAM: Caisse primaire d'assurance maladie (Local Public Health Insurance Centre)

CPE: Conseillers principaux d'éducation (Head educational advisors)

CRAM: Caisse régionale d'assurance maladie (Regional Public Health Insurance Centre)

CRAMIF: Caisse régionale d'assurance maladie d'Ile-de-France (Ile-de-France Regional Public Health Insurance Centre)

CRES: Comités régionaux d'éducation à la santé (Regional Health Education Committees)

CRIPS: Centre régional d'information et de prévention du sida (Regional AIDS Information and Prevention Centre)

CSS: Comité scientifique sectoriel (Sector-Wide Scientific Committee)

CSST: Centres spécialisés de soins aux toxicomanes (Specialised Care Centres for Drug Users)

CTRI: Comité technique régional et interdépartemental (Regional and Inter-departmental Technical Centre)

DASES: Direction de l'action sociale, de l'enfance et de la santé (National Directorate on Social Action, Children and Healthcare)

DATIS: Drogue alcool tabac info service (Drug, Alcohol and Tobacco Information Service)

DAV: Dispensaires antivénérien (Anti-venereal disease medical care centres)

DDASS: Direction départementale de l'action sanitaire et sociale (Departmental Directorate on Health and Social Action)

DESCO: Direction de l'enseignement scolaire (National Directorate on School Teaching)

DFA: Département français d'Amérique (French Department of America)

DGS: Département français d'Amérique (National Health Directorate)

DHOS: Direction de l'hospitalisation et des soins (National Directorate on Hospitalisation and Healthcare)

DO: Déclaration obligatoire (Mandatory reporting)

DRASS: Direction régionale de l'action sanitaire et sociale (Regional Directorate on Health and Social Action)

DSDS: Direction de la santé et du développement social (National Directorate on Health and Social Development)

EMIPS: Equipe mobile d'information et de prévention santé (Roving Health Information and Prevention Team)

ENVEF: Enquête nationale sur les violences envers les femmes en France (National Survey on Violence toward Women in France)

EPG: Enquête presse gay (Gay Press Survey)

FASILD: Fonds d'action et de soutien pour l'intégration et la lutte contre les discriminations (Action and Support Fund for Integration and Anti-Discrimination)

Fnap-psy: Fédération nationale des associations de patients et ex-patients psychiatriques (National Federation of Mental Patient and Ex-Patient Associations)

FNPASS: Fonds national d'action sanitaire et sociale (National Fund on Health and Social Action)

FNPEIS: Fonds national de prévention d'éducation et d'information sanitaires (National Prevention fund for Health Education and Information)

FSE: Fonds de solidarité européen (European Solidarity Fund)

FTCR: Fédération des tunisiens pour une citoyenneté des deux rives (Federation of Tunisians for Bicoastal Citizenship)

GIP: Groupement d'intérêt public (Public interest grouping)

GRSP: Groupements régionaux de santé publique (Regional public health groupings)

HPA: Health Protection Agency

IAURIF: Institut d'aménagement et d'urbanisme d'Ile de France (Institute for Planning and Urban Development in Ile de France Region)

IGAS: Inspection générale des affaires sociales (National Inspectorate on Social Affairs)

IMEA: Institut de médecine et d'épidémiologie africaine (Institute of Medicine and African Epidemiology)

INED: Institut national des études démographiques (National Institute for Demographic Studies)

INPES: Institut national de prévention et d'éducation à la santé (National Institute for Healthcare Education and Prevention)

INSERM: Institut national de la santé et de la recherche médicale (National Institute for Health and Medical Research)

IVS: Institut de Veille Sanitaire (Desease control Institute)

IVG: Interruption volontaire de grossesse (Voluntary pregnancy termination)

KABP: Knowledge, Attitudes, Beliefs and Practices

LGBT: Lesbian, gay, bi, trans

LGV: Lymphogranuloma Venereum

LOLF: Loi organique sur la loi de finance (Framework Law on Finance Act)

LSI: Loi de sécurité intérieure (Domestic Security Act)

MDM: Médecins du monde

MFPF: Mouvement français pour le planning familial (French Movement for Family Planning)

MILC: Mission interministérielle pour la lutte contre le cancer (Interministerial Task Force for the Fight on Cancer)

MILDT: Mission interministérielle de lutte contre la drogue et la toxicomanie (Interministerial Task Force against Drugs and Drug Addiction)

MISP: Médecin inspecteur de santé publique (Physician-public health inspector)

OIP: Observatoire international de prisons (International Observatory on Prisons)

OMI: Office des migrations internationales (International Migration Office)

WHO : World Health Organisation

ORS: Observatoire régional de santé (Regional Health Observatory)
PACA: Provence Alpes Côte d'Azur
PASS: Permanences d'accès aux soins de santé (All-day healthcare centres)
PASTT: Prévention, action santé travail pour transgenres (Prevention, action, health and labour for transgenders)
PDAE: Programme départemental d'aide à l'emploi (Departmental Job Assistance Programme)
PES: Programme échange de seringues (Needle-Exchange Programme)
PMI: Prévention maternelle infantile (Prevention for Mother and Child)
PRAPS: Programmes régionaux d'accès aux soins (Regional Healthcare Access Programmes)
PRIPI: Programmes régionaux d'intégration des populations immigrées (Regional Integration Programmes for Immigrant Populations)
PRS: Programmes régionaux de santé (Regional Healthcare Programmes)
RDR: Réduction des risques (Risk reduction)
RMI: Revenu minimum d'insertion (Minimum subsistence income)
SIS: Sida info service
SMPR: Services médico-psychologiques régionaux (Regional medical and psychological services)
SNEG: Syndicat national des entreprises gaies (National federation of gay enterprises)
SONACOTRA: Société nationale de construction pour les travailleurs (National Construction Society for Workers)
SPIP: Service pénitentiaire d'insertion et de probation (Penitentiary Mainstreaming and Probation Society)
SREPS: Schéma régional d'éducation pour la santé (Regional Health Education Plan)
SROS: Schéma régional de l'organisation sanitaire (Regional Health Organisation Plan)
STI: Sexually-transmitted infection
SVT: Sciences de la vie et de la terre (Life and earth sciences)
TPE: Traitement post exposition (Post-exposure treatment)
UCSA: Unités de consultation et de soins ambulatoires (Medical visit and roving care units)
UDVI: Usagers de drogues par voie intraveineuse (Intravenous drug use)
UNAFAM: Union nationale des amis et famille de malades mentaux (National Union of Families and Friends of the Mentally Ill)
UNALS: Union nationale des associations de lutte contre le sida (National Union of Anti-AIDS Associations)
URCAM: Union régionale des caisses d'assurance maladie (Regional Union of Public Health Insurance Offices)
UVF: Unité de visite familiale (Family Visiting Unit)
VESPA: VIH enquête sur les personnes atteintes (HIV survey on infected individuals)
VHB: Hepatitis B virus
VHC: Hepatitis C virus
VIH: Human immune deficiency virus

PERSONS HEARD BY CONSEIL NATIONAL DU SIDA'S PREVENTION COMMITTEE

28 May 2004

Mr Philippe Lamoureux, Director General, INPES.

Ms Isabelle Grémy, Director, Ms Nathalie Beltzer, researcher, ORS d'Ile-de-France.

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Ms Véronique Doré, Head, "Research into Public Health, Human Sciences and Society in HIV-infection" Commission, ANRS.

Ms Nicole Solier, Head, Anti-HIV Bureau, National Health Directorate, Ministry of Health and Social Protection.

Ms Nadine Neulat, Head, Health and Social Action and Prevention, Ms Félicia Narboni, in charge of health-related issues, Directorate on School Teaching, Ministry of National Education.

10 November 2004

Mr Didier Lestrade, Founder, Act Up Paris and Têtu Magazine.

Mr Romain Mbiribindi, Chairman, Afrique Avenir (association).

24 November 2004

Mr Michel Colls, Treasurer, ACTIS Saint-Etienne Association, Vice President, UNALS.

Mr Yves Ferrarini, Director, Sida info service Association.

1 December 2004

Mr Jean-Yves Le Tallec, Sociologist, Toulouse-Le Mirail University.

8 December 2004

Ms Corinne Monnet, Director, Ms Lara Peyret, Field Action Coordinator, Cabiria Association.

Mr Antonio Alexandre, National Prevention Delegate, SNEG.

22 December 2004

Dr Camille Cabral, Chairperson, PASTT Association.

Mr François Berdougo, Head, Association Programmes, Sidaction.

5 January 2005

Dr Rida Nouiouat, Head, Prison Programme, Migrations Santé Association.

Mr Jérôme Martin, Chairman, Mr Emmanuel Château, Head, Prevention Committee, Act Up Paris Association.

12 January 2005

Dr Carine Favier, Member, MFPF Bureau, Head AIDS Committee.

Dr Jean-Pierre Lhomme, Head Local Risk Reduction in Urban Areas and Methadone Bus Programme, Paris, Médecins du monde Association.

2 February 2005

Ms Barbara Wagner, Chairperson, Mme Florence De Pina, Founder, Femmes Positives Association, Marseilles.

Mr Thibaut Tenailleau, Director, ARCAT Association.

9 February 2005

Mr Antonio Ugidos, Director, CRIPS Ile-de-France Association.

2 March 2005

Dr Eric Schwartzentruber, Regional Inspecting Physician, DRASS/DDASS Alsace/Bas-Rhin.

Dr Hélène Prodhon, Regional Inspecting Physician, DRASS Provence-Alpes-Côte d'Azur.

9 March 2005

Ms Isabelle Million, Coordinator, Couples contre le sida Association (Couples Against AIDS), Lyons.

Mr François Bês, Delegate on Local Groups, OIP.

16 March 2005

Mr Eric Schneider, Chairman, ASUD Association, ACCES Association leader, Marseilles.

Mr Reda Sadki, Chairman, Maghreb-Afrique des familles pour survivre au sida (Families of North Africa/Africa Surviving AIDS)

30 March 2005

Dr Christiane Charmasson, Hospital Practitioner, Coordinator, Sida sexualités et prévention de l'établissement public de santé de Ville Evrard Committee (AIDS, Sexuality and Prevnetion Committee, Ville Evrard Public Healthcare Establishment).

Ms Hélène Rossert, Director General, AIDES Association.

6 April 2005

Mr Tarik Ben Hiba, Mr Sassi Ben Moussa, Members of Board of Directors, Mr Claude Denré, Coordinator, FTCR Association.

Dr. Laurence Pallier, Coordinating Physician, Var Region EMIPS

20 April 2005

Mr Christophe Martet, Journalist, Têtu Magazine.

25 May 2005

Ms France Lert, Director, Unit 687, « Public Health and Epidemiology and Epidemiology of Professional and Social Determinants of Healthcare", Inserm.

Mr Olivier Jablonski, Mr Georges Sideris, Warning Association.

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