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THE EPIDEMIC OF HIV INFECTION IN FRENCH GUYANA: A POLITICAL PROBLEM; REPORT BY THE FRENCH DEPARTMENTS OF AMERICA COMMISSION

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THE EPIDEMIC OF HIV INFECTION IN FRENCH GUYANA: A POLITICAL PROBLEM

For several years, the epidemic of HIV infection in French Guyana has been a significant concern and has attracted the attention of the Conseil national du sida (CNS). The first report on the subject was published in 1996 and focused on all the French overseas departments (DOM). It particularly highlighted the serious shortcomings in terms of resources and insisted on the essential equality of rights between people living in the overseas departments and those living in mainland France. The second report, published in March 2003, was written in the context of a completely different environment following the implementation of effective treatments. Without underestimating the numerous problems that professionals face in the fight against AIDS, the report from 2003 noted that the epidemic was still not under control, especially in the French Departments of America (FDA). As in 1996, the deficiencies in terms of access to rights, the shortfalls in healthcare, the inadequacy of prevention policies and the potentially positive effects of regional cooperation were again highlighted. Following on from this publication, ten recommendations were submitted to the government. The latter of these specifically related to French Guyana and urged the implementation of a general public health and social care plan[1].

Given the persistence of certain problems originally set forth in 1996 and 2003, the Conseil felt it necessary to re-examine these departments. The context has evolved. For instance, the framework of healthcare policies has been changed by the public health legislation and the organisation of HIV treatment and care is undergoing a transformation with the establishment of regional steering committee to fight HIV infection (Corevih). French Guyana has also witnessed changes in terms of action against the epidemic of HIV infection with the reinforcement of the network of associations and the publication of various public action programmes in the healthcare sector. It is also benefiting from the completion of the first action plan against HIV which ran from 2003 to 2006. 2007 therefore seemed an auspicious year for the CNS to cast a retrospective glance over the actions carried out since 2003 in order to review how things have changed in recent years and to see how things stand now. The objective of this exercise is to make plans for the future.

Unlike the two previous reports, the CNS has this time felt it more appropriate to produce separate documents for French Guyana and the West Indies. In fact, despite characteristics that the departments appear to have in common, specific reports would seem to allow a closer examination of the problems currently being faced and the progress made. They would also allow recommendations to be made that are particular to each of the departments. The need for this has become more acute following the mission carried out by a delegation of the CNS in French Guyana and Guadeloupe at the end of October 2007 [2].

For reasons relating to the level of prevalence in the department and the significant problems that have to be overcome by local professionals (elected representatives, institutions, associations), the CNS's first target is thus French Guyana, a department that is unique by virtue of its vastness and its sparse population: Officially, some 200,000 people live on an area of 91,000 square kilometres, around 16% of the country's total land mass.

French Guyana has the highest rates of prevalence in France. In 2006, the number of diagnoses of HIV infection per million inhabitants was 308, compared to 150 in the Ile de France region[3]. The prevalence rate among women who have just given birth in

[1] See the list of recommendations from 2003 attached.

[2] The members of the delegation included: Willy Rozenbaum, President of the CNS, François Bourdillon, Vice President, Chantal Lebatard, Pierre Mathiot, Jean-Luc Romero.

[3] In 2005, this rate was 891 in French Guyana compared to 170 in the Ile de France region. The difficulties in obtaining information in 2006 is the reason for the significant difference between 2005 and 2006. Invs, data from 31/12/2006.

Saint-Laurent-du-Maroni is 1.3 %, which constitutes a widespread epidemic[4]. The infection is primarily transmitted through heterosexual sex, and women represent the majority of people receiving treatment and care. The reported number of cases of AIDS has fallen, however it is still higher than in mainland France, with a figure of 141 per million compared to 43 in the Ile de France region, the area of mainland France with the highest rates of infection. The delay in screening is significant, at 42.9% for the first semester of 2006 compared to 33% in mainland France[5]. Nevertheless, the number of people receiving treatment and care is low, that is fewer than 2,000 (i.e. 1 - 2% of the total of people receiving treatment and follow-up in France).

Moreover, French Guyana is facing problems of many kinds, from the significant epidemics of dengue fever to more specific issues such as sickle-cell anaemia or diabetes. The more general issues of environmental health also require sustained attention. The population's economic and social situation in French Guyana is more unfavourable than in other overseas departments and more unfavourable still than in mainland France. More than 30% of the population receives income support (RMI)[6], unemployment rates are higher and the number of single-parent families, who are in the most serious economic situation, is greater[7]. That said, French Guyana represents a haven of wealth compared to other islands or states in the region. Its appeal causes significant immigration, which brings with it recurrent problems to Guyanese society. The problem of immigration, coupled with economic and social issues in a context of high prevalence rates of infection, creates links in people's minds as regards the cause of the department's epidemic.

The epidemic of HIV infection in French Guyana therefore represents a public health problem as much from an epidemiological point of view as from a social point of view. An understanding of how this works requires approaches based on ethnography and sociology research. However, the fight against this epidemic first poses a political problem. What is at stake here remains the paradigm that shapes the main conceptions and which defines the definition of choice, the governance of the response to the epidemic by professionals and its control, as well as the allocation of financial and human resources. In this sense, the problem is a wholesale one that cannot be resolved by singular public health and medical approaches.

Given the local and regional context, the epidemic of HIV infection remains a preoccupying issue as much by virtue of its dynamic nature as by the persistent problems associated with producing responses through healthcare policies. This report will not revisit the ethnographic issues of the epidemic, since these considerations are largely well-known[8]. Sometimes, these considerations even attempt to analyse the political processes that also explain the inadequacies of the results[9]. Similarly, the epidemiological parameters and the economic and social problems are sufficiently documented for there to be no need to revisit these issues in depth here.

The report is the result of the work by the French Departments of America Commission of the Conseil national du sida. Several series of interviews were carried out in Paris and French Guyana in order to gather an analysis of the situation using the largest number of people involved in the response to the epidemic. The data available on the active file populations and epidemiology was gathered from the Inserm, the Invs and Guyana's hospital services. The literature used cites official reports by various state bodies and services as well as social science texts. In order to document the issues surrounding the epidemic more coherently, the commission has endeavoured to understand the nature of the relationships between the various players involved, the relevance of the tools they have available and the networking of the various levels of the public decision-making process and its implementation.

One approach, where the epidemic of HIV infection is restricted to the public health and social sector, is possible in a mainland France environment, but French Guyana must be considered with the analytical frameworks and responses adopted for countries with widespread epidemics: The involvement of the entire social and political body and the adoption of public policy frameworks designed to respond to the epidemic - not just their adaptation to a challenge that would be considered as temporary. Care providers, public health and social services professionals, members of associations and state services have largely contributed towards changing the environment of the fight against HIV over the course of the past five years. Today, these actions must be built upon with the clear involvement of local political leaders.

The report will therefore first of all outline the obstacles that healthcare professionals are facing and also highlight their successes. These obstacles relate as much to public policy frameworks in general as they do to more specific healthcare policies. Secondly, the report will focus on the shortcomings of the political management of the epidemic, both from the steering point of view within the department and from the perspective of relationships with neighbouring countries.

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[4] The WHO states that, if the quota of pregnant women infected with HIV is above 1%, the epidemic is considered as widespread. Prevalence rates by nationality and by hospitals, CISIH report 2006, p. 20. PRSP review, p. 8.

[5] RICE France and French Guyana, September and October 2007.

[6] Source: Cnaf, Fileas file, data as of 31 December 2006.

[7] *L'e-ssentiel*, L'impact sur les minima sociaux de la loi d'orientation pour l'Outre-mer de décembre 2000: état des lieux à la fin 2004, No. 48, April 2006 (Cnaf, Dser).

[8] Among the plentiful literature available, the following can be cited: Bourdier F, Malades et maladies en exil : les migrations brésiliennes vers la Guyane à l'épreuve du sida, Sciences sociales et santé, 20 (3), 2002. Gallibour E, Itinéraires épistémologiques et thérapeutiques : autour d'une recherche sur les haïtiens infectés par le VIH en Guyane, 2002.

[9] Buton, La lutte contre le VIH/sida en Guyane française. Dispositifs et représentations, December 2002, CURAPP, p. 45.

PART I THE LIMITS OF THE CONSTANT BATTLE BY HEALTHCARE PROFESSIONALS

The work carried out since 2002 by organisations within the public health and social welfare sector has improved the general response to the epidemic. All of the players involved, however, remain faced with persistent obstacles which limit the impact of their efforts, which are nonetheless significant. The response in recent years to the epidemic of HIV infection has now reached the point at which no further progress can be made by healthcare professionals alone. No more progress will be possible unless the public political frameworks are adapted to reflect the situation in French Guyana more accurately. Similarly, medical treatment and care also has to face up to the social problems of people living with HIV and must wrestle with a political context that stifles the practice of medicine, both from the point of view of the stigmatisation associated with the condition and from the perspective of the problems linked to a worrying ageing medical population.

1.1 THE EFFORTS OF THE MEDICAL WORLD VERSUS POLITICAL AND SOCIAL BURDENS

The treatment and care of people infected with HIV requires the nursing staff to adjust to a very specific context. The successes achieved in terms of treatment must be congratulated. However, the fact remains that these successes are always mitigated by the problems of general treatment and care, which needs to integrate the great vulnerable situation of the people being treated. On a wider scale, medical actions are carried out in a more general context that limits any efforts that are made. This context is characterised by a local political environment that somewhat hinders the fight against the epidemic, and a medical background that appears to be severely restricted by the desperate inadequacy of resources compared to the healthcare issues.

1.1.1 THE CHALLENGES OF GLOBAL TREATMENT AND CARE

Healthcare professionals are facing a constant rise in the active file. It seems that the results of treatment and care are good when people can be followed up in the long-term. The main concern of health care providers relates first of all to the difficulties of an early identification of people infected with HIV, then to the long-term maintenance of links with them.

THE PECULIARITIES OF THE ACTIVE FILE IN FRENCH GUYANA

In French Guyana, the active file is around 1,100 people, increasing by 10% per annum. Just as in mainland France, this rise is due to new diagnoses and a reduction in the number of deaths. The main route of infection reported is heterosexual transmission, accounting for more than 70% of cases, however almost 20% do not know how they were infected[10]. The doubling of the active file in ten years' time is a strong likelihood that must be borne in mind. Two-thirds of the active files are in Cayenne, while the rest is based between Saint-Laurent-du-Maroni and Kourou. Women account for 53% of the people followed up in hospital in French Guyana, and 59% of new patients in 2006[11]. In 2006, the over-50s account for 28% of new diagnoses. Women are mostly diagnosed between the ages of 20 and 30, while men are generally diagnosed after 40.

The nationalities of the people being followed up are a significant element, both in terms of methods of prevention and lessening of the sex ratio. In France, two-thirds of people with HIV are men. 80% of the active file population is of foreign nationality, with varying distributions depending on which hospital they attend and their locality. Haitians represent the majority of the active file population in Cayenne, while Surinamers make up the majority of the population in Saint-Laurent-du-Maroni[12]. Nevertheless, Haitians account for 50% of the foreigners in the total active file population.

Prevalences by group at risk of exposure are not well-known and are based on data collected outside a research framework. It would appear that 6% of the prostitutes in Cayenne are infected with HIV, and the prevalence of infection is 50% among the homosexual men tested.

The active file population in French Guyana also suffers from a number of other conditions. Histoplasmosis is one significant and growing part of the AIDS pattern, and 30% of deaths within six months of treatment and care being commenced are attributable to this infection. Effective treatment is available, but although the indication for treatment can sometimes be limited to a few days, this very expensive treatment occasionally has to be administered over a period of two weeks. It may therefore be necessary to initiate presumptive treatment, before laboratory results are obtained.

[10] Source: InVS – Surveillance du VIH, données cumulées 2003- 31/12/2006 uncorrected.

[11] Rice Guyane, p. 22 and p. 42.

[12] CISIH activity report, 2006, p. 6 and p. 17.

DRUG SUCCESSES IN TREATMENT AND CARE

Since 2002, the results of drug treatment have improved as the data relating to viral load and CD4 count demonstrate[13]. These results are also expressed by a reduction in the number of cases of AIDS and deaths since 2005. The data on treatments prescribed show the frequent use of drugs that require only one dose of more powerful agents per day. At the same time, virological failures are in decline.

The general improvement in the commencement of treatment has also benefited the care of pregnant women who are infected with HIV. Following a consensus meeting between physicians organised in 2004, treatment strategies were modified, a fact which has facilitated the good results being achieved today.

The improvement in these results can also be put down to widespread organisational effort. Treatment and care in Cayenne Hospital thus appears to be benefiting from the structured programme for treatment and care dedicated specifically to infectious diseases, and which is linked to the dermatology service that has historically been in charge of HIV. The improvement of the day hospital also means that the follow-up of patients can be enhanced. Outside the hospital, efforts to improve monitoring in coordination with private nurses during home visits deserve to be highlighted. These visits are supported by the Department of Social Security, which has adapted its rates to the need for follow-up.

THE PROBLEMS ASSOCIATED WITH ENTERING AND STAYING IN THE HEALTH CARE SYSTEM

There are difficulties with entry into the health care system, then with the follow-up of treatment and care. Screening is done very late in French Guyana, and the proportion of people lost to follow-up is substantial. In French Guyana, screening is carried out frequently, with the level of positive results being almost five times that of the Ile de France region. However, the percentage of people receiving late treatment and care is in excess of 40%[14]. From an individual point of view, this delay to screening raises the issue of increased risk of morbidity / death when patients come late to treatment. From a collective point of view, the objective of preventing transmission is clear. The emergency department in Saint-Laurent-du-Maroni has launched a more systematic approach to offering screening, which has allowed the number of people screened and diagnosed as HIV positive to be increased[15]. According to the hospital staff and other healthcare professionals, rapid tests are a necessary solution if the results of screening are to be improved, especially in terms of ensuring effectiveness in health centres. As in mainland France, but with specific limitations, there are questions regarding the improvement in the provision of screening, in particular the adequacy of anonymous and free screening consultations (Cdag) *vis-à-vis* the level of demand. The screening services can be improved, for example, by clarifying and coordinating screening services between the hospital and the Red Cross, which is in charge of the Cdag centre in Saint-Laurent-du-Maroni, in order to ensure a continuous link between screening and treatment and care. The Cdag centres in French Guyana, in their current form, appear to be poorly-equipped to cope with the demands placed upon them, with access being difficult either because the opening hours are too limited or because the entrance to the consulting area is situated in an extension to the Cayenne hospital's reception – a fact that discourages people from going along. On a more general note, as was highlighted in the KABP inquiry on the FDAs[16], the heavy use of screening is not correlated to risky practices. The provision of services must therefore be targeted more effectively at people who are most at risk of exposure to transmission[17]. Nevertheless, given the significant number of people aged 50 and over who become new additions to the active file population, it would seem essential to consider offering tests in a way that is more age-appropriate. The offer of testing in the emergency department in Saint-Laurent-du-Maroni has yielded encouraging results. The offer of testing in the context of any contact with the healthcare system would, by making the test commonplace, also help reduce the negative image of the infection.

Those lost to follow-up represent a significant concern for hospital staff: In five years, 50% of the people who have been screened as HIV positive have disappeared. The loss of contact with the patient is to a greater or lesser extent temporary and varies with age (with younger people being more easily lost to follow-up) and sex (with men being more likely to lose touch with the hospital than women). However, there does not appear to be any clear strategy adopted by the authorities and professionals due to a lack of consensus among care providers on the solutions that need to be considered. The option of recontacting patients by telephone appears to be a solution that would have varying degrees of success, depending on the person being called. Contact via mediators is also cited as one possible approach. It even seems that certain professionals experience difficulty in accepting any need for any action at all as regards those lost to follow-up. Despite the difficulties experienced by care providers in agreeing on the methods to be used, it is essential to define an offensive strategy to get back in touch with those lost to follow-up. The issue at stake here is as much an issue of the prevention policy as it is a matter of quality of life and life expectancy for the patients affected. These strategies, adjusted according to the sex and age of the individuals involved, need to be discussed and drawn up in concert with the various associations who must not only be the mediators of these strategies, but also the bodies in charge of ensuring general treatment and care.

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[13] CISIH activity report French Guyana 2006, October 2007.

[14] Rice Guyane, p. 17.

[15] Interview.

[16] Halfen S, Fenies K, Ung B, Gremy I, Les connaissances, attitudes, croyances et comportements face au VIH/sida aux Antilles et en Guyane en 2004, Ile de France Regional Health Observatory, ANRS, 2006/04.

[17] BEH, Dépistage du VIH dans les populations et territoires prioritaires, no. 7-8, 2008.

1.1.2 THE POLITICAL ENVIRONMENT OF HEALTHCARE IN FRENCH GUYANA

Added to the public health issues are the social and political objectives that need to be integrated into an analysis of the problems that healthcare professionals may face in the implementation of general treatment and care. The work carried out by medical and paramedical staff needs to take account of the great degree of great precarious situations to which people infected with HIV are exposed. This work is carried out in a context of medical services provided under strain. Ultimately, the silence that surrounds the epidemic in French Guyana is limiting the scope of action.

SCREENING AND FOLLOWING UP PATIENTS IN PRECARIOUS ENVIRONMENTS

The social situation of the Guyanese population is largely a difficult one. The proportion of the population aged 15 and over without a school-leaving certificate reaches 43.3%[18]. The rate of unemployment is very high, at 26.5%. The growth of the population of working age is set to take this figure up to 36% in 2010[19]. In 2004, 17% of the population was directly or indirectly dependent on income support (RMI). The rise in this figure is worrying: Between 2003 and 2004, it reached 14% and has been increasing by an average of 8% per annum since 2000[20]. Out of the 130,000 people insured under the general programme provided by the social security department, more than 70,000 receive universal health care coverage (CMU), representing 38% of the population according to data from Insee[21], and 16,000 are in receipt of state medical aid (AME)[22]. Given the knowledge about the link between controlling the risks of HIV infection, the use of condoms based on social class and the level of education[23], the social data on the population of French Guyana is an element of concern for any healthcare policy.

Moreover, access to accommodation is a serious problem[24]. Despite considerable need, very little housing has been built and existing land is of mediocre quality and is deteriorating very quickly; shantytowns are commonplace. In terms of finance, rents are very high at around €500 per month for a two-roomed place of very questionable quality in Saint-Laurent-du-Maroni, for example. The lack of a stable, regulated market makes the difficult situation faced by many people worse, since they sometimes have to pay exorbitant deposits. The fight against unsanitary housing is being lost due to a lack of homes built to rehouse evicted people. In these conditions, it is very easy to state helplessly, as has already been stated several times to the CNS commission: "you knock down one shantytown, and another will grow immediately". This generalised housing crisis is even more pronounced when it comes to considering follow-up care or providing accommodation adapted to the needs of the sick. Thanks to action by the "SOS Habitats et soins" association, Cayenne now has around twenty therapeutic coordination apartments, although this number is still clearly insufficient. For specific groups of individuals such as drug users, for example, there are no support hostels.

Only a few sick people are able to work in order to access resources due to the fatigue associated with their state of health and the obligation for women to look after the children. Access to work is very difficult and random. Unofficial labour seems to be very well-developed, and does not just affect illegal immigrants. It is therefore hard to believe that there is a labour market in western Guyana beyond the jobs that administrative organisations offer.

Access to social rights is also a matter of concern for social workers in charge of looking after people in need. These difficulties with access to rights do not appear to be limited to foreigners, even though the complexity of the procedures for granting residence permits in order to receive treatment exacerbates the precariousness of their situation. Quite apart from the very exhaustive nature of the documents required, the delay in processing files by administrative services has, up until recently, been considerable. Social workers therefore are seeing their workloads increased markedly by the preparation of these files, which takes up a significant amount of time to the detriment of other social actions. An improvement in the way these files are managed is essential for the effective treatment and care of the sick. It seems that the recent progress in the relevant office of Cayenne's *Préfecture* will bring a significant reduction in the waiting periods.

Therefore, people affected by HIV accumulate problems quite beyond those relating to healthcare issues: Exclusion or self-exclusion *vis-à-vis* their families and peer groups, additional health problems, in particular untreated depression, a lack of housing or unsanitary housing, no regularisation of administrative issues and the consequential access to rights. This widely deteriorating situation often leads sick patients to sort out their problems in order of priority and to make compliance and preventative behaviour non-essential.

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[18] *Préfecture* of French Guyana, General Secretariat of Regional Affairs, Europe Department, Feder Operational Programme 2007-2013 French Guyana region, p. 10.

[19] Feder 2007-2013 French Guyana region, p. 7.

[20] Feder Ibid, p. 11.

[21] SREPS states the number of 72,000 people, p. 17

[22] Interview, this represents 15% of the number of recipients of AME in France.

[23] Halphen S, *et al*, *op. cit.*

[24] Opinion presented on behalf of the French Committee of Economic Affairs, Environment and Territory on the 2007 draft finance law (no.3341), volume IV, Overseas, Joël Beaugendre, National Assembly, 12 October 2006, p. 14.

THE LIMITATIONS OF MEDICAL SERVICES

The health care delivery in French Guyana is inadequate, and has led to numerous patients being sent elsewhere for treatment. These problems are not limited to the treatment and care of acute or complex cases. The department is under-resourced both in terms of equipment and staff, and is currently facing an aging medical population. Numbers of general practitioners are inadequate, and there are precious few who are able to treat people infected with HIV or indeed who would be willing to do so.

The average age of doctors is around 50. Specialities are unequally represented, and the doctors who are present are reaching the end of their careers without any replacement being lined up. It also seems that the medical community currently in place does not in itself hold any appeal for young doctors. Staff turnover is high as a result of the professionals reaching exhaustion. The only response to healthcare problems is often medical because of the shortage of social support. This situation implies that the job of physician is very different from the one that the majority of doctors became used to during their training. The difficulties surrounding adaptation that result from this situation explain both the high turnover and the difficulty filling certain jobs. The management of active file populations is always a cumbersome task, as the report by the CNS in 2003 has already pointed out[25]. The shortfalls in medical personnel also relate to the medical services of the education authority, since five nurses' posts and eight doctors' posts remain unfilled due to a lack of candidates[26]. The problems of human resources in the healthcare sector spill over beyond the framework of healthcare personnel, with difficulties in the collection of hospital-related data, inadequate secretarial services and sometimes serious interpersonal problems between hospital managers and care providers. As the picture in French Guyana illustrates, efforts to modernise the hospitals, in particular with regard to budgetary expenditure, collide with the specific situations that cannot be resolved by the simple and straightforward application of the "mainland model". On a wider scale, the human resources crisis is commonplace in French Guyana, affecting various areas of the public sector that are linked to the treatment and care of patients[27].

The possibility of tax relief was considered for a time and was revisited when the creation of a free zone was announced by the French President. Doctors who have been met by the commission expressed high expectations of this. Nevertheless, bearing in mind the many perks that already exist and that are not used, these tax exemptions will probably not provide a means of attracting professionals in any great number or from the specialities needed. There is also the fear that, once the tax breaks have been used up, the people who have benefited from the effect of the windfall will leave the country, as has been the case with other economic zones in the West Indies.

The recent revival of two clinics, however, raises the hope of renewed medical activity and a variation in the care provision package. From this point of view, the work by the Regional Hospitalisation Agency (ARH) towards maintaining and stimulating the variety of medical services available deserves to be highlighted. The organisation of healthcare delivery within French Guyana remains a complex issue, not just because of its vast nature, but also due to the repeated choices made when it comes to the skills practiced in healthcare centres, the importance of which is however well-understood. Clarification of their expertise and status is therefore needed in order to identify what structures are the responsibilities of the General Council, and which are dependent on hospital funds[28]. These questions largely go beyond the treatment and care of HIV infection and, as the inquiry report on the private practitioner population of French Guyana has already recommended, an in-depth audit of the health organisation is absolutely essential.

DENIAL OF THE EPIDEMIC AS A BARRIER TO ACTION IN HEALTHCARE

In French Guyana more than anywhere else in France, the epidemic of HIV infection remains a difficult subject to discuss. The stigmatisation and discrimination associated with HIV infection sequester local society and its various community components in denial, silence and secrecy – all factors that propagate the epidemic very directly. In fact, the fight against the epidemic needs to be considered as a *continuum*, stretching from prevention to the provision of care and treatment. The negative effects of stigmatisation and discrimination can be felt at each of these stages[29]. Stigmatisation is a process where individuals are discredited – a phenomenon that affects the people who are infected as well as those who are believed to be. People can internalise this stigmatisation, developing feelings of shame and guilt. These feelings, because they damage an individual's self-esteem, undermine the efforts to provide treatment and care and discourage the involvement of people who are nevertheless essential to the fight against the epidemic. Reticence on the part of Guyanese society to face up to the reality of the epidemic contributes on the whole to limit the effects of the policies aimed at fighting the problem.

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[25] Conseil national du sida, Rethinking the response to HIV/AIDS in the French overseas departments, 11 March 2003.

[26] The education authority currently employs forty nurses and eight doctors.

[27] Carde E, L'accès aux soins dans l'Ouest guyanais : représentations et pratiques professionnelles vis-à-vis de l'altérité : quand usagers et offre de soins viennent "d'ailleurs", PhD in medicine, page 146, note.

[28] Regional Hospitalisation Agency of French Guyana, Regional health organisation plans (Sros), 2006 – 2010, Guyane, Prise en charge de la santé des populations des territoires isolés.

[29] HIV-Related Stigma, Discrimination and Human Rights Violations**,** case studies of successful programmes, Geneva, UNAIDS, Best Practices Collection, 2005, p. 4.

This general situation can also devaluate the views regarding prevention. The lack of public debate in turn can contribute to fostering the idea of a foreign epidemic, or one that is attributable to second-order French (Maroons vs Creoles). This idea is even sometimes supported by defending the methods used in the fight against immigration which turn out to be factors that actually reinforce discriminatory behaviour. In this context, people who are exposed to infection are loath to consider screening.

Prevention policies are therefore difficult to implement and tend to fail. By making disclosure to partners impossible, silence and discrimination regarding HIV infection thwart prevention and promote exposure to transmission. The results of the Vespa inquiry reveal that foreigners, especially Haitians, are less likely to disclose their status to partners[30]. In French Guyana, around 20% of people do not disclose their status either to their spouse or to their family or friends. In the same vein, the stigmatisation of homosexuality represents a barrier to prevention to the point that men who have sexual relationships with men cannot recognise themselves in messages aimed at a gay audience. This stigmatisation propagates risky behaviour during furtive sexual encounters. Ultimately, men infected with HIV do not want to divulge their infection given that it would designate them as homosexuals.

The treatment and care of patients is also limited and complicated by infected individuals' compulsion to conceal their status. The fear of a breach of confidentiality tends to make people visit hospital less often, furthering the development of people who become lost to follow-up by virtue of the "tunnel effect": An appointment is missed and there is no alternative offered. Stigmatisation also restricts field work in shantytowns, for example with the follow-up of children.

Born of stigmatisation, discrimination involves treating people who are infected differently, thereby aggravating their feeling of exclusion. People infected with HIV are however key players in the fight against the epidemic. By speaking out publicly, they can help change the general public's perception of the infection. Unfortunately, it seems impossible for people living with HIV to express their opinions publicly without running the risk of even greater exclusion, even to the point that they will have to move house. Migrants are often the subject of harsher stigmatisation. Programmes aimed at fighting HIV that are geared towards such migrants are more effective when people are involved as stakeholders in their development[31]. Consequently, stigmatisation and discrimination have a very negative impact on efforts to treat people individually, but also restrict the use of the voices of those directly involved in the promotion of prevention measures. In French Guyana, strong action needs to be taken against the stigmatisation of HIV infection, and this means involving local leaders. By so doing, the people living with HIV, who are the key players in the fight against the epidemic, will be able to make an impact at the heart of their own community.

1.2 SIGNIFICANT PROGRESS IS HAMPERED BY PUBLIC POLICIES THAT ARE UNEVENLY ADAPTED TO LOCAL ISSUES

Specific developments are by and large the result of work carried out jointly by local state services, healthcare agencies and association representatives. This work in the state's fields of expertise must benefit from support by the central administration department if it is to be deepened and continued long-term. This support will come, inter alia, through the possibility of developing public policies in line with the Guyanese framework which are not simply an adaptation of French national policies to local situations. The epidemic of HIV infection in French Guyana is not an exception for France as such, but rather an epidemic that is coherent with the Caribbean region's particular situation.

1.2.1 HIV PLANNING THAT NEEDS COMPLETION

Information, prevention, screening organisation and medical treatment and care are based on efforts made by the Guyanese Department of Health and Social Development (DSDS, a unique organisation that combines the DDASS and DRASS) in 2002 and which are manifested through the 2003-2006 regional healthcare programme for HIV/AIDS in French Guyana. This significant progress needs to be continued in the long-term by a new programme that will retain the advances made while at the same time setting out lines of direction for the future. As this programme indicates, the fight against the epidemic of HIV infection in French Guyana not only calls for healthcare programmes, but also for a review of economic and social elements that are beyond the healthcare sector. This programme is thus based on the objectives of providing resources for the fight rather than epidemiological objectives[32]. This choice has allowed the response to the epidemic to be structured, a response that now needs to be refined in order to complete the important work that began five years ago.

A WELL-ESTABLISHED FIGHTING STRATEGY

Unlike the situation in 2002, at the time of the last mission by the CNS in French Guyana, the public policy of the fight against HIV is now well-structured, enjoying clear guidance and actions that have been adapted to the department's specificities. A dynamic movement has begun. Associations are involved with the issue, and the DSDS has supported associations and communities. In many

[30] Bouillon K, Lert F, Sitta R, Schmaus A, Spire B, Dray-Spira R, Factors correlated with disclosure of HIV infection in the French Antilles and French Guiana: results from the ANRS-EN13-VESPA-DFA Study, S89, AIDS 21(1), 2007, S 91 and S 93.

[31] Migrants' right to health, UNAIDS, Best Practices Collection, Geneva, 2002, p. 52.

[32] PRS VIH/AIDS Guyana, 2003-2006, p. 32.

respects, French Guyana is now a pioneering department, although it has seemed very behind in many respects, including the limited scope for action due to cultural reasons.

The positive points of the current policy in the fight against HIV relate to an adaptation to the specific needs of French Guyana. The programme has allowed key areas of action to be set out and the presence of HIV justified in the nine priority areas of action in the regional healthcare programme. Several positive developments can be highlighted: firstly, access to condoms, which has become much more widespread. The implementation of a central purchasing office for condoms and the installation of dispensers in all colleges and universities is one of the particularly successful achievements of the regional HIV healthcare programme. The number of condoms distributed is much higher than in other regions, and is undoubtedly benefiting from this concept[33]. This widespread distribution has been accompanied by the work of the INPES organisation, which has gradually developed by diversifying the range of documentation and information available. The INPES publishes documents in the various vernaculars of French Guyana, adapting its products – such as photo novels – to the different groups at the greatest risk of exposure. It remains a very complex task to adapt to all communities and their characteristics, since doing so runs the risk of losing the message[34].

The support given to networks such as Matoutou and Kikiwi allows relationships to be formed between various key players and a skeleton to be provided to the response to the epidemic. Healthcare education is reliant on the training of people able to educate young people about sexuality. Prevention and education about sexuality in educational institutions are in place thanks to the work of school nurses or mediators. In particular, the financing of training for prevention workers in order to reduce sexual risks within the framework of the work carried out by the French movement for family planning appears to represent one route that should receive long-term support.

Moreover, other public action programmes link in to the lines of action taken by the regional HIV healthcare programme. The regional education scheme for healthcare in Guyana (2007-2009) devotes one of its two themes to HIV with offers of strategic areas of action and recommendations set in the context of the regional public healthcare programme (Prsp). Action 13 of the regional programme to integrate immigrant populations (Pripi, project dated 13 September 2007) urges the development of healthcare mediation towards immigrants and the health workshop for immigrants organised to draw up the Pripi joins forces with areas of action in public health aimed at informing people about disease, developing exchange between mediators and strengthening their skills. In particular, the prospect of setting up an education and healthcare promotion resources centre in 2008 is an encouraging sign for the creation of a healthcare education culture. The centre, by bringing together funding from the state, local communities and the INPES organisation to begin with, will illustrate the possibility of joint action between various key players involved in healthcare policies with their own distinct areas of expertise.

The weakness of the associative network in French Guyana has always been pointed out, but associations are now enjoying a higher profile, either as a result of familiarity over time (Sida info service) or by a move back into the department (Aides). Actions to help prostitutes are better-structured. The "communication" group, set up by the branch of Sida Info Services in Cayenne, may represent a learning opportunity for associations, especially with regard to relationships with central institutions in mainland France. Support from the DGS and INPES allows this presence, which is indispensable to the implementation of policies pertaining to the fight against HIV, to be maintained.

PROGRAMME ELEMENTS REQUIRING CLARIFICATION

These many forms of progress need to be sustained, but it is equally important to develop certain lines of action in order to refine these strategies further. The response to the epidemic of HIV infection is helping to structure healthcare policy, although the importance of HIV is contested and calls for permanent efforts from state-run services to convince the Regional health conference. Out of the nine priorities announced, AIDS has moved from first place to fourth. Given the scale of the epidemic in French Guyana and in neighbouring countries, this priority appears anything but contestable. Moreover, it would appear unfortunate to the CNS to have to once again justify what has already been considered as a priority in the national AIDS prevention programme for a number of years. These problems certainly represent an indication of the tremendous embarrassment that the epidemic causes in the department.

The national programme remains the framework of the fight against HIV, but it seems essential in French Guyana to take into consideration local issues that are very different from those of mainland France. The reasoning behind the programmes must draw inspiration from the recommendations made for countries facing a widespread epidemic. Therefore, the fight against stigmatisation assumes a plea to local authorities that goes beyond the framework of normal national policies.

Bearing in mind their shortfalls in terms of human resources, associations are unable to play a role that is identical to that played across the Atlantic in mainland France. Discrimination makes the involvement of people infected with HIV in local campaigns difficult, and hampers their investment in actions organised by associations. Despite these difficulties and the problem of how long the staff will remain, intervening organisations such as INPES need support to draw up their responses. As a consequence, the role expected of associations needs to be outlined in specific terms and the resources implemented to support them need to be developed. These resources already exist, from the funds provided by the ministry for health, but also from the ministry in charge of

[33] Quantity of 600,000 per annum, for a population of 200,000 people.

[34] Interview.

the overseas departments. Support to community associations and what is expected from them also need to be spelled out, in particular with regard to public debate about HIV infection. The work of social assistance is important, but it cannot be considered as an action in the fight against the epidemic and against the stigmatisation of individuals. Agreements on objectives will allow these expectations to be clarified from this perspective.

The choices of prevention for men who have sex with men need to be made clear. Data on the reported modes of transmission paint a picture of an epidemic that is largely heterosexual, but the proportion of homosexual transmissions reported is 15%, which is not a figure that can be ignored, and all the more so since the stigmatisation of homosexuality can lead to under-reporting of such modes of transmission or the use of non-recognised practices.

Ultimately, if it is accepted that the epidemic in French Guyana also requires an approach from the social determinants of health, then the growth of the population, the level of education and unemployment and data relating to the correlation between the level of education and awareness of risk need to be taken into account. The department is facing many and various problems that are a burden to its inhabitants, especially those who are most deprived and at greatest risk, which accounts for the majority. They have all the more difficulty observing instructions regarding prevention or care since they are not always aware of them, and most of all are constantly being made to make life choices that cause them to sort out their problems in order of priority, most commonly to the detriment of their general health. The results of the Vespa inquiry show that 47% of the people living with HIV in French Guyana have completed only primary school education, while 33% have completed secondary school. 59% of Guyanese people are unemployed[35]. At the same time, given the growing population, a rise in unemployment is expected and there is nothing to indicate that the proportion of the population over the age of 15 without a school-leaving certificate will decrease. The demographic dynamism of French Guyana and the demands that accompany it are sometimes described in official publications as "factors of risk and instability"[36]. The prospects of the overall evolution of Guyanese society need to be integrated to create a programme that is appropriate for the department.

RESPONSES ADAPTED TO THE NEEDS OF WOMEN

The aforementioned problems in terms of screening and the loss of patients to follow-up share the persistence of problems relating to the prevention of mother-to-child transmission. The results of the treatment and care of pregnant women are as good in French Guyana as they are in any other French department, but there are still too many women being offered treatment late, or receiving inadequate follow-up. Children are being born infected with HIV, although the health care delivery is in principle complete.

The prevention of mother-to-child transmission in successive pregnancies raises the question of the economic, cultural and social context and the gender relationships that hospital staff would not know how to manage. Teenage pregnancies are more common than elsewhere: 9% of pregnancies are among minors, and a total of 296 pregnancies among young girls receiving secondary education. The high birth rate, at 6,000 births per annum, and the mobility of the populations across Western Guyana and beyond its borders are a problem to the implementation of long-term policies that are geared towards stable populations. Specific responses for the treatment and care of women need to be developed.

Among the ideas suggested by the regional healthcare conference, perinatal care was strongly advocated. Given the profile of the epidemic (heterosexual transmission and the majority of the infected population being female) and the particular characteristics of the area in terms of teenage pregnancies, the issues of the prevention of sexually-transmitted infections (STIs) and pregnancies that share the same economic and social issues of heterosexual relationships, there appears to be a need to develop a line of action for women. The regional HIV healthcare programme needs to be able to offer a more targeted focus on women by breaking down the various groups (young/adolescent girls; women; prostitution; single parents; specific groups; places of residence). The long-term work of the French movement for family planning (Mfpf) should allow this response to be formulated. This pro-women policy needs to be matched with a voluntary policy that defends women's rights. Healthcare education, the prevention of teenage pregnancies, STIs and HIV all need to be factored in. Given the advanced age of certain pupils, differentiated strategies may be considered for secondary schools. Bearing in mind the early age at which many have their first sexual experience, and the high number of teenage pregnancies, there needs to be more information provided in secondary schools. School nurses already have the experience required to know what kind of speech is the best-suited to the needs of secondary school students.

IMPROVING AWARENESS OF THE EPIDEMIC

The development of these lines of action requires a better understanding of the epidemic. All of the public action programmes that feature actions against the epidemic of HIV infection or healthcare more generally highlight the lack of data on the epidemic or actions carried out. The ARH, for example, laments the lack of indicators similar to those available for the majority of Caribbean countries[37]. The Sreps, as an evaluation project for the regional HIV healthcare programme, laments the lack of data pertaining to the

[35] Bouillon K, Lert F, Michelot F, Schmaus, Spire B, Dray-Spira R, Les patients vivant avec le VIH-sida dans les départements français d'Amérique : résultats de l'enquête ANRS-VESPA 2003. *BEH*, No. 46-47, 2005, p. 240.

[36] ERDF Operational Programme 2007-2013 Guyana region, p. 9.

[37] ARH, Sros, 2006-2010, Région Guyane, prise en charge des patients infectés par le VIH, p. 9.

campaigns in place[38]. In the same vein, it is very difficult to tell whether the portrayals of the disease and those infected with it have changed within the population, nor is it possible to tell whether information on prevention and screening is being provided due to a lack of any baseline survey. The profiles of those lost to follow-up and the estrangement factors need to be specified in order for efficient strategies aimed at rebuilding the link to care to be defined.

In particular, certain groups of people are virtually completely unaware of the practices and risks of exposure to transmission. Gold-washing sites, illegal or otherwise, are places that are not well-known and which need to be focused on with the prospect of fighting the epidemic. For men who have sex with men, clandestine practices or more widespread bisexuality than in mainland France are often reported, but without any further details. Moreover, there may be mention made of specific sites where homosexual encounters take place, which belies the idea that such practices are not common. The adaptation of local prevention measures to the needs of the most exposed populations is therefore difficult if there is a lack of understanding or awareness.

The same goes for prostitution, the practice of which in towns is fairly well-known about empirically, but which would probably require more detailed work for prevention to be adapted to the various forms of prostitution and action to be taken as regards the different types of clients. As the results of the HIV PRs point out, there needs to be a review of prostitution within the department, but also work that will allow local observations to be sorted through to reach the point where the practices that take place are actually documented. This would also allow the rumours, which are propagated with varying degrees of willingness, to be halted - a fact that would increase the understanding of the practices carried out by foreigners as regards matrimonial or maternity issues. There must also be a distillation of understanding as regards the use of prostitution. Among the men interviewed as part of the KABP inquiry, 7% of them stated that they had used prostitutes, but this figure rises to 50% of the men who receive late treatment, according to the results of a survey carried out at Cayenne Hospital[39].

1.2.2 THE DIFFICULT APPLICATION OF MAINLAND FRANCE PUBLIC POLICY FRAMEWORKS

French Guyana is a region that is classified as being within the areas of widespread epidemic, given the prevalence of the infection among pregnant women. This is something that sets it apart from other French departments, but which fits in with its regional epidemiological environment. For this reason, national public policies need to be able to be adjusted to the local conditions and environment, as well as the issues of the epidemic of HIV infection: The policy for managing migrants and the prices of medical treatments are public policy models that need to be adapted in order to be functional in French Guyana and not appear to be in contradiction with the policy of the fight against the epidemic of HIV infection. Beyond this essential adaptation, it seems to go without saying that the formulation of the solution to the HIV epidemic also needs to be considered based on frameworks recommended for countries with widespread epidemics.

FRENCH GUYANA: A CHALLENGE FOR HEALTHCARE FINANCING?

French Guyana is not only a vast department, but it is also a region where most of the population lives on the coast, although people live along it in "isolated zones". The department is segregated between the urban area of Cayenne-Kourou, the region to the east bordering Brazil, and the Saint-Laurent-du-Maroni area. This latter area is appropriately named "grand ouest guyanais", insofar as the administrative border that the Maroni river follows seems to be loosely linked to the department's internal border represented by a police control point between Cayenne and Saint-Laurent-du-Maroni. These geographic constraints have very specific implications for the healthcare system in Guyana and the budgets of the different healthcare bodies or those that provide finance for the healthcare system. The opening of an aerodrome in Grand Santi will help improve access to care for the population in general, but is not being portrayed as an investment in healthcare.

The organisation and distribution of skills, especially in healthcare centres, remain a matter for discussion. The distribution between the department and the hospital remains a source of confusion, partly due to the poorly-defined denominations, as the paper published by the SROS on the treatment and care of populations in isolated areas highlights[40]. The financing and management of healthcare centres, which is in part down to hospitals, represents a significant additional burden for them.

Limited hospital capacities in French Guyana mean that patients are very often sent to Martinique for treatment. The helicopter is very often used to transport people living in isolated areas to hospitals. As a result, hospitals have to sustain a particularly high financial burden as compared to hospitals in mainland France, without obtaining any funding commensurate with these very specific constraints. Hospital financing is becoming a major headache, due to a common nationwide French rule that loses its applicability in French Guyana. The prospect of the implementation of specific prices in the department should logically be considered insofar as there is no foreseeable reason why the need to send patients elsewhere will change. Precariousness and estrangement can be integrated into the calculations of fees[41]. Travel is not always reimbursed, and the cost of canoes for parts of the river that are

[38] Regional education scheme for healthcare in Guyana, 2007-2009, Guyana DSDS, p. 65.

[39] Interview.

[40] ARH, SROS 2006-2011, Guyana region, Prise en charge de la santé des populations des territoires isolés, p.13.

[41] Interview.

supposedly impossible to navigate is not reimbursed by the social security[42]. The financial difficulties of the Guyanese healthcare system are well-known, but the central state is not completely committed to providing resources that are commensurate with the department's very specific constraints.

AN IMMIGRATION POLICY THAT DOES NOT TAKE ACCOUNT OF THE EPIDEMIC ISSUES

The migratory movements in French Guyana occur in a different regional context to the one which underpins the policies for border control in Europe. In the same way that a healthcare financing policy in mainland France could cope with adjustments to the specific characteristics of French Guyana, a policy for dealing with influx of migrants defined in France, and which functions within the coherent policies at European level, could work if adjusted to the department. Movements between populations are an ancient and permanent feature of the Caribbean region and have taken place across borders that are not just those of the states. There was a time when Guyanese would go to Surinam to receive care. It is therefore important to take account of the socio-historical context of migration in the region as far as the policy for the fight against HIV is concerned, but also in the way the French immigration policy is implemented. Moreover, people living on the river may be French, but without papers, and this does not make them foreigners. A policy for the fight against immigration developed for continental Europe is even more contradictory in this region *vis-à-vis* the policies of the fight against HIV than it already is in mainland France.

The evaluation of the link between immigration and the epidemic of HIV infection is always tricky and lends itself to interpretations that are in part determined by the prevailing ideas on immigration. It is therefore common to hear that immigrants come to be treated in France in the hope of being granted a residence permit for healthcare reasons. Nevertheless, there is nothing on which to base this assertion; foreigners often migrate for reasons that are primarily economic and for survival, and then learn of their infection in France.

Epidemics among migrant groups have been staggered over time, with the initial epidemic affecting the French, Creole or not, and the Haitians, then the second wave bringing an epidemic among the Surinamese and Guyanese. As far as Brazilian migrants who receive treatment and care in Guyana are concerned, their choice is the result of the distance of Oyapoce from the capital of the state of Apama. It takes several weeks for results of tests to be available, not to mention the cost of transport to gain access to treatment and care. It therefore makes sense to use the most accessible offer of treatment and care. For women, economic migration involves taking risks through prostitution, occasional or otherwise. Female migration via Surinam would be via networks. The journey would be paid for by men living in Cayenne and "repaid" via "services" rendered to them. This explanation of a particular link between immigration and exposure to the risk of transmission is frequently put forward, but as for many other subjects, there is no specific research to back up these assumptions. As has already been highlighted elsewhere, prostitution is not necessarily a reason for migration, but it does sometimes represent an economic choice among the work opportunities in the country of residence[43].

The evaluation of the link between immigration and epidemic also depends on the professionals in contact with individuals. Doctors think that immigration for care is not the main motivation behind the move. People come for work, to be closer to members of their family, and then get screened if they are admitted to hospital. They therefore ask to benefit from the AME. Given the proximity between Surinam and the town of Saint-Laurent-du-Maroni, and in particular the lack of any border between the countries and the homogeneity of the population, it is likely that the situation in this town is different. This proximity certainly favours better control of the services available, thus justifying for some the belief that the French system creates migration. For the department's services, the influx of migrants creates significant uncertainty as regards the resources that need to be allocated to education, for example, and represent an uncontrolled restraint in the planning of required investments.

The combination of heavy immigration and an epidemic that largely affects foreigners nurtures opinions on the movements of populations and the problems that these present, without bringing in any debate regarding public health. However, it must be pointed out that none of the contributors considered closure of the borders to be an acceptable solution. There also seems to be a relative understanding of the issues by local key players who are faced with implementing control over people in irregular situations.

THE NEED FOR A MULTI-SECTORAL APPROACH

The lines of action for policies in the fight against HIV in areas with a widespread epidemic place the emphasis on the need for a multi-sectoral approach that involves all of the key players in the public health and social sector, but also those in civil society and the world of business. The objective of this approach is two-fold. It must lead to the taking into account of the epidemic in all sectors of public action, be it on a national or local scale. The contradictions between public policies are less, and in particular the policies implemented in the healthcare sector do not appear to be incoherent with those from other sectors. Assistance provided to foreigners to prepare their file to apply for a permit to stay on health grounds includes a financial aspect that is supported by associations that enjoy subsidies from the state. To a certain extent, administrative fees are paid by the Ministry of Health. The multi-sectoral approach must also allow all influential social figures to take up the issues of the fight against HIV and to contribute, each in their own way and in line with their abilities, to the fight against stigmatisation and discrimination, to prevention or to the care of the sick, for example.

[42] Interviews.

[43] CNS, Report on Public Policy for HIV Prevention in Mainland France, 17 November 2005.

This approach does not clash with the nationwide programme. The CNS has previously referred to these principles, especially in its report on the policies of prevention in mainland France, which concludes with an invitation to take a multi-sectoral approach.

PART II THE INADEQUACIES OF THE POLITICAL MANAGEMENT OF THE EPIDEMIC

Some of the hurdles that hamper the scope of action taken by healthcare professionals can only be removed by leading political investment in the fight against HIV. This investment, by the state and local politician figures, calls for a fundamental change in the relationships with neighbouring countries and a public debate by political leaders, without which no progress will be possible.

2.1 A LACK OF STEERING FOR THE RESPONSE TO THE EPIDEMIC

The response to the epidemic of HIV infection is in part a problem of political engineering that requires strong investment from local representatives and healthcare policy professionals. However, governance of the fight against AIDS appears to be poorly structured and the lack of commitment by political figures is preventing this handicap from being overcome.

2.1.1 THE FRAGILE GOVERNANCE OF THE FIGHT AGAINST AIDS

The governance of the fight against AIDS needs to overcome two problems. Departmental social services, healthcare and social associations and institutions are not coordinated enough, due to a lack of a clear leader who would coordinate their actions effectively. From the perspective of civil society, associations still need to find a balance that would allow them to act both as a unified representative in the political arena of healthcare in French Guyana, and as a group of organisations representing specific and clear areas of intervention.

POORLY-MAINTAINED RELATIONSHIPS BETWEEN PUBLIC FIGURES

French Guyana faces problems relating to the distribution of skills between professionals that are under state control and those at the local level, and also problems relating to issues of administrative reasoning. This fact is evident in all political arenas, be they in mainland countries or otherwise, but in French Guyana it has maximum effects by virtue of the significance and diversity of the problems.

Between the state administrative bodies, it is clear that reasoning as regards implementation can be, if not contradictory, certainly competitive. One exception can be picked out – that of the good relationship between the overseas department administrative bodies and healthcare department in the constant efforts to provide support to associations. In the hospital sector, practitioners – who, it is worth reiterating here, face the permanent risk of exhaustion - are constantly battling hospital administrators because the treatment of HIV "costs" a lot of money, even more so when the people being cared for are not receiving either CMU or AME. By emphasising health needs in the treatment of individuals, especially foreigners, public health and social administrations can find themselves in an awkward position *vis-à-vis* the local departmental administration organisation, which is itself drowning in the sheer mass of files it has to manage.

The DSDS has "a problem with the General Council" which experiences "apparent organisational and responsiveness problems". These repeated comments come from all directions and have given rise to one interpretation highlighting the numerous divisions between the groups of populations found in French Guyana[44]. Another interpretation may also consider that the DSDS is focusing on problems that local leaders would prefer to conceal in order to promote an appealing image of the region. The General Council gives the impression that it does not want to have anything to do with state services when these are dealing with sensitive issues relating to French Guyana's image. Relationships with services in the region are improving, but always complex. These services have developed their own expertise, in particular with regard to European financing, which in some cases avoids adjudication by the state. In certain key areas, it appears that relationships between the professionals that have a direct interest are less than what they could be. Such is the case for the issue of women and relationships between the delegation for the rights of women, associations, and care providers. The same applies with policies for immigrants. There is no go-between mediating between the various groups of professionals; their relationships appear to be very limited. The poor level of interaction probably results from a local key player group that is still too small to create a link between the different political arenas. The regional public health bodies, such as the Corevih organisation, may represent a forum for developing these interactions.

ASSOCIATIONS LOOKING FOR A CLEARLY-ESTABLISHED POSITION

The associations are key players in the fight against AIDS. They play numerous roles: they provide alerts and expertise and they implement innovative interventions or public policies. They must therefore be able to gradually assume distinct fields by gleaning skills that are particularly adapted to their specialist area.

[44] Carde E, Les discriminations selon l'origine dans l'accès aux soins. Study in mainland France and French Guyana, PhD in public health, p. 383 et seq.

Associations face a myriad of problems in terms of resources. The prevailing image is that of understaffed teams who are engulfed by the sheer volume of problems and their interconnected nature. Staff numbers are inadequate; people very clearly know the files, know each other and work together, and are initially motivated by a humanist ideal. However, the common theme is the chronic difficulty in coping with frustration and not being able to do anything other than retain what matters. Some representative bodies, such as the *Préfecture*, may sometimes note a certain lack of "professionalism", especially in the processing of residence permit applications on health grounds and in the relationships with public figures. Sources of financing vary, including the DSDS, the region, the department, Fondation de France and Sidaction. However, these funds do not represent working subsidies or material assistance and are used only to fund projects. As was already pointed out in a previous report by the CNS, the associations need financial security in order to be effective sources of assistance in state-led actions[45].

The associations appear to be penalised by the position of providers of social services which they have assumed. They are far removed from the political investment and the advocacy of people infected with HIV that associations in mainland France practice. They work behind the screen of social assistance and play the role of adjunct to the hospital and, in so doing, are reduced to this role alone. However, they could get involved very directly in general treatment and care, but this would require a change of opinion from medical personnel and without doubt a reinforcement of skills. The nature of the relationships between associations and hospital staff varies. In Saint-Laurent-du-Maroni, cooperation between medical personnel is good, and to a large extent ruled by routine. The fairly limited number of people involved in the field of HIV in town, be they medical staff or not, means that the relationships are characterised by closeness and cooperation. It would be a good idea to strengthen the town-hospital networks and, on a broader scale, make efforts to reinforce forums for exchange and confrontation between all the parties involved.

Associations must be supported while at the same time taking care to distinguish between the associations that are effectively involved with HIV issues and those that are happy to claim healthcare objectives in order to increase their chances of funding, although their main objective relates more to cultural and community life. However, there is a need to expand the support to civil society in the fight against AIDS beyond the single circle of specialist associations. The entire social body needs to be involved. It would appear important to make community leaders that are outside the fields of healthcare and social welfare cognizant of the severity of the epidemic in these regions, so that they too can play their part in encouraging prevention, as is starting to be the case among religious leaders.

The associative network needs to be divided up into areas of intervention. The return of the Aides organisation to French Guyana is part of a revival of community action, while at the same time representing a disruptive force. Aides is an association for people who are already infected – which is not the model claimed by other organisations and which brings about a different type of relationship with the hospital sector. It appears that relationships are gradually becoming more organised. Associations are able to organise themselves on a flexible basis into inter-community entities which objective would first of all be to have an influence in the strategic discussions relating to objectives and resources. It is fairly clear that speaking with one single voice to political and/or administrative leaders, or even in the media if necessary, is a vital necessity in French Guyana.

THE NEED FOR A CLEAR LEADER

The regional authorities which co-exist on an identical ground with departmental authorities without always appearing to have a particular use, apart from the elected representatives themselves, do not appear ready to make HIV a key issue. The authorities put forward, in particular in the regional healthcare programme, other public health issues (such as neonatal care, cancer, diabetes) in order to push HIV further down the list, thereby reducing the political risks that are inherently associated with the acknowledgement of HIV. By so doing, the authorities are setting themselves at odds with the DSDS, the ARH and, more generally, the state-run structures and the associations that are generally highlighting the fact that HIV needs to be put at the top of the list of priorities. The need to reach a consensus, under the aegis of the *Préfet*, has led to HIV being moved to 4th place in the 9 healthcare priorities, which is without doubt the worst thing that could happen, since nobody is then able to say that the problem has gone away, but everybody can see quite clearly that the situation is less urgent.

In general, the conditions needed for long-term cooperation that follow a clear line of action are difficult to fulfil. From the state's perspective, it is not so much the people that are in question here, but rather the resources and the conflicting orders between administrative entities. From the point of view of the local authorities, although the devotion of administrative personnel appears to be assured, the general political positioning appears unstable beyond matters of principle. Although meetings counted only few participants, the Conseil has been able to notice a resolve to fight stigmatisation from certain key players. This voluntary advocacy, in the interests of public health, needs to be the standard. On a wider scale, it is the authorities' human and material resources relative to the significance and diversity of the problems that represent the main handicap.

The piling-up of services, the resulting complexity and the line losses that this involves make a case for a certain degree of organisational innovation. French Guyana could speak in favour of a type of experimentation on its territory in the field of HIV. In such a situation, it would have to be decided that one administrative body, both at local and state levels, would play the role of clear leader, and thus ultimate arbiter, for all projects and issues relating to HIV. This would in particular allow the problems linked to the dilution of responsibilities to be limited, and the chances that general policies would be harmonised and non-contradictory

[45] Report on Public Policy for HIV Prevention in Mainland France, 17 November 2005.

would be increased. In this framework, the question that must be asked is: which is the best-prepared administrative body to carry out this responsibility?

2.1.2 A LACK OF COMMITMENT FROM LOCAL POLITICAL AUTHORITIES

The epidemic of HIV infection is progressing across the world, as was highlighted by the CNS in documents relating both to the epidemic in mainland France and in developing countries. Although drugs are extending people's lives, the number of new infections is by no means on the wane. The political leaders in these departments therefore need to look at this epidemic over the long term and distance themselves from the most distorted portrayals of the dynamics of the epidemic. The involvement of political leaders is essential in the battle against the epidemic, since it will safeguard the successful implementation of approved political plans. Nevertheless, first and foremost, the involvement of leaders encourages debate about the epidemic, the use of screening and thus prevention.

OUT OF SYNCH IDEAS ABOUT THE EPIDEMIC

All too often, ideas among local key players still appear out of synch, and in some cases unacceptable, in relation to the present understanding of the epidemic and international strategies to combat it. Given the number of foreigners in the active file population, people see the influx of migrants as the primary cause of the HIV epidemic. The resulting debate over the fight against illegal immigration helps nurture denial of the epidemic to the detriment of a response adapted to a process linked to the country's history and geography, and one that would involve regional cooperation.

The appreciation of the situation varies, depending on the professionals involved, and this unequal understanding generates very different actions. All of the professionals involved admit the severity of the situation and recognise that it has got worse since the report by the CNS in 2003. The outlook for the short-term future is not an optimistic one. This realist approach sometimes takes the form of relativism that is all the more assumed since it is based on a view situated between culturalism and ostracism. For some, some practices cannot be changed. For others, the problem is more about the impossibility of controlling immigration, with the underlying belief that HIV in French Guyana is a problem linked to immigration in the first place, especially the illegal kind.

As outlined above, opinions in French Guyana can sometimes be out of synch with each other, depending on whether those expressing an opinion are care providers in hospitals, private practice physicians or political leaders. These competing opinions reveal the insufficient involvement of political leaders, who are content with rapid explanations. Immigration feeds the incorrect ideas about the epidemic, which do not take into account the economic reasons and the urge to find safety. Population movements, just like pregnancies, would be planned according to the legislation granting foreigners residence permits or the access to healthcare, and not according to the need to survive. The situation of children would be dramatic; there is a large number of AIDS orphans and children infected with HIV, but this description does not stand up to an examination of the data.

THE NEED FOR REALISTIC DEBATE ON THE EPIDEMIC AND THE RESOURCES AVAILABLE

The epidemic in French Guyana is unusual for France, but perfectly normal in this part of America and the Caribbean. Although prevalence rates are high, the number of people receiving treatment and care is within the reach of a wealthy state and is not a burden. The growth of the epidemic is a fact relating to the transmission of the virus, not to movements of the population. The epidemic will be controlled by preventing transmission, not controlling migratory traffic.

Often, the more generalised problems of a country "abandoned" by mainland France, one that has been "left to fend for itself", are set forth. It is true that France is facing difficulties in French Guyana, and that this situation should produce specific responses with policies that will help the country to catch up. Nevertheless, it must also be stressed that this would too easily lead certain players, especially those in the local authorities, to legitimise the current situation.

It is acknowledged, and this includes for an understanding of the situation in mainland France, that HIV is not something that can be reduced to a public health issue, but also has implications for society. This societal aspect of the disease is extremely pronounced in French Guyana, where it is undoubtedly more difficult than elsewhere, despite the objective severity of the situation, to make the population and political and administrative leaders recognise that HIV needs to be a priority. The proportion of the population affected at the same time by other problems is very high, which means that HIV issue is put in perspective.

Unlike the suggestions put forward, local authorities have the skills needed that allow them to contribute to the fight against HIV, with the implementation of their basic expertise in the field of healthcare and social welfare, but also by using the flexibilities that they have been accorded by the law of August 2004. It is true that the actions implemented to date (aerodrome, roads, schools, prevention for mother and child welfare services) are helping in the fight against the epidemic. The commitment to healthcare is also being seen in the work of the office of the National Healthcare Conference on the regional healthcare programme and the programme initiated by the French Guyana Regional Health Observatory (ORSG). Other actions may be considered, such as the development of shared projects with administrative bodies, the recruitment of social workers and the continuation of efforts to educate a very young population. Most of all, the establishment of an education and health promotion resources centre that can reinforce the skills of healthcare providers represents a real, practical means of intervention. The investment of local authorities in this resources centre needs to be assured over the long term.

WORD FROM THE KEY PLAYERS: THE VITAL LEVER IN THE FIGHT AGAINST THE EPIDEMIC

The expansion of the areas of intervention by local authorities in healthcare may be subject of discussion. Nevertheless, the responsibility of key political and social players is not an issue for debate. The main hurdles to screening, follow-up, treatment and care and prevention remain ignorance, rejection and denial. Public proclamations against stigmatisation and denial of the disease are essential, and do not cost much. Local political figures need to set the example: They cannot shirk their responsibility by citing a lack of commitment from national leaders. This problem has already been highlighted by the CNS[46]. The political reasoning behind this debate also needs to be embedded in the region, a process which can only be legitimised by the Guyanese themselves. Each player can affiliate themselves with certain areas of intervention. Churches, for example, can support the care of the sick and the fight against stigmatisation. Debate regarding prevention and the use of condoms can be promoted by other representatives.

The involvement of leaders, politicians, representatives of the state, religious figures and representatives of associations is crucial for the opening-up of public debate to encourage positive attitudes in the fight against the epidemic. One of the tools that encourages prevention is the permission to broadcast messages about prevention. People must also be allowed to believe that finding out that they are HIV positive does not mean they will face a life of discrimination.

2.2 THE UNDER-EXPLOITED OPPORTUNITIES OF REGIONAL COOPERATION IN HEALTHCARE

The opportunities for cooperation between French Guyana, its border countries and the countries of the Caribbean are under-exploited and their usefulness probably under-estimated. Despite numerous reiterations of the reciprocal benefits that such agreements could generate, regional cooperation from French Guyana in the fight against HIV appears to be poor. This cooperation could help improve the response to the epidemic and increase the quality of care and treatment both in French Guyana and in neighbouring countries. The regional context supports migration towards the two departments under consideration, which impacts on the profile of the epidemic and the provision of medical treatment and care[47]. At regional level, exchanges are still new; the first Caribbean conference on the fight against AIDS only took place in March 2004[48].

2.2.1 THE OBSTACLES TO DEVELOPMENT OF COOPERATION IN HEALTHCARE

Despite existing actions and the resources available, the policy of cooperation in public health remains under-developed and faltering, due to a lack of clear plans on the strategies that need to be deployed in such a complex environment. There needs to be coordination between French public and private figures, be they local or metropolitan, a clarification of expectations and the development of a multi-layered strategy with partner countries. This development will undeniably present a significant challenge, given that exchanges between French Guyana and the countries of South America are very under-developed.

A COMPLEX ENVIRONMENT

The framework in which any cooperation that would benefit French Guyana and its neighbours would operate is particularly complex. The issues of the cooperation are not the same for the entire region, clashing with other public policies – in particular those relating to the control of immigration and security policies in response to illegal goldwashing, for example. French Guyana can be divided up into three regions, each one of them representing a line of cooperation. The heart of French Guyana, with Cayenne and its neighbouring villages, is home to a strong population of Caribbean origin, mainly Haitian. The west of French Guyana, fairly appropriately named "grand ouest guyanais", maintains strong relations both with neighbouring Surinam and Guyana itself. The lack of any administrative border on the river is clearly apparent. At the same time, the presence of an interior border set up by the police control point in Iracoubo, halfway between Saint-Laurent-du-Maroni and Cayenne, is equally apparent. Ultimately, the eastern sector of the department, which borders with Brazil, is France's longest terrestrial frontier and remains impassable without a canoe. A bridge is soon to be built, however.

The institutional and financial environment is also varied. The responsibilities of the various political authorities able to operate in the territory, namely the state, the local authorities and the French development agency, intertwine. The choices of these players need to be able to be coordinated or linked, while at the same time considering the contribution to these choices or the specific actions of private figures such as associations or the Pasteur Institute. Since the act laying down the basic principles for government action in the overseas departments in 2000, the local authorities have been able to exercise skills relating to cooperation that go beyond the decentralised cooperation of the authorities in mainland France. As parliamentarians point out, these skills are under-utilised[49]. The

[46] Report on Public Policy for HIV Prevention in Mainland France, 17 November 2005.

[47] For more details on population movements in Guyana, see the report by the CNS entitled "Rethinking the response to HIV/AIDS in the French overseas departments", 11 March 2003, p. 64 et seq.

[48] Mulot S, La première conférence caribéenne de lutte contre le sida, Transcriptase, No.116, June/July 2004.

[49] Rapport de la commission d'enquête sur l'immigration clandestine, Senate, No. 300, 7 April 2006, p. 128.

current scene of French cooperation policy, which is geared towards co-development and an increased presence on the part of the French development agency, must help to find solutions to the epidemic in Guyana. The cooperation of the state in matters relating to HIV in the region is long-standing, and needs to be taken into account. Until 2006, it funded the presence of a French expert at the Caribbean Epidemiology Centre (Carec). The outlook from 2008 onwards is based on the development of relationships between the Pan-American Health Organisation (PAHO, the regional branch of the WHO) and the FDAs thanks to the presence of a French technical assistant.

The funding available reflects the diversity of the partners in the cooperation agreement. The regional cooperation funds, which management is the responsibility of *Préfets*, represent financial resources to promote regional cooperation. They can be used for actions in the healthcare sector. However, these funds are not dedicated, and programmes in the healthcare sector are rare. Given this situation, it would seem necessary for strategic plans to be drawn up on the use of these funds, ideally in a way that is shared with the other French Departments of America. Moreover, the ministry in charge of the overseas departments has a support budget for community projects in the healthcare and social welfare sector. Despite its minimal amount and the diversity of the projects that are supported[50], it has allowed associations to increase their capacities. International organisations can make their own contributions, like the PAHO which gives money to the FDAs for healthcare projects. European financing is available for cross-border projects, and is principally used for Pancap projects. The European Union, as backer, can play an important role via the Interreg funds that support transnational cooperation, with specific adaptation for the FDAs, since the funds can be used in these departments in projects with countries that are not members of the EU.

AN UNEASY AND FALTERING COOPERATION

Local figures are implementing partnerships that can appear to be cooperation actions. The healthcare facilitators from Saint-Laurent-du-Maroni work on both sides of the river. Doctors in Cayenne and Saint-Laurent-du-Maroni work with their colleagues from Surinam. Medical emergencies from neighbouring countries are sometimes treated in French Guyana. Therefore, cooperation is a reality. Given the sometimes very close links between populations in neighbouring countries and French Guyana, a vision of the various forms of cooperation is needed that is at the same time realistic and adapted to the needs of the region.

Two types of cooperation have developed over time and need to be affirmed: A cooperation agreement with Caribbean countries for migrants of these countries, and a cross-border cooperation agreement with Surinam and Brazil. Bearing in mind the universal access to treatment in Brazil, it is easy to fall into the trap of thinking, wrongly, that Brazilians do not have any need to enter French territory. The reality of access to medications in Brazil depends greatly on the regions and distances to care. Apama is not a state where treatment is easily accessible for people who live on the border with France. It is much easier for people living on the Brazilian border to come into French territory than to cross the hundreds of kilometres between their homes and the nearest care centres. Moreover, cooperation with the federated states is complex. Apama has better healthcare facilities than Brasilia, and the French state primarily maintains relations with the federal capital. Cooperation between France and Brazil aimed at improving the management of the epidemic in the border area requires working with the federated state of Apama and the federal state of Brazil. On a more local level, the links need to be created with the authorities of towns where the residents of French Guyana spend weekends.

The civil war in Surinam during the 1980s has led to the regional capital abandoning the region around the Maroni river. This phase appears to be drawing to a close, but the existing health care delivery is still feeling the effects of this disaffectation. Given how easy it is to travel between the two banks, the homogeneity of the population and the difference between the health care delivery in Surinam and the quality of the hospital in Saint-Laurent-du-Maroni, it is fairly natural that residents of Surinam should use the services of the French city. Surinam receives funding via the framework of the Global Fund, which should change the conditions for implementing the treatment and prevention programme. France must be able to get involved with the responses supported by the Global Fund. Part of the cooperation needs to take the form of regular, daily work by integrating the division of the region between administrative and geographic borders. This is more a matter relating to the treatment and care of foreign citizens in the framework of an agreement established between France and its neighbours. Relationships with the islands of the Caribbean are necessarily different; the to-ing and fro-ing of populations between France and their countries of origin is not subject to the logic that applies with bordering countries. The cooperation will help improve the health care delivery in these countries. However, migration is not an occasional phenomenon and it is doubtful that any decent health care delivery would put an end to migration from Haiti, for example. A cooperation agreement to improve the quality of the treatment and care of migrant populations in French Guyana therefore needs to be developed, in the same vein as actions that have already been initiated. The challenge is to make the bringing-in of expertise as regards community action and its possible transfer to other groups of the population a long-term phenomenon.

2.2.2 COOPERATION WITH MULTIPLE OBJECTIVES

The epidemic in French Guyana reflects the epidemiological situation in the northern part of South America and the Caribbean. The cooperation agreement must allow French Guyana and its representatives to be integrated into the management of the regional response. It is also the ideal opportunity to offer neighbouring countries expertise that they may need, but it should also be regarded

[50] The sum of the budget was Euro 44,000 in 2006 and Euro 67,000 in 2007, around 20% of which goes to projects in the healthcare sector.

as a solution to make up for deficiencies in French Guyana. The cooperation agreement should therefore be considered as a wider advantage.

INVOLVING FRENCH GUYANA IN THE REGIONAL POLICY FOR THE FIGHT AGAINST THE EPIDEMIC

French Guyana does not appear as an individual country in the data produced by UNAIDS since it is a French department. This invisibility of the department in the Caribbean epidemic maintains the false idea of an unusual epidemic. Nevertheless, the steering of the response from France makes the local, fairly commonplace characteristics appear exceptional.

The involvement of French Guyana in the regional response to the epidemic must allow ideas to be developed relating to population migration. The question of immigration is raised very directly when the issue of the epidemic is broached. The development of relationships with neighbouring countries raises numerous fears, such as the building of the bridge on the Oyapoc to facilitate exchange with the state of Apama in Brazil. This building project is considered either as a factor conducive to the influx of immigrants or as a gateway for drugs[51]. A strategy of regional cooperation on HIV therefore needs to be developed in order to overcome the problems encountered by immigrants and thus to improve their treatment and care in French Guyana.

The cooperation must allow the response between the different levels of intervention – be they local, regional or multilateral - to be made more coherent. The presence within the Pan-American Health Organisation of a French technical assistant whose role includes the development of relationships with the FDAs is therefore crucial. The development of local micro-responses must receive greater cohesion with the wider response on the Caribbean scale. The coherence of the French system between the Ministry of Foreign and European Affairs, which is in charge of the multi-lateral aspect and the AFD, which is in charge of the bilateral aspect, needs to be clarified for local figures. The strategy does not have to be defined solely to deal with the Caribbean issue, but it should also serve the interests of the French response in Guyana.

IMPROVING TREATMENT AND CARE IN FRENCH GUYANA AND THE WIDER REGION

France is able to contribute its expertise in the provision of medical treatment and care, but in terms of prevention and screening, the practices in place in Caribbean countries represent a resource that needs to be exploited further. This bilateral cooperation must allow the provision of health care delivery and treatment and care in French Guyana and the Caribbean to be improved, and also help provide practical responses to the epidemic. The appeal of France results from the quality of the health care delivery and the effective presence of doctors, while the cooperation agreement must help improve the health care delivery in border countries. The increased presence of the Red Cross could represent one solution. Support for keeping medical staff in the area could also take the form of financial reward. The CDAG centre established in Albina is useless if it is unable to offer treatment and care following screening.

The cooperation agreement is also intended to improve expertise in community healthcare. Support for the strengthening of associations is effectively in place thanks to the Pancap project. This project is particularly well-rounded, but this exhaustiveness also presents a difficulty since it makes identifying strategic lines of action difficult. Support for the stepping-up of expertise and community healthcare techniques requires support for the cooperation agreement between the associations within the FDAs. This coordination between the French Departments of America with regard to cooperation appears to be vital. The Corevih organisations can play a role in which exchanges are stepped up. The issue is to assure long-term investments in associations by retaining peer counsellors or supporting cooperation actions across the river. The support of French cooperation services will allow the Guyanese political authorities to be steered towards the better appropriation of these issues and of the skills that have been bestowed upon them.

While France is getting ready to take over the presidency of the European Union, the issue of the regional cooperation agreement for Guyana and France is also an issue of coherence with the policy of the European Union both at the level of far-outlying regions and in the fight against HIV. The plan of action for the "*grand voisinage*" allows the dispensation of territorial rules of eligibility in order to use funds geared towards promoting transnational cooperation and now receives support from European institutions to help boost it[52]. The European Commission does not always include countries that adjoin French Guyana in the fight against HIV[53]. However, the regional cooperation agreement with the Caribbean is envisaged with support for the Global Fund and healthcare cooperation in the region[54]. All of the representatives involved with the regional cooperation agreement must also be able to get involved in the

[51] Emerging phenomena linked to drugs in 2004, recent trends in Guyana, November 2005, French monitoring centre for drugs and drug addiction.

[52] Commission Communication, A stronger partnership for the outermost regions, COM(2004) 343, p. 8. European Parliament, Committee on Regional Development, Report on a stronger partnership for the outermost regions, A6-0246/2005. Commission Communication, Strategy for the outermost regions: achievements and future prospects COM (2007) 507, p. 7.

[53] Commission Communication to the Council and European Parliament on the fight against HIV/AIDS in the European Union and neighbouring countries 2006-2009, COM(205) 654, p. 12. The countries involved are: Algeria, Armenia, Azerbaijan, Belarus, Egypt, Georgia, Israel, Jordan, Lebanon, Libya, Moldova, Morocco, Palestine, Syria, Tunisia and Ukraine.

[54] Commission Communication to the Council, European Parliament and the European Economic and Social Committee, An EU-Caribbean partnership for growth, stability and development, COM(2006) 86, p. 10.

framework of policies from the Union by bringing together European efforts for overseas regions and those fighting the epidemic of HIV infection.

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APPENDICES

ACRONYMS

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

ACT: Appartements de coordination thérapeutique (Therapeutic coordination apartments)

AME: Aide médicale d'Etat (State medical aid)

ARH: Agence régionale d'hospitalisation (Regional hospitalisation agency)

Carec: Centre caribéen d'épidémiologie (Caribbean epidemiology centre)

Cdag: Consultation de dépistage anonyme et gratuit (Anonymous and free screening centre)

CMU: Couverture maladie universelle (Universal healthcare coverage)

Comede: Comité médical pour les exilés (Medical committee for exiles)

Corevih: Coordination régionale de lutte contre l'infection due au virus de l'immunodéficience humaine (Regional steering committee for the fight against the human immunodeficiency virus infection)

Crips: Centre régional d'information et de prévention du sida (Regional centre for AIDS information and prevention)

Csst: Centres spécialisés de soins aux toxicomanes (Drug addiction treatment centre)

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

FDA: French Department of America

DGS: Direction générale de la santé (National Health Directorate)

Dhos: Direction de l'hospitalisation et de l'organisation et des soins (Directorate for hospitalisation and organisation of care)

DO: Déclaration obligatoire (Obligatory declaration)

DOM: Département d'outre mer (French Overseas department)

Dsds: Direction de la santé et du développement social (Directorate of Health and Social Development)

Emips: Equipe mobile d'intervention et de prévention du sida (Mobile AIDS prevention unit)

Fasild: Fonds d'action et de soutien pour l'intégration et la lutte contre les discriminations (Fund to support integration and fight discrimination)

FSE: Fonds de solidarité européen (European solidarity fund)

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

Halde: Haute autorité de lutte contre les discriminations (High authority against discrimination and for equality)

HAS: Haute autorité de santé (French national authority for health)

MSM: Men who have sex with men

Igas: Inspection générale des affaires sociales (General Inspectorate of Social Affairs)

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

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

STI: Sexually-transmitted infection

IVG: Interruption volontaire de grossesse (Elective abortion)

IVS: Institut de veille sanitaire (National Institute for Public Health Surveillance)

KABP: Knowledge, Attitudes, Beliefs and Practices

Lgbt: Lesbian, gay, bi, transgender

Mfpf: Mouvement français pour le planning familial (French movement for family planning)

Mildt: Mission interministérielle de lutte contre la drogue et la toxicomanie (Interministerial mission for the fight against drugs and drug addiction)

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

PAHO: Pan-American Health Organisation

ORS: Observatoire régional de santé (Regional Health Observatory)

Pass: Permanences d'accès aux soins de santé (All-day healthcare centres)

PMI: Prévention maternelle infantile (Prevention for mother and child)

Praps: Programme régional d'accès à la prévention et aux soins (Regional programme for access to prevention and care)

Pripi: Programme régional d'intégration des populations immigrées (Regional programme for the integration of immigrant populations)
PRS: Programme régional de santé (Regional Healthcare Programme)
RMI: Revenu minimum d'insertion (Income support)
SIS: Sida info service (AIDS information service)
Sreps: Schéma régional d'éducation pour la santé (Regional education scheme for healthcare)
Sros: Schéma régional de l'organisation sanitaire (Regional healthcare organisation plan)
Vespa: VIH enquête sur les personnes atteintes (Survey of HIV-infected people)
HIV: Human Immunodeficiency Virus

RECOMMENDATIONS BY THE CONSEIL NATIONAL DU SIDA IN 2003

1. Respect the rights of patients;
2. Fight against denial and stigmatisation;
3. Involvement of the state, local authorities, elected representatives;
4. Promote social integration and rehabilitation;
5. Promote general health education;
6. Adapt messages of prevention and guarantee anonymous and free access to screening;
7. Train professionals in the fight against the epidemic;
8. Improve access to care and health care delivery;
9. Implement a policy of regional cooperation and encourage access to ARTs in neighbouring countries ;
10. Implement a general public health and social care plan in Guyana.

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