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**REPORT FOLLOWED BY
 RECOMMENDATIONS**

SCREENING

EN

2006 NOVEMBER 24TH

REPORT FOLLOWED BY RECOMMENDATIONS ON
 DEVELOPMENTS IN HIV INFECTION SCREENING
 PROGRAMMES IN FRANCE

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REPORT

At the suggestion of the "Screening" Committee

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INTRODUCTION

Screening tests for Human Immunodeficiency Virus (HIV) infection have been available since 1985. At that time, however, there were no antiretroviral treatments. The principal aim of these tests was to safeguard donations of blood, organs, tissue, cells and gametes. With the emergence of treatment options, screening has also become extremely important to individual patients. The use of antiretroviral therapy has without doubt increased the life expectancy of people infected with HIV. Screening tests allow the detection of asymptomatic infection so that a diagnosis can be made and early treatment commenced. Immunovirological assays make it possible to determine the best time to commence treatment with antiretroviral drugs. The screening programme has been devised to enable the dissemination of information regarding prevention before and after the test is carried out. This process, known as *counselling*, has been adopted, together with its English name, by French healthcare professionals. It has changed little since.

In recent years, the screening policy has raised questions for two reasons: Firstly, while early treatment offers a significant improvement in the life expectancy of people infected with HIV, epidemiological data has confirmed that there is a delay in testing and treatment. Depending on the methods of calculation used, the prevalence of HIV infection is estimated at between 106,000 and 134,000 people at the end of 2005¹. The number of people infected who were unaware of their infection with HIV is high, estimated at around 40,000². In 2004, of the people in whom AIDS had been diagnosed, 45% were unaware they had been infected with HIV³. New infections are estimated at 5,200 per year⁴.

In 2004, France, after Austria, was the second European country to have the highest number of tests carried out per citizen (82‰), amounting to 4.9 million tests with an increase of 4% every year since 2001⁵. In 2004, the number of new diagnoses of HIV infection was estimated at 7,000. The *Institut de Veille Sanitaire* (IVS - National Institute for Public Health Surveillance) estimated that transmission among people who have heterosexual relationships is more common, accounting for between 55% and 67% of all new diagnoses⁶. Of these, 54% of women and 41% of men were nationals of countries in sub-Saharan Africa⁷, although this trend fell between 2003 and the first semester of 2005⁸. There are also regions where the prevalence is higher, resulting in the need for a modified response that takes account of the geographical location in order to reinforce the screening programme. Among the individuals who were previously unaware of their infection with HIV, almost half (48%) live in the Île-de-France region⁹. The situation is also of concern in France's overseas departments (DOM), notably in French Guiana and Guadeloupe. At the same time, certain groups are more exposed to HIV. As such, transmission among men who have homosexual relationships continues at between 24%

¹ Prevalence means the total number of people infected at any given moment in a given population. The lower figure is the one calculated through retrocalculation, while the higher figure is obtained using a direct method. With a plausibility interval from 88,000 to 185,000 people. "La prévalence de la séropositivité VIH en France", *BEH* n° 11 (15 March 2005).

² The number of patients receiving treatment is estimated at between 73,000 and 88,000 (FHDH [French Hospital Database on HIV]); the number of people infected between 106,000 and 134,000; the interval of the number of people unaware of their infection probably lies between 18,000 and 61,000 people.

³ *Op. cit.* p. 11.

⁴ With deaths being estimated at 1,700 per year, the annual increase in the prevalence of infection with HIV may therefore be extrapolated to 3,500 cases (*BEH* n° 11, *op. cit.*)

⁵ Institut de Veille Sanitaire, "Surveillance du VIH/sida en France", report n° 3, data to 30 June 2005, p. 16.

⁶ *Op. cit.* p. 23.

⁷ These countries are chiefly: Cameroon, Ivory Coast, Congo and Mali, Institut de Veille Sanitaire, *op. cit.* p.5.

⁸ *Ibid.*

⁹ *Op. cit.* p. 7.

and 29% of all new diagnoses¹⁰, having increased between 2003 and the first semester of 2005¹¹.

In September 2005, a number of people became concerned about how screening would be organised in the future in France. Sidaction thus informed the Conseil national du SIDA of its fears regarding the negative impact on anonymous and free screening centres (CDAGs) caused by the enactment of the law pertaining to freedom and local responsibility, which restores responsibility to the state in the fight against sexually-transmitted infections (STIs)¹². In its report in June 2006, the group of experts on the medical treatment of people infected with HIV suggested that the Conseil national du SIDA should pursue its careful consideration of screening provision¹³. Tackling this question, the CNS spoke to the key figures involved in the fight against AIDS and the players affected by matters relating to screening (cf. appendix).

In order to identify people infected with HIV who are unaware of their condition more quickly, this report suggests offering the test on a wider scale and improving screening practices. Indeed, it would appear that knowing one's status encourages early treatment as well as a change in behaviour towards safer practices¹⁴.

First of all, the report will discuss the necessary changes to paradigm relating to screening programmes. It will advocate the broadening of screening opportunities in general and a more targeted effort in regions where prevalence is high. The report will also defend the idea that screening practices, such as counselling and the use of rapid tests, need to develop.

Secondly, the report will take a look at ways of optimising screening. From this perspective, regional policies need to be suggested by the COREVIHs (Coordinations régionales de lutte contre l'infection due au virus de l'immunodéficience humaine - Regional Coordination on the Fight Against Human Immunodeficiency Virus Infection), whereas the CDAGs need to do more to achieve their goals. Finally, people at high-risk of exposure to HIV need to benefit from a more customised range of services.

¹⁰ *Op. cit.* p. 23.

¹¹ Yeni P [Dir.], Rapport 2006 : Prise en charge médicale des personnes infectées par le VIH, recommandation du groupe d'experts, Paris, Flammarion, 2006, p. 8.

¹² Law n° 2004-809 dated 13 August 2004 relating to freedom and local responsibilities, article 71.

¹³ Yeni P [Dir.], *op. cit.*, p. 336.

¹⁴ Marks G, Crepaz N, Senterfitt JW, Janssen RS, "Meta-analysis of high-risk sexual behavior in persons aware and unaware they are infected with HIV in the United States. Implications for HIV prevention programs", *J Acquir Defic Syndr*, 2005 Aug 1;39(4):446-53.

I CHANGING THE SCREENING PARADIGM

Infection with HIV is a serious illness that can be detected before symptoms develop using screening tests that are reliable, cheap, straightforward and minimally invasive. Treatment given before symptoms develop has shown benefits in terms of a reduction in sickness and mortality. The cost of these treatments, in relation to their potential benefits, is reasonable. Knowing their serological status allows patients, in the majority of cases, to commence treatment and care¹⁵, as illustrated by the results of the *Retard* survey¹⁶. In this study, almost all of the people who took part in the survey (94%) got in contact with a physician three months after having been told of their serological status.

In 2004, half (52%) of people infected through heterosexual intercourse were unaware of being HIV-positive at the time AIDS was diagnosed¹⁷. The logic behind screening is to identify people who are asymptomatic. However, the analysis of data relating to the circumstances surrounding the discovery of their HIV infection demonstrates that the primary motive for screening is the appearance of clinical or biological signs of the disease in 32% of cases who were found to be HIV-positive in 2004¹⁸. Despite this widespread screening in France, there is a delay in access to care, since 35.7% of patients only enter the care system once they are already at the AIDS stage or their immunity is already significantly impaired¹⁹. This delay affects two different types of patients. Some have delayed their recourse to healthcare after they were diagnosed with the infection. In the more common scenario, others were screened only shortly before their entry into the healthcare system, but long after their initial infection. This delay increases the risk of death within six months of entering the healthcare system fourteen-fold²⁰. As a result, the continuity of care after screening must be improved²¹.

The number of serologic tests confirmed positive in relation to the number of serologic tests carried out is estimated at 2.4‰ in 2004, but it is much higher in certain regions. Indeed, the figure for the Ile-de-France region is estimated at 5.3‰, while the figure for French Guiana is 17.2 ‰²². These regions are classed as "priority" by the national programme against HIV/AIDS and STIs for 2005-2008. In the light of this data, screening needs to be stepped up in regions where prevalence is high and the tools used need to be adapted in order to provide better screening.

Faced with these acknowledgements, the screening paradigm, whereby people are screened according to their pursuit of high-risk practices, needs to be re-evaluated.

1.1 MOTIVES FOR SCREENING OFFERS TO BE DEVELOPED

In the majority of situations²³, the screening offer generally follows an evaluation of its appropriateness, based on the risks of exposure to infection with HIV. This offer needs to become more routine in the case of certain situations where recourse is had to healthcare and also needs to take more account of the prevalence in the region in which it is made.

ACCORDING TO PREVALENCE

Unlike in the United States²⁴, there is no French study²⁵ on the relationship between costs and effectiveness for generalised screening. However, it would not seem unreasonable to believe that, in France, this cost-effectiveness ratio may also be relevant, subject to the prevalence of infections with HIV that have not been screened exceeding 0.1%. The efficiency of a widespread offer is measured on two levels. Firstly on an individual level, by the quality of life and number of years of life gained for the infected

¹⁵ In 2004, 30% of people who had been diagnosed with AIDS were aware of their HIV-positive status but had not been given antiretroviral treatment before this stage of the disease.

¹⁶ Calvez M [Dir.], *Le recours tardif aux soins des personnes séropositives pour le VIH : Modalités d'accès et contextes socioculturels*. <http://halshs.ccsd.cnrs.fr/halshs-00007973>.

¹⁷ Institut de Veille Sanitaire, *op. cit.*, p. 14.

¹⁸ *Op. cit.* p. 6.

¹⁹ CD4 lymphocytes < 200/mm³.

²⁰ This elevated risk lasts for up to 4 years after care commences.

²¹ Lanoy E, Mary-Krause M, Tattevin P, Perbost I, Poizot-Martin I, Dupont C, Costagliola D and ANRS C004 French Hospital Database on HIV Clinical Epidemiological Group, "Frequency, determinants and consequences of delayed access to care for HIV infection in France", *Antiviral therapy* (now printing).

²² Institut de Veille Sanitaire, *op. cit.*, p.16.

²³ Apart from routine screening services such as during pregnancy.

²⁴ Walensky RP, Weinstein MC, Kimmel AD, et al, "Routine human immunodeficiency virus testing: an economic evaluation of current guidelines", *Am J Med* 2005; vol.118, p. 292--300. Paltiel AD, Weinstein MC, Kimmel AD, et al, "Expanded screening for HIV in the United States---an analysis of cost-effectiveness". *N Engl J Med* 2005, vol. 352, p. 586-595. Sanders GD, Bayoumi AM, Sundaram V, et al, "Cost-effectiveness of screening for HIV in the era of highly active antiretroviral therapy", *N Engl J Med* 2005, vol. 352, p. 570-585.

²⁵ The *Institut de Veille Sanitaire* is currently working on a study for France in concert with teams who have worked on the United States.

person, and secondly on a broader scale, within the framework of public health services, since knowledge of one's serological status has a positive impact on high-risk behaviour and reduces medical costs thanks to earlier treatment and care.

In areas where the prevalence exceeds 0.1%, a test should be offered as a matter of course to patients when they attend for medical consultation, either at their GP or in hospital, and more specifically in the emergency services²⁶. Although the epidemiological data on the prevalence of untested HIV infection only represents an estimate, one may consider that, in France, at least three regions are concerned. These three regions are the DOM, Île-de-France and Provence-Alpes-Côte d'Azur (PACA).

Beyond the number of serologic tests confirmed positive in relation to the number of tests carried out in certain regions, almost half (45%) of the people diagnosed at the AIDS stage in 2004 were unaware of their HIV-positive status at the time the diagnosis was made²⁷. It is notably in the Île-de-France and the DOM that this percentage is the highest²⁸.

UTILISING SPECIFIC OPPORTUNITIES TO OFFER A TEST

More than two-thirds of 18-24-year-olds have never had a test²⁹. When a patient attends for a contraceptive prescription, this should give physicians the opportunity to talk about the merits of carrying out a screening test and also to suggest a test for the patient's partner, where applicable. In the same vein, changes in a patient's sexual lifestyle or the taking of unknown risks should lead the practitioner to offer a screening test and, if possible, to accompany this with counselling or at least the provision of informative documentation. In the event of a marital break-up, the subject could also be discussed since less than 25% of people take a screening test after a break-up³⁰ and 65% of people having had an extramarital affair did not consistently use a condom³¹.

Additionally, when women attend for pregnancy screening, this is an ideal time to suggest testing for the couple. Among the women found to be HIV-positive in 2004, 18% were diagnosed as part of a pregnancy check-up³² and this is one of the elements that may explain why women are screened earlier than men. Somewhat surprisingly, although the test is offered to the mother by the physician, the test is not offered to the father, who is nevertheless just as affected by any infection that may be present. As the CNS recommended in a previous statement on the voluntary testing of pregnant women, the offer must be repeated over the course of the pregnancy³³ and be extended to include the partner. It could be done, for example, during the free health check offered to the father of the unborn child during the third month of pregnancy.

In the case of a voluntary pregnancy termination, the screening test for the main STIs, including HIV, is not always offered to the patient as a matter of course. However, the rate of infection among these women is four times higher than in those who continue with the pregnancy³⁴.

The screening strategy described above is very different from the current strategy, which offers the test depending on high-risk behaviour. This unique strategy has demonstrated it has limits. Treated like any other health problem, HIV infection would be less regarded as a separate disease, one associated with stigma, which quite obviously discourages part of the population, such as migrants, from obtaining screening³⁵. Such normalisation would allow HIV screening to become a common practice for the entire population, in particular in the French Departments of America (DFA) where the stigma of HIV infection seems to remain marked³⁶.

1.2 RETHINKING COUNSELLING PRACTICES

It is agreed that routine offering of screening is well-accepted and useful, for example within the framework of pregnancy monitoring where the acceptance rate is virtually 100%. A prenuptial certificate represents another opportunity to offer HIV/AIDS testing, but it

²⁶ This offer must also involve psychiatric institutions where rules forbidding sexual relationships and the use of drugs perform the role of prevention and where screening is rarely carried out.

²⁷ Institut de Veille Sanitaire, *op. cit.*, p. 11.

²⁸ *Op. cit.* p. 14.

²⁹ ORS île de France, Les connaissances, attitudes, croyances et comportements face au VIH/sida en France, November 2005, p. 106.

³⁰ ORS île de France, La gestion du risque VIH-sida après une rupture conjugale, December 2002, p.16.

³¹ *Op. cit.* p. 24.

³² Institut de Veille Sanitaire *op. cit.*, p. 6.

³³ Statement on screening for infection with HIV during pregnancy and perinatal prevention of infection of the child, approved at the 14 March 2002 plenary session.

³⁴ Prévagest survey.

³⁵ INPES, Enquête sur les connaissances, attitudes, croyances et comportements face au VIH/sida des populations originaires d'Afrique subsaharienne vivant en Ile de France, to be published.

³⁶ ORS île de France, Les connaissances, attitudes, croyances et comportements face au VIH/sida aux Antilles et en Guyane en 2004, April 2006, p. 109.

would appear that a legislative bill is set to do away with such papers³⁷. People who are unaware of their serological status are at risk of being the source of new infections³⁸. It is therefore important to rethink the screening system in order to encourage these individuals to get themselves tested, so that testing can be a preventative tool at both individual and collective level.

LIMITING COUNSELLING WHEN IT PRESENTS A BARRIER TO SCREENING

Current thinking encourages physicians to offer pre-test counselling before any test is offered to screen for HIV infection³⁹. For anonymous and free screening centres (CDAG), this counselling remains obligatory⁴⁰; this obligation is broadened to include centres providing information on the screening and diagnosis of sexually transmitted infections (CIDDIST) and Prevention for Mother and Child welfare services (PMI)⁴¹. This counselling comprises an exchange with the patient on infection with HIV. It is aimed at understanding the circumstances surrounding their decision to take a test and at evaluating their understanding of the methods of transmission and their subjective perception of risk. But this exchange also aims to anticipate the emotions linked to the results. Counselling is regarded as an opportunity to reinforce the prevention messages. In the context of this discussion, the physician must decide upon the appropriateness of offering a screening test or not⁴².

In the majority of cases, the intrusiveness of counselling on the patient's private life, in particular regarding his or her sexual lifestyle, poses problems to non-specialist physicians who find raising the matter with a patient difficult, particularly if he or she is that patient's family physician⁴³. The obligation to provide pre-test counselling may therefore seem to be a barrier to offering the test. Often, as a result of the physician believing that the patient is not adequately informed, or because of lack of time, physicians do not provide counselling nor offer any screening test. What's more, numerous surveys show that patients who are not infected with HIV do not change their attitude towards prevention, despite counselling⁴⁴. If the counselling requirement were removed, the physician could more easily offer the test to the patient during the course of other examinations that are carried out on a more regular basis.

IMPROVING AND DELEGATING COUNSELLING WHEN NECESSARY

In certain circumstances, pre-test counselling needs to be retained with the offer of a test: when the patient requests a screening test, for example; after the patient has taken a risk; in the presence of symptoms of an STI or within the structures geared towards screening such as the CDAGs or CIDDISTs.

Post-test counselling is also rarely offered. It must however help assess the patient's understanding of the results and evaluate the impact of these results on the patient's preventative behaviour⁴⁵. Nevertheless, in the vast majority of cases, the medical analysis laboratory hands over the results directly to the patient. A survey carried out in the Isère region (France), in partnership with the region's union of biologists, shows that 2% of the results are handed over to physicians only, while 84% are handed over directly to the patient and to the physician⁴⁶.

A study by Sida Info Service demonstrated widespread differences in counselling practices used among the CDAGs⁴⁷. In order to limit the differences between practices, there needs to be greater harmonisation in terms of objectives, organisation and resources between the state and the local authorities. Improved initial and ongoing education needs to be put in place in order to offer good quality counselling that is as uniform as possible across the entire country.

³⁷ The Council of Ministers, meeting on 12 July 2006, approved a legislative bill aimed at simplifying the law, notably allowing the abolition of pre-nuptial certificates for individuals. This law has not yet been debated before the Parliament.

³⁸ According to the *Centers for Disease Control (CDC)*, an HIV-positive individual who is unaware of his/her status is 3.5 times more likely to transmit the infection. Marks G, Crepaz N, Janssen R S, Estimating sexual transmission of HIV from persons aware and unaware that they are infected with the virus in the USA, *AIDS*, 2006, 20:1447-1450.

³⁹ ONUSIDA, *Conseil et test volontaire*, September 2000, Collection Meilleures pratiques.

⁴⁰ Decree n° 88-61 of 18 January 1988, article 3 taken for application of article L355-23 of the *Public Health Code* "concerning anonymous and free screening for the human immunodeficiency virus".

⁴¹ Decree n° 92-691 of 17 July 1992 amending the decree of 18 January 1988 which widens access to personalised medical information and counselling consultations prior to screening and delivery of the result.

⁴² Tourette-Turgis C, *Le counseling*, Paris, Editions PUF, Coll. Que Sais-je, 1996.

⁴³ CNS interview.

⁴⁴ Weinhardt LS, Carey MP, Johnson BT, Bickham NL. "Effects of HIV counseling and testing on sexual risk behavior: a meta-analytic review of published research, 1985-1997". *Am J Public Health*, 1999; vol 89, pp. 1397-1405.

⁴⁵ Tourette-Turgis C, *op. cit.*

⁴⁶ Brisson M and Fontaine D, *Journée de réflexion sur le dépistage en CDAG, 16 June 2003*, "Recommandation et pratique dépistage en médecine libérale, dispositif Isère". http://www.sida-info-service.org/telechargement/actes_depistage_2003_liberal_isere.pdf

⁴⁷ Lefranc M, Les consultations de dépistage anonyme et gratuit : un regard sur les pratiques d'entretiens, Sida info service, 24 February 2004.

To try and alleviate the shortage of time and training among physicians, other structures should be allowed to offer counselling. Associations set up to fight AIDS whose professional capabilities are still unrecognised, or family planning and education centres, should be able to offer counselling on a more systematic basis. As is already the case in other countries, counselling could be provided by trained personnel to whom the task would be outsourced, under the supervision of a physician, in accordance with established protocols. This would avoid counselling becoming the poor relation of testing⁴⁸. In fact, this practice already exists within Sida Info Service. A move towards this telephone-based structure should be offered more systematically by healthcare or social action professionals. The task therefore is to increase opportunities for advice and to move towards good quality counselling without limiting this counselling to medical settings.

1.3 RE-EVALUATING SCREENING TEST PRACTICES

In France, screening must be carried out using two different methods, at least one of which must be an ELISA test (*Enzyme-Linked ImmunoSorbent Assay*)⁴⁹. France is one of the very few countries to insist on this double test. The CNS recommends evaluating the relevance of using two screening tests, as previously recommended by an expert group from the ANAES in 2000⁵⁰. At the present time, rapid blood tests can be used to carry out one of these two tests. These typically permit testing for the presence of anti-HIV antibodies without sophisticated equipment, involve very little input and deliver a visual read-off of the result that can be obtained within between 20 and 40 minutes. Rapid tests and ELISA tests have shown comparable results in terms of predictive values, apart from testing for the early detection of primary infection⁵¹. If it turns out that a single screening test is sufficient, rapid tests must be evaluated along with their use as the only test in certain circumstances.

The suggestion of using rapid tests by no means confers approval of their use in the context of self-testing. At this point, the CNS reiterates its opposition to their use for self-testing, a practice which offers individuals no support in the reading and interpretation of the results⁵². In fact, this lack of explanation is a real problem and does not allow the patient to enter into a healthcare programme. This is in direct contrast to the situation in which the rapid test is carried out by a healthcare or qualified professional⁵³.

RAPID TESTING NEEDS TO BE SUPERVISED

Four rapid tests have been approved in the United States for market release by the *Food and Drug Administration* (FDA). Their specificity and sensitivity appear to be identical to those of classical tests, except at the moment of seroconversion⁵⁴. This reliability only applies to rapid tests involving blood samples. Rapid tests that use saliva are less sensitive⁵⁵. Several rapid tests other than those that have been approved for market release in the United States bear the CE mark in Europe. Their use as a sole test in France requires appraisal, then a change in the law which, at the present time, demands the use of at least one further ELISA test. In all cases, a positive test result needs to be confirmed by a Western blot test⁵⁶.

Given that the question of reliability has been resolved, the use of these tests offers undeniable advantages for global screening programmes, most notably as a consequence of their technical simplicity⁵⁷ and speed. In fact, they can be carried out with just a single drop of blood obtained from the fingertip or using blood taken in the form of a normal blood test. The read-off of the result when the blood is taken from the finger can be carried out in the presence of the person being tested, which allows the result to be given directly during the consultation. If the result is positive, the rapid test allows a formal blood test to be carried out immediately in order to confirm the result. The final result will therefore be obtained in a shorter period of time. This period will be

⁴⁸ Rapport sur les transferts de compétences, October 2003. Training that could be validated within the framework of validation of achievements (VAE).

⁴⁹ Decree of 4 February 1994, modifying the decree of 3 April 1985, standardising the nomenclature of bio-medical procedures.

⁵⁰ ANAES, Stratégies du diagnostic biologique de l'infection due au VIH chez les sujets âgés de plus de 18 mois (à l'exclusion du dépistage sur les dons de sang et chez les donneurs d'organes ou de tissus), www.anaes.fr/anaes/Publications.nsf/nPDFFile/RA_LILF-4JGK3F/SFile/VIH_rap.pdf?OpenElement.

⁵¹ Paltiel, *op. cit.*, p. 591.

⁵² Note pertaining to the commercialisation of HIV self-tests, adopted at the 9 December 2004 plenary session.

⁵³ It is conceivable that people carrying out self-testing will have taken risks a short time previously and wish to reassure themselves. The recent taking of risk may have led to infection, but if the test is carried out during the seroconversion window period (the mean window period being 22 days), the result will be negative. What's more, the use of self-testing also results in a loss of epidemiological data and raises the risk of this test being used incorrectly. The ease with which the test can be used reinforces the risk of it being used in coercive situations. One may also worry about the use of this test before a sexual relationship in order to justify the non-use of preventative means, a fact which would aggravate the current renewed upsurge in sexually transmitted infections.

⁵⁴ Greenwald JL, Burnstein GR, Pincus J, Branson B, "A rapid review of rapid HIV antibody tests", *Current infectious disease reports*, 2006, volume 8, pp.125-131. Seroconversion is the period during which specific antibodies to the virus appear in the blood. This period between infection and the appearance of antibodies in the blood can vary.

⁵⁵ Greenwald JL, Burnstein GR, Pincus J, Branson B, *op. cit.*

⁵⁶ DGS Circular n° 9 dated 29 January 1993, regarding anonymous and free screening programmes or free screening programmes for the human immunodeficiency virus.

⁵⁷ In the study carried out by the CDCs on the ability of people who have no experience of laboratory procedures to carry out self-testing, only 9% failed to carry out the test correctly.

all the shorter since a formal link is established between the structure carrying out the rapid test and the laboratory that confirms the result. In the case of a negative result, it will nevertheless be important to ensure the absence of any high-risk behaviour in the three months prior to the test. If risks have been taken, however, a second test will be necessary to take account of the seroconversion window period.

Rapid tests also mean that more patients get their results. An American study shows that, with a traditional test, 45% of patients who have tested HIV-positive come back to get their results, while 34% have to be recalled and 21% never return at all. On the other hand, when a positive result has been declared using a rapid test, 94% of people screened come back of their own accord and 3% return after having been recalled⁵⁸. Rapid tests therefore offer an undeniable advantage in this situation.

CARRYING OUT THE TEST

Treating physicians who wish to do so can carry out the tests in their surgeries. Rapid diagnostic tests are already used in this context to identify streptococcal throat infections. In other contexts, and bearing in mind the population that consults in such contexts, the physicians in the CDAGs would benefit greatly from using these rapid tests. It would seem reasonable to envisage the outsourcing of duties under medical supervision following validation of skills and expertise⁵⁹. Other structures could also benefit from the ability to use rapid tests, such as family planning and education centres, humanitarian medical associations and associations set up to fight AIDS, all subject to medical supervision.

The use of rapid blood tests facilitates access to screening, as it reduces material and psychological barriers and should therefore make it easier to offer screening. In certain regions, it would also allow confidentiality to be reinforced. In certain towns, in fact, stepping over the threshold of a screening centre, no matter how anonymous, is far less confidential than visiting a physician's surgery to see your regular GP.

II OPTIMISING SCREENING

In France, screening can be offered in different circumstances and in a variety of structures. Despite the extremely high number of procedures carried out, the delay remains significant for people who need screening most. The screening offer therefore needs to be optimised within the structures geared towards HIV, in regions where prevalence is high and within the structures set up to provide care services to groups who are at the highest risk of exposure to HIV.

2.1 MAKING BETTER USE OF SPECIFIC SCREENING SYSTEMS

In France, the epidemic of HIV infection has promoted the establishment of healthcare institutions whose mission is specifically orientated towards the fight against AIDS, whether they be cooperative institutions such as the COREVIHs (previously CISIHs) or institutions geared specifically towards screening, such as the CDAGs or CIDDISTS⁶⁰. Efforts to ensure optimum screening must therefore necessarily be channelled through these institutions.

DEFINING A REGIONAL POLICY BACKED BY THE COREVIHs

The public health legislation of 2004 establishes regional organisation and invites local communities to get involved in healthcare policies⁶¹. It promotes the principles of cost-effectiveness, such as the evaluation or precocity of treatment, and insists on the principle of coordination between the different agencies. In a position paper on *the evolution of the organisation and coordination of care in response to the epidemic of HIV infection*⁶², the CNS highlighted the key role of the COREVIHs at the heart of this new organisation of the healthcare system.

A COORDINATING STRUCTURE FOR SCREENING

The COREVIHs need to facilitate collaboration and coordination between the agencies involved in hospital-based and non-hospital-based screening systems at regional level⁶³. Their composition will allow the link between prevention, screening and treatment to be improved by developing interaction with Regional Hospitalisation Agencies (ARH) and Departmental and Regional Directorates on Health and Social Action (DDASS and DRASS)⁶⁴. By participating in the organisation of initial and ongoing education associated with screening, a COREVIH could be set the task of standardising best practices in various screening centres in the region. Within the

⁵⁸ Hutchinson AB, Branson BM, Kim A and Farnham PG, *op. cit.*

⁵⁹ Report on the transfer of expertise, October 2003, *op. cit.*

⁶⁰ These latter nevertheless existed before the emergence of HIV/AIDS.

⁶¹ Law n° 2004-806 dated 9 August 2004 regarding public health policy.

⁶² Position paper on the evolution of the organisation and coordination of care in response to the epidemic of HIV infection, adopted at the plenary session of 17 March 2005.

⁶³ The COREVIHs replace the CISIHs (Information and Healthcare Centres in Human Immune Deficiency). Decree n° 2005-1421 dated 15 November 2005 regarding the coordination of care in the fight against infection with the human immunodeficiency virus.

⁶⁴ They bring together representatives of the health and social or medico-social institutions, healthcare and social action professionals, patients, users of the healthcare system and qualified personnel. An overview of the missions, functions and funding of the COREVIHs can be found in section 17 entitled "l'organisation de soins et infection par le VIH" in Yeni P [Dir.], *Rapport 2006, op. cit.*, pp. 324-334.

same context, it could review the need to put in place structures dedicated specifically to screening within its geographical area, their number and their requirements, particularly the opening hours, in accordance, for example, with their location.

The COREVIH would also have a role to play in the considerations regarding the delegation of counselling to non-medical personnel. In places where screening is a priority for the COREVIH, it could get involved with regional public health groupings to ensure that the regional public healthcare programme (PRSP) offers financing for certified associations that provide counselling services.

THE COREVIHS' ROLE IN COORDINATING SURVEYS

Moving towards an analysis of the region's medico-epidemiological data and possessing an overview of the situation, the COREVIH would be able to request the refinement of certain data on screening from the *Institut de Veille Sanitaire*. While the information concerning screening in the CDAGs is extensive, it is more severely lacking for other screening centres. As a consequence, equipped with a deeper understanding of the local situation and its specificities, the COREVIHs would be able to offer advice on epidemiological and behaviour surveys.

In the same vein, the COREVIH could offer pilot studies on screening, submitted for evaluation⁶⁵, in partnership with institutions such as the National AIDS Research Agency (ANRS) or the National Institute for Healthcare Education and Prevention (INPES). These studies would be adapted to the specificities of the region and its population.

MAKING BETTER USE OF THE SYSTEM SPECIFIC TO THE CDAGS

When they were set up, the CDAGs were established in healthcare institutions and anti-venereal disease medical care centres across all of France's departments in order to receive, inform, test and advise patients⁶⁶. It was also important to meet the demand for free and anonymous screening, which people were obtaining through blood donation, thereby making inappropriate use of blood transfusion centres and markedly increasing the residual risk of HIV transmission by transfusion⁶⁷.

Today, France has 353 anonymous and free screening centres (CDAGs)⁶⁸ whose funding depends on the institution to which they are affiliated. The 180 hospital-based CDAGs are financed through national funding of general interest missions and contractual activities (MIGAC). These CDAGs do not have a dedicated budget for each of their missions of general interest. Their budget may therefore remain stable, even though their projects may increase, with the consequence that their funding will become disproportionate to their actual activities. The 133 non-hospital-based CDAGs, on the other hand, are the responsibility of the CPAM (Local Public Health Insurance Centre) following agreement with the CRAM (Regional Public Health Insurance Centre). Their funding is based on the town's ONDAM (national target ceiling for health insurance expenditure) and set at an annual rate. For these latter, it is pleasing to note that funding is changing with the projects outsourced to the CDAGs. However, although the law allows for their being financed according to their activity, it is regrettable that this funding is in fact a flat-rate sum in many cases.

THE CDAGS ARE NOT USED TO THEIR FULL EXTENT

In 2004, the CDAGs carried out 274,641 screening tests, out of 327,000 people attending for consultations. This represents around 7% of the total number of screening tests carried out in France⁶⁹. The proportion of positive serologic tests is stable and twice as high as tests carried out outside the CDAGs (2.4‰), with 4.8‰ tests turning out positive⁷⁰. The proportion of positive serologic tests within the CDAGs represents 12% of the total number of positive tests recorded in France⁷¹. The majority of attendees belong to the 20-29 age group (52%), but those who tested positive primarily belong to the 30-39 age group (40%), although the 20-29 year olds still account for a high proportion (35%). The majority of people attending the CDAGs are male (55%), but the proportion of men who test positive is falling (5.3‰ in 2004 compared to 6.1‰ in 2001), whereas the number of women testing positive remains stable but at a high level (4.2‰)⁷².

Given their performance⁷³ or the number of tests carried out, one may wonder about the appropriateness of having kept certain CDAGs in operation during the recentralisation process. Moreover, many CDAGs have restricted opening hours, during working hours and/or only on certain days of the week, which severely limits their access and the reach of their projects. The development and reinforcement of the CDAGs also appear to be more urgent in regions where prevalence is the highest. At the same time, the CDAGs must also focus their activities on groups among whom there is a high prevalence, including those in regions with a lower prevalence.

⁶⁵ Some of which may require regulatory dispensations.

⁶⁶ Decree n° 88-61, 18 January 1988, taken for application of article L. 355-23 of the Public Health Code concerning free and anonymous screening for the human immunodeficiency virus.

⁶⁷ DGS/PGE/1C circular n° 85 dated 20 January 1988 regarding the setting up of a system of free and anonymous screening for the human immunodeficiency virus.

⁶⁸ A list of these centres, classified by department, is available on the Sida Info Service website: www.sida-info-service.org/orienter/depistage.php4

⁶⁹ Institut de Veille Sanitaire, *op. cit.*, p.22.

⁷⁰ *Op. cit.*, p. 18.

⁷¹ *Ibid.*

⁷² *Op. cit.*, p. 19.

⁷³ Mignot S, "Dépistage, la tentation de la banalisation", *Transversal*, n° 32, September-October 2006, pp. 14-15.

It is also worth noting that the staff of the CDAGs experience tedium, given the repetitive nature of their duties. The impact on the service delivered may discourage people from attending a CDAG and be detrimental to its efficiency⁷⁴. Finally, in certain CDAGs, the training and scientific expertise of the staff do not always appear to be optimum⁷⁵.

THE REQUIRED REFORMS

It is therefore essential to reform and reinforce the CDAGs or indeed suggest innovative solutions if these systems turn out to be less efficient or insufficient in certain regions. In particular, the CDAGs need to be able to undertake outreach activities. However, in this context, their actions would be targeted at a public among whom the prevalence is higher than in other sectors of the population⁷⁶. Moreover, the integration of the CDAGs into larger structures, such as nursing homes, may provide an answer to some of the problems being encountered. Their integration in a location that offers other services would in fact reassure patients, particularly in terms of the assurance of anonymity⁷⁷. The risk of tedium among nursing staff could also be limited by offering the opportunity to carry out more diversified tasks as part of a varied portfolio of services⁷⁸.

The development of the CDAGs' role must also be considered in terms of the assurance of anonymity. This principle, although actively sought by certain individuals, does not always seem to be conducive to the continuity of care. The possibility of removing anonymity during medical consultation would help move towards a healthcare institution in the event of a positive infection. For example, an appointment would be organised with the care institution which would then confirm, where applicable, that the patient has turned up. The patient could also be accompanied to his or her first visit, if he or she wishes. The removal of anonymity would also enable the CDAGs to get involved in the care of accidental exposure cases, provide post-exposure treatment and initiate follow-up if the situation is amenable to this. However, this would entail regulatory changes.

CDAGs must respond to the specifications of the French decree issued in October 2000 pertaining to the rules of good practice, staff, linking with the local medico-social network, the practical details of operation and follow-up of activities⁷⁹. Their objectives have been reinforced by the Public Health Act⁸⁰, the 2005-2008 National Anti-HIV/AIDS and STI Programme and the campaigns organised by INPES. To achieve these new objectives, the CDAGs need the allocation of funds commensurate with their needs (for those that are to be maintained).

2.2 INCREASING THE SCREENING OFFER IN PRIORITY REGIONS

OFFERING SCREENING WHEN HEALTHCARE SERVICES ARE USED

The screening programme must take account of the prevalence in the various regions and the different groups exposed to the risk of HIV infection transmission. In regions with high prevalence rates (DOM, Île-de-France, PACA), when individuals use healthcare services, it is essential to extend the screening offer to the entire sexually active population who would not have been tested in the previous year. In particular, this offer could be made in the context of emergency services.

THE SINGULAR CASE OF THE DOM

Sexual transmission is responsible for 90% of cases in heterosexuals and affects all strata of the population⁸¹. The number of serologic tests carried out in the DFA is the highest in France, on average 127‰, with a mean of 9.2‰ of tests returning positive. This average is also the highest⁸². However, this large-scale use of screening is not the result of high-risk practices, but rather it is carried out at the time of a medical consultation⁸³.

The differences between this region and mainland France are not only epidemiological, but also cultural. As far as men are concerned, being pronounced HIV-positive is tantamount for them to a question mark over their virility and they fear being "accused" of homosexuality⁸⁴. This rejection of infection and the discrimination that surrounds it, notably for homosexuals, represents a major

⁷⁴ CNS interview.

⁷⁵ Ibid.

⁷⁶ This point will be elaborated upon in the section of the report discussing the screening system for groups among whom the prevalence rate is higher.

⁷⁷ This is of primary importance in areas such as the DFA where stigmatisation is very pronounced.

⁷⁸ Nursing staff can take care of other duties and medical staff will only have to look after a few patients each week.

⁷⁹ Order dated 3 October 2000 regarding free and anonymous screening consultations.

⁸⁰ Law n° 2004-806 dated 9 August 2004 regarding public health policy.

⁸¹ Cabié A, Georger-Sow M-T, Nacher M, "Particularité de l'infection à VIH aux Antilles et en Guyane française en 2004", *Infection VIH-sida en France : vision d'ensemble et spécificités des départements français d'Amérique*, BEH, n° 46-47, 29 November 2005, p. 238.

⁸² Institut de Veille Sanitaire, *op. cit.*, p.16. 4.1‰ in Martinique, 8.6‰ in Guadeloupe, 17.2‰ in French Guiana

⁸³ ORS île de France, *Les connaissances, attitudes, croyances et comportements face au VIH/sida aux Antilles et en Guyane en 2004*, April 2006, p. 181.

⁸⁴ Report followed by recommendations by the CNS, *Repenser la politique de lutte contre le VIH/sida dans les départements d'outre-mer*, adopted at the 11 March 2003 plenary session.

barrier to early screening and treatment⁸⁵. Women's economic dependence on men is also a barrier to screening.

Utilisation of the CDAGs is important for facilitating anonymity, particularly in French Guiana and Guadeloupe⁸⁶, even though the use of private practice services remains the most popular solution⁸⁷. Moreover, isolated populations in the forests of French Guiana or on the islands of Guadeloupe also find access difficult.

Since discrimination is particularly severe in these regions, any contact must be on the basis of strict preservation of confidentiality, or anonymity. The question of distance from any screening centre and the preservation of anonymity was the object of an innovative experiment in New Caledonia which could be reproduced or adapted to the context of the DFA⁸⁸. This is an experiment involving the extension of screening, with the aim of facilitating access to anonymous and free screening from volunteer private practice or hospital-based physicians. At the same time, the use of mobile outreach structures must be based on general health services in order to preserve confidentiality or anonymity which, if breached, is liable to bring with it severe social consequences.

In this case, it is not about offering exhaustive solutions but rather lines of thought, since the most relevant ideas will most likely emanate from the COREVIHs.

2.3 DEVELOPING SCREENING SERVICES FOR THE MOST AT-RISK GROUPS

The 2005-2008 National Anti-HIV/AIDS and STI programme has set itself the goal of encouraging people who belong to "priority groups" to undergo early screening for HIV⁸⁹. Certain groups have a higher prevalence of infection: the homosexual community, people from regions with high prevalence rates (sub-Saharan Africa, Eastern Europe, South-East Asia), people in precarious living conditions⁹⁰, intravenous drug users, and prisoners. These groups share different day-to-day situations. It is therefore important to reinforce screening activities among these groups by offering responses that accommodate factors specific to the group and centres that have been adapted as much as possible to their needs⁹¹. The specific issue of sex workers⁹² may be integrated in the statements made for other groups in precarious living conditions, for example by community associations escorting these individuals to screening.

THE SPECIFIC PROBLEMS OF THE HOMOSEXUAL COMMUNITY

The "declared"⁹³ rate of infection with HIV among the homosexual community is particularly high, estimated at between 12% and 14%⁹⁴. The homosexual community occupies an unusual position with regard to screening. The proportion of homosexual men among new cases of HIV-positive individuals diagnosed in 2004 is on the increase⁹⁵. Of these, 43% were infected less than six months before their diagnosis, which may indicate both a relaxation in preventative behaviour and greater use of screening⁹⁶. The proportion of homosexuals among those who discover their infection at the diagnosis stage remains high at 11%⁹⁷ and this figure reaches 31% for the over-50s⁹⁸. Particular efforts therefore need to be made among the older members of this community.

Bearing in mind the high prevalence rates among the homosexual community, all men who have had sexual intercourse with other men must be offered screening as a matter of course.

However, the serial screening that is widespread among this population is worth examining, since it indicates a degree of failure on the part of prevention and counselling. Thus, it is not simply a matter of screening, but rather the entire system of primary prevention

⁸⁵ Cabié A, Georger-Sow M-T, Nacher M, *op. cit.*, p. 239.

⁸⁶ Institut de Veille Sanitaire, *op. cit.*, p.20. The recent changes in the law have not settled this problem. On the contrary. The law of 13 August 2004 relating to freedom and local responsibilities leading to centralisation has led to the closure of CDAGs in Guadeloupe without these closures being compensated for by another programme.

⁸⁷ DFA-Caribbean Seminar, 15-19 October 2006, Saint-Martin, *Restitution des ateliers, synthèse et recommandations*, "atelier 7 : améliorer le recours et l'accès au dépistage".

⁸⁸ Anti-AIDS Committee of New Caledonia: Extension of anonymous and free HIV screening to volunteer private practice physicians.

⁸⁹ 2005-2008 National Anti-HIV/AIDS and STI programme, p. 41.

⁹⁰ Population facing social exclusion, housing, income, health and social isolation.

⁹¹ The DRASS Île-de-France plans to issue a brochure on screening for HIV/AIDS resulting primarily from ideas developed within the working group devoted to HIV/AIDS screening in Île-de-France and offering strategies for screening that are derived from field experiences.

⁹² A long discussion is devoted to these individuals in the CNS's report on the *politique de prévention de l'infection à VIH en France métropolitaine*, chiefly in the section entitled "les succès fragiles de la prévention auprès des personnes prostituées".

⁹³ There is currently no data in France on the HIV prevalence rate among homosexuals based on biological examinations (in other words from a blood sample taken to carry out screening for HIV).

⁹⁴ Institut de Veille Sanitaire, *Infection par le VIH chez les homosexuels en France, Synthèse des données disponibles*, June 2005.

⁹⁵ Institut de Veille Sanitaire, "Surveillance du VIH/sida en France", report n° 3, data to 30 June 2005, p. 4.

⁹⁶ *Op. cit.* p. 9.

⁹⁷ *Op. cit.* p. 6.

⁹⁸ Yeni P, *op. cit.*, p. 321.

that needs to be reviewed.

ADDRESSING PEOPLE WHO COME FROM AREAS WITH HIGH PREVALENCE RATES OF HIV

Among the 55% to 67% of heterosexual people who discovered they were HIV-positive in 2004, half came from a country in sub-Saharan Africa⁹⁹. HIV screening among migrants living in France needs to be the focus of particular efforts: 55% of them have never been tested, with this figure reaching 67% among the under 30s¹⁰⁰. These problems are compounded by migrants' ignorance of their rights, added to which is often a lack of fluency in French which, as already noted by a group of experts in 2002, represents an obstacle to access to healthcare institutions¹⁰¹. This has a significant impact since, among the heterosexual migrants who developed AIDS between 2003 and 2005, 60% were unaware of their serological status¹⁰² and 16% of those who tested positive had AIDS when tested. It is therefore absolutely essential to improve screening in situations specific to migrants.

In centres for asylum seekers (CADA), associations could offer, under medical supervision, a test which forms part of a wider health check offer. Screening offers could be made within medical facilities that these groups attend: municipal healthcare centres and all-day healthcare centres (PASS)¹⁰³.

Although the majority of the sub-Saharan African population does not attend these centres, the offers of screening tests within the context of a health check offer should be reinforced¹⁰⁴. The use of health mediators is also necessary, through the formation of peer counsellors, for example, who would pass on prevention messages and establish the link between local residents and the screening structures. The point of these outreach activities is also to form structures that will reach out to the target public but which do not actually get involved with healthcare issues¹⁰⁵. It is a matter of carrying out the tests directly within the agencies involved and of capitalising on healthcare services received by particular individuals in order to reach their family members and their wider community. All lines of thought on this matter must be aimed at approaching a certain group in order to bring that group towards a healthcare system from which it is largely excluded.

DEVELOPING THE TESTING OFFER IN CENTRES FOR PEOPLE IN PRECARIOUS LIVING CONDITIONS

The living conditions of people in precarious situations, the level of their resources and their level of education have serious consequences on the state of their health in general and impact on their decisions to seek medical assistance¹⁰⁶. Precariousness and poverty therefore require that the screening offer be adapted. As the *Retard*¹⁰⁷ survey highlighted, people whose living conditions are characterised by precariousness find themselves in situations of social and relational isolation.

Numerous experiments underline the importance of a voluntary HIV screening policy. At the Healthcare and Assistance Centre (CASO) operated by Médecins du Monde in Paris, out of 4,500 patients who were admitted, and although only 20% had a screening test, 3.2% were positive, which represents an extremely high rate of infection¹⁰⁸.

In the healthcare and screening centres that welcome people in precarious living conditions, encouragement to be tested and the diffusion of information are required. Generalised HIV screening offers within the wider health check offer are crucial within several structures: municipal healthcare centres; all-day healthcare centres (PASS)¹⁰⁹; "low threshold" facilities; centres run by humanitarian organisations; regular health check centres set up by local public health insurance centres.

Regional healthcare and prevention access programmes for people in precarious living conditions (PRAPS)¹¹⁰ are one of the ways of consolidating and coordinating activities in order to put in place quality healthcare services aimed at these groups.

⁹⁹ Institut de Veille Sanitaire, *op. cit.*, p. 23.

¹⁰⁰ Sida info service, assessment of the campaign entitled "promouvoir le dépistage volontaire du VIH auprès des personnes primo-migrantes", 2002.

¹⁰¹ Delfraissy J-F, Rapport 2002 : Prise en charge médicale des personnes infectées par le VIH, recommandation du groupe d'expert, Paris, Flammarion, 2006, p. 312.

¹⁰² Lot F, "Point épidémiologique du VIH/sida chez les personnes étrangères, évolution depuis 2003", *Journée du 25 septembre 2006 autour du programme national VIH/Migrants*.

¹⁰³ PASS services were put in place in application of article L 6112-6 of the Public Health Code, within public and private healthcare facilities that are part of the public hospital service. They are estimated to number 400.

¹⁰⁴ MED'AF magazine, Quarterly edition, n° 1, July 2006.

¹⁰⁵ CNS interview.

¹⁰⁶ Auvray L, Dumesnil S and 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.

¹⁰⁷ Calvez M [Dir.], *op. cit.*

¹⁰⁸ CNS interview.

¹⁰⁹ PASS services were put in place in application of article L 6112-6 of the Public Health Code, within public healthcare and private healthcare facilities that are part of the public hospital service. They are estimated to number 400.

¹¹⁰ Circular n° DGS/SP2/2000/324 dated 13 June 2000 regarding the follow-up of health campaigns aimed at people in precarious situations.

USING STRUCTURES GEARED TOWARDS DRUG USERS

Among the people who discovered they were HIV-positive in 2004, it is estimated that only 2% of these were infected through the use of injectable drugs¹¹¹. This figure confirms a decline in HIV transmission among this group, thanks to a policy of risk reduction. However, among those who discovered they were HIV-positive at the AIDS stage, 27% used injectable drugs¹¹². We are therefore facing the problem of delayed screening among this community too. The routine offer of screening for HIV/AIDS and hepatitis C virus in assistance and risk reduction support centres for drug users (CAARUD) and specialised care centres for drug users (CSST) could allow intravenous drug users to become aware of their serological status and thereby be able to benefit from earlier treatment. In the same way, when organisations aiming to prevent HIV visit drug users in squats, test offers could be added to the risk reduction policy. By virtue of their immediate and minimally invasive nature, rapid tests would be fully appropriate in this situation.

TOWARDS AN ADEQUATE SCREENING OFFER IN THE PENITENTIARY ENVIRONMENT

The penitentiary environment still occupies a unique position, with a prevalence rate estimated at around 1% in 2003¹¹³. A survey in 2003 by the Ministry of Health estimates that inmates who are known to have been infected with hepatitis C represent 4.2% of the total prison population¹¹⁴. When admitted to prison or in the days that follow, each inmate is in theory offered screening for HIV, hepatitis B and hepatitis C¹¹⁵. In 2004, 8,500 tests were performed, with positive results returning in 3‰ of cases¹¹⁶, while on 1st January 2005, the prison population stood at 59,197 men and women, with an annual influx of 84,710 individuals¹¹⁷. Despite the high prevalence rate, it is therefore evident that the number of tests carried out is low. The creation of UCSAs (medical visit and roving care units), which are intended to facilitate early diagnosis¹¹⁸, and campaigns carried out by the CDAGs¹¹⁹ in penitentiary environments, have achieved an improvement in the healthcare and screening offer. This offer, however, still remains inadequate.

The continuity of care between the open world and prison is not always assured. The organisation and accessibility of screening programmes vary from one penitentiary institution to another. Moreover, confidentiality is not always guaranteed, especially in the CDAGs¹²⁰. The screening offer on admission to prison cannot be sufficient, bearing in mind the high-risk practices that go on even though sexual relationships, in visiting rooms or in cells, and the exchange of needles are forbidden. The stigmatisation and discrimination that HIV-positive inmates suffer remain an obstacle to the use of screening¹²¹. It is hoped that the organisation of screening services in penitentiary institutions will be improved and revitalised.

¹¹¹ Institut de Veille Sanitaire, *op. cit.*, p. 4.

¹¹² *Op. cit.* p. 6.

¹¹³ Dab W, "une loi qui a introduit une éthique de soin en prison", Colloquium "Health in prison", Ten years after the law: what changes have there been in the treatment of prisoners? 7 December 2004, p. 5.

¹¹⁴ International Observatory of Prisons, *Les conditions de détention en France*, Paris, la Découverte, 2005, p. 134.

¹¹⁵ Decree n° 98-1099 dated 8 December 1998 amending the code of criminal procedure (third part: Decrees) and regarding the organisation and functioning of penitentiary institutions.

¹¹⁶ Institut de Veille Sanitaire, *op. cit.*, p. 19.

¹¹⁷ http://www.justice.gouv.fr/minister/DAP/chiffresclesAPdec05_2.pdf

¹¹⁸ Law n° 94-43 dated 18 January 1994 regarding public health and social protection. Circular n° 739 dated 5 December 1996 regarding the fight against infection with HIV in penitentiary institutions.

¹¹⁹ 80 prison-based units are listed.

¹²⁰ Brochure on HIV/AIDS screening issued by the DRASS Île-de-France.

¹²¹ Report by the CNS on the policy of HIV prevention in mainland France.

RECOMMENDATIONS

- Improving the understanding of screening practices outside the CDAGs.

EXTENDING THE AVAILABILITY OF SCREENING TESTS

- During consultation, broadening the availability of screening tests for the sexually active population in regions with high prevalence rates, subject to the patient's consent, as screening without the patient's knowledge is strictly prohibited.
- Strongly encouraging screening among men who have had sex with men.
- Broadening the availability of screening tests as part of a wider health check offer within PASS centres, healthcare centres, family planning and education centres, "low threshold" facilities, regular health check centres set up by local public health insurance centres and centres run by humanitarian healthcare organisations.
- Extending HIV/AIDS screening tests, linked to screening for hepatitis, in centres for drug users and by associations responsible for reducing risks.
- Ensuring associations better promote screening offer within contexts specific to the welcoming of migrants as part of a wider health check offer.
- Supporting associative action to help people at high-risk of exposure to consult screening and healthcare institutions.
- Ensuring more widespread use of screening test offer when people are incarcerated and during the course of their sentence.
- Educating general practitioners on the offering of screening, on how to carry out rapid testing and how to deliver the result.

THE ROLE OF THE CDAGS

- Reinforcing the CDAGs' ability to welcome groups who are at high-risk of exposure.
- Gearing the activities of the CDAGs towards the groups who find it difficult to access healthcare services.
- Allowing CDAGs to offer access to post-exposure treatment.
- Financing hospital-based and non-hospital-based CDAGs in line with their needs and according to agreed local objectives.
- Extending the opening hours of CDAGs in areas with high prevalence rates.
- Making it possible for anonymity to be lifted in CDAGs during medical consultation, in order to facilitate support during the healthcare process.

ANONYMITY ISSUES

- Allowing private practice or hospital-based physicians in the DOM to prescribe HIV screening where the tests will be carried out with guaranteed confidentiality or anonymity.
- Integrating the CDAGs in the DOM into more general healthcare institutions in order to provide a better guarantee of anonymity.

DEVELOPMENT OF COUNSELLING

- Offering tests with or without counselling, depending on the situation.
- Reinforcing counselling during consultations linked to requests for screening tests following risk-taking or changes in sexual habits.
- Improving counselling in structures specialising in screening for HIV and STIs.
- Facilitating the offer of counselling by trained personnel without limiting this to medical settings.
- Reminding biological analytical laboratories of good practices when giving results.

USE OF RAPID BLOOD SCREENING TESTS

- Evaluating the relevance of using a single test in the screening strategy for anti-HIV antibodies.
- Following evaluation of their performance and validation by the relevant authorities, broadening the use of rapid blood tests which could then be the only tests used.

- Making it possible for rapid blood tests to be carried out by medical personnel or by outsourcing following validation of expertise.

LIST OF PERSONS HEARD

The Conseil national du SIDA expresses its sincere thanks to the people below who kindly agreed to be heard by the Screening Committee:

- Mr. Stéphane Le Vu, Pharmacist and epidemiologist, *Institut de Veille Sanitaire*;
- Dr. Gérard Muller, Chief Physician, CDAG of the Centre médico-social de Belleville (75);
- Dr. Christine Barbier, Physician-public health inspector, DRASS Île-de-France;
- Dr. Pascal Chevit, National Health Directorate, Health and Society under-directorate, SD6 Head, Bureau 6A "Anti-HIV";
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- Dr. Françoise Normandin, Department Head, Maison départementale de la Santé de Gironde;
- Mr. Vincent Jobin, Dialogai Representative, Federal Office of Public Health (OFSP), HIV Prevention, Geneva;
- Mrs. Dominique Vamur, Coordinator of Aremedia Association;
- Dr. Marc Shelly, Aremedia Director, Head of CDAG Fernand Widal;
- Mr. Emmanuel Château, Co-President, Act Up-Paris;
- Dr. Pierrick Cressard, President of the Ethics and Deontology Section, Conseil National de l'Ordre des Médecins;
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