EVALUATION OF THE HIV/AIDS PREVENTION STRATEGY IN SWITZERLAND

Abridged version of the seventh synthesis report, 1999-2003

Françoise Dubois-Arber
André Jeannin
Giovanna Meystre-Agustoni
Brenda Spencer
Florence Moreau-Gruet
Hugues Balthasar
Fabienne Benninghoff
Karen Klaue
Fred Paccaud
Study funded by the Swiss Federal Office of Public Health in Bern
Contracts no: 99.001343, 02.000227, 02.000781, 02.000782

Collaboration:
Marie-Jo Glardon
Mary Haour-Knipe
Phí Huynh-Do
Daniel Kübler
Peter Neuenschwander
Yannis Papadopoulos
Margrit Schmid
Barbara So-Barazetti
Ralph Thomas

Acknowledgements
The evaluation was greatly assisted by the outstanding cooperation with the Swiss Federal Office of Public Health in Bern, the excellent work of all the research scientists responsible for the studies and the wonderful support provided by Myriam Maeder, Kirsten Sandberg-Christensen, who work in the Unit for the Evaluation of Prevention Programmes of the UISPM.

We would have nothing to report were it not for the valuable cooperation of the many people who agreed to participate in the various studies – be it amongst the population or those playing a professional role.

Our very warmest thanks to them all.

Suggested citation

Address for corresponding
Institut universitaire de médecine sociale et préventive
Unité d’évaluation de programmes de prévention
Rue du Bugnon 17
1005 Lausanne

Phone 0041 (0) 21 314 72 92
Fax 0041 (0) 21 314 72 44
E-mail uepp@hospvd.ch

Link: http://www.hospvd.ch/iumsp/

Translation
BMP Translations AG, Basle
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Since 1986, the University Institute of Social and Preventive Medicine, Lausanne has monitored Switzerland’s AIDS prevention strategy at the request of the Swiss Federal Office of Public Health. The Institute’s evaluation report for the period 1999-2003 can be accessed on the SFOPH’s web site. The present document is an abridged version of the full report.

It summarises the epidemiological situation in Switzerland, then describes the behaviour of different population groups in relation to HIV/AIDS (protective measures taken and exposure to risk), focusing in turn on the general population, adolescents and young adults, men having sex with other men, drug users, migrants, male and female prostitutes, and persons living with HIV/AIDS.

The document also describes the implementation of the national HIV/AIDS prevention programme, distinguishing between the three levels of intervention: measures intended for the population as a whole; measures aimed at specific target groups, and in-depth measures based on personal interaction.

It concludes with a series of recommendations which advocate maintaining, or even reinforcing, the strategy followed by the SFOPH to date.

1 http://www.bag.admin.ch/coe/studien/aids/e/index.htm or http://www.hospvd.ch/iump
HIV/AIDS prevention strategy in Switzerland

Switzerland’s HIV/AIDS prevention policy has three objectives:
• to prevent new cases of infection;
• to counter the negative consequences for those affected by the epidemic;
• to promote solidarity.

The primary prevention strategy introduced throughout the country in 1986 by the Swiss Federal Office of Public Health (SFOPH) provides for three levels of intervention:
• level I: measures intended to inform and motivate the population as a whole, in particular prevention campaigns, and activities undertaken in schools and targeting all students;
• level II: measures aimed at specific target groups (drug users, homosexuals, etc.), conveying appropriate messages via suitable channels;
• level III: in-depth measures over the longer term, based on personal interaction (counseling, imparting information). These measures depend on persons whose situation or role makes them potential multipliers of prevention messages (doctors, parents, teachers, etc.).

The strategy applies an integration model based on the belief that individuals are able to learn preventive behaviour and can be persuaded to adopt it. This involves passing on information, motivating and helping them to acquire skills, and encouraging them to continue with existing preventive behaviour. The model also requires the existence of an environment favourable to the prevention and management of HIV/AIDS.

The strategy is pragmatic. It recognises the existence of high-risk behaviour, but does not seek to impose solutions. It encourages freedom of choice by pointing out the different means of prevention available and encouraging behaviour that is free from the risk of infection.

The prevention strategy was confirmed and brought up to date with the publication of the 1999-2003 national HIV/AIDS programme. The planning of this programme was the result of
collaboration between the SFOPH and its national [Swiss Aids Federation, Swiss Red Cross, etc.] and regional partners (cantonal authorities, regional representatives of the Swiss AIDS Foundation, etc.).

CONTINUOUS EVALUATION, APPROACH AND METHOD

Since 1986, the University Institute of Social and Preventive Medicine² (IUMSP), Lausanne has monitored Switzerland’s AIDS prevention strategy at the request of the SFOPH. This is an abridged version of the report summarising its evaluation activities for the period 1999-2003.

In carrying out this task, the Institute adopted a global approach to evaluation, taking into account both the process and results of prevention measures, as well as relevant factors in the social environment. The aim is to improve HIV/AIDS-prevention measures by providing information to those responsible for their implementation. The evaluation programme complements the strategy and evolves as new questions emerge. In particular, it seeks to answer the following questions:

- Regarding the results of prevention: Are people better informed and are behavioural changes taking place in the fields targeted by prevention efforts (sexual habits, forms of drug use, quality of counselling, etc.)? Are attitudes of solidarity or fear emerging? Is the epidemiological situation changing? Is prevention having unexpected or unwanted side-effects?
- Regarding the prevention process: What prevention activities have been established? How are they developing? With what difficulties and success? Do they meet the real needs? Are there any gaps in prevention coverage? Is prevention developing at all the intended levels? Are the SFOPH’s partners in the prevention field (cantons, associations, professional groups, multipliers, etc.) working actively and efficiently? Are there elements in place that guarantee the long-term sustainability and quality of the prevention activities?
- Regarding the environment in which prevention activities are taking place: Is the environment favourable to the prevention methods being implemented? What is the relationship between the setting (environment) and the progress of the prevention measures adopted?

² Institut universitaire de médecine sociale et préventive de Lausanne.
The evaluation programme consists of a series of successive phases. Each phase comprises a number of complementary studies, some of which are repeated regularly, while others look at new fields or adopt a new approach to a field which has previously been reviewed.

During the 1999-2003 phase of the evaluation programme, the following areas received priority attention:

- On-going monitoring of behaviour in the general population and among young people, homosexuals and drug users; on-going monitoring of condom sales;
- Analysis of the implementation of the programme at all three levels:
  - Level I: The STOP AIDS campaign and sex education measures in schools;
  - Level II: The gathering of information on measures targeting specific groups, in particular men having sex with men (MSMs), male and female prostitutes, drug users, young people at risk, migrants and persons living with HIV/AIDS;
  - Level III: The emphasis was on evaluating prevention by primary care physicians (investigation of the sustainability and institutionalisation of counselling activity of this kind in the daily practice of medicine).
RESULTS OF THE PREVENTION STRATEGY: SITUATION AT THE END OF 2002

EPIDEMIOLOGY

The SFOPH’s monitoring of the epidemiological situation shows that new cases of AIDS and of AIDS-related deaths increased until the mid-1990s. Subsequently, the number of cases decreased and fewer than 200 new cases of AIDS were recorded in 2002. Since 2000, deaths seem to have stabilised at around 100 to 120 a year. These decreases are attributed mainly to highly active antiretroviral treatments (HAART).

The figures for persons testing HIV positive exhibit a different trend (Figure 1). After a peak in 1991, there was a steady decline until the end of the 1990s, though the decline slowed towards the end of this period. Since then, the trend has gone into reverse. There was an increase of 8% between 2000 and 2001, and of 25% between 2001 and 2002. This applies to the whole of Switzerland, though the large urban areas are more seriously affected.

The principal characteristics of the population testing HIV positive can be summed up as follows:

- Heterosexual relations have been the main mode of transmission since 1991.
- Taking into account the size of the population groups concerned, infections resulting from homosexual contacts and drug injecting are nonetheless proportionally more common.
- The increase recorded in 2002 applied to both modes of sexual transmission (heterosexual and homosexual/bisexual).
- Homosexual transmission concerns primarily persons of Swiss nationality.
- The observed increase in cases of heterosexual transmission concerns mainly persons of sub-Saharan African origin. This tendency is particularly pronounced among women.
- In recent years, more than 60% of the men and 40% of the women infected by heterosexual contact have been diagnosed at a very late stage as having AIDS, their condition being discovered only when they underwent the test. This is also true of over 40% of the men infected by homosexual contact.

THE GENERAL POPULATION

Since 1987, a periodic telephone survey (EPSS) of the population resident in Switzerland aged between 17 and 45 has been used to monitor changes in sexual behaviour in relation to HIV/AIDS. The most recent survey was conducted in 2000.
HIV/AIDS prevention did not seem to have had any major effect on indicators of sexual activity such as number of partners and relations with prostitutes.

- The median number of lifetime sexual partners was stable in the different age groups, for both men and women.
- Stability was also reflected in the number of respondents reporting casual sexual relationships during the previous six months (Figure 2, lower line) and reporting a new steady partner in the course of the year (Figure 3, lower line).
- The figure for recourse to prostitutes was stable: 2% of men aged 17 to 45 had paid for sex during the previous six months.

On the other hand, there was an appreciable increase in the systematic use of condoms over the period as a whole.

- The increase applied to both relations with casual partners and relations with steady partners (Figure 2 and Figure 3).
- Young people adopted protective measures more readily than members of the older age group (Figure 2 and Figure 3).
- Men were more likely to adopt protective measures than women. Nevertheless, young women were more likely than their male counterparts to adopt systematic prevention measures in steady relationships.

As compared with the previous period (the late 1990s), developments in the use of protective measures appeared to be mixed. The general trend seemed to be one of stability, or perhaps a slight decrease.
Figure 2

Proportion of respondents reporting relations with one or more casual partners during the six months prior to the survey, and whether or not condoms were used in these situations, for the 17-30 age group (1987-2000) and the 31-45 age group (1989-2000)

% with casual partner

% always with condom

IUMSP/UEPP
Figure 3
Proportion of respondents reporting a new steady partner in the year prior to the survey, and whether or not condoms were used with this partner, for the 17-30 age group (1987-2000) and the 31-45 age group (1989-2000)

Increased use of condoms over the period as a whole and a recent stabilisation in their use are confirmed by statistics for condom sales, with figures up from 7.6 million in 1986 to 18.1 million in 2002 (Figure 4).
Figure 4
Condom sales in Switzerland (these figures are estimated to account for over 80% of the market)

Millions of condoms sold

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<td>Sales</td>
<td>7.6</td>
<td>11.7</td>
<td>10.5</td>
<td>13.4</td>
<td>12.7</td>
<td>13.8</td>
<td>15.0</td>
<td>15.1</td>
<td>15.8</td>
<td>16.1</td>
<td>16.7</td>
<td>16.6</td>
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<td>16.2</td>
<td>16.7</td>
<td>17.2</td>
<td>18.1</td>
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Protective strategies in steady relationships

Most of the respondents who reported having had a steady partner in the two years prior to the 2000 edition of the EPSS\(^1\) (70%) opted to use a condom when they first had sexual relations with the person concerned.

Of those who used a condom when first having sexual relations with this steady partner:
- 52% continued to use condoms subsequently.
- 17% stopped using condoms after taking the HIV test.
- 21% consulted with their partner and assessed the risks they had run previously, before they stopped using condoms.
- 9% stopped using condoms without having considered their past history or taking the HIV test; a further 2% took some other course of action or were not willing to answer the question.

Of those who did not use a condom when they first had sexual relations with this partner, approximately three-quarters continued to abstain from using one.

HIV TEST

Between 1992 and 2000, the proportion of respondents who had been tested at least once during their life increased from 23% to 38% in the 17-30 age group and from 23% to 46% among 31-45 year olds. However, the rate of increase is tending to level out.

If we also take into account tests performed when people give blood, 63% of the 17-45 age group had been tested at least once prior to 2001.

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\(^1\) A special module intended for persons who had had a steady partner in the two years preceding the survey.
ADOLESCENTS AND YOUNG ADULTS (17-20 YEAR OLDS)

The proportion of young people sexually active at the age of 17 seems to have resumed its long-standing upward trend after an interruption. Girls tend to become sexually active slightly later than boys (50% of girls and 58% of boys said they were sexually active at the age of 17).

After decreasing between 1987 and 1997, the number of partners is tending to increase again among 17-20 year olds, though the median continues to be one. In 2000, 31% of the respondents reported having had three or more lifetime partners (24% in 1997).

Condom use remains high among young people. In 2000, 69% of 17-20 year olds reporting a new steady relationship had used condoms (Figure 5). 76% of young people reported systematic use of condoms with casual partners (Figure 6). When they last had sex, 59% of adolescents had used a condom (61% in 1997). Of these, only 2% had had experience of a condom breaking or slipping off (6% in 1997).

The survey of adolescent health in Switzerland (SMASH) – conducted in 1993 and 2002 – confirms the stability of condom use among young people. There has been practically no change in this respect between the two surveys, regardless of the age and sex of the respondents.

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4 This represents a slight decrease on the 1997 figure, which seems to have been extreme.

Figure 5
Proportion of young people (aged 17-20) reporting a new steady partner in the previous 12 months, and whether or not they used condoms with this partner (1988-2000)
Figure 6
Proportion of young people (aged 17-20) reporting having had sexual relations with one or more casual partners in the previous 6 months, and whether or not they used condoms in these situations (1987-2000)

Homosexuals/bisexuals are treated as a separate segment of the population of young adults. The beginning of their sexual career is completely different from the more traditional ways in which young people become sexually active. Most of them live in settings where HIV is particularly prevalent (among homosexuals), and have not necessarily benefited from adequate prevention measures. Moreover, among young homosexuals/bisexuals, the risk of infection is compounded by psychological and social problems directly linked to their social and family backgrounds. These problems may give rise to a significant risk of suicide. Schools have a vital role to play in this area, by putting these young people in contact, at the earliest possible
stage, with resources which will enable them to manage the risk of contracting HIV and overcome the family and social difficulties they have to contend with.

**MEN HAVING SEXUAL RELATIONS WITH OTHER MEN (MSMs)**

There have been six IUMSP surveys (1987, 1990-92-94-97, 2000) monitoring the preventive behaviour adopted by MSMs. In each case, questionnaires were distributed through the gay press and gay organisations.

**Sexuality**

Some aspects of sexuality in MSMs have not changed since the early 1990s.

- They tend to have a large number of partners: until 1990, the median reported number of partners for the previous twelve months was in the 2-5 category; it then rose to 6-10 and has remained constant at that level since 1992. Three quarters of the respondents had had more than one partner in the twelve months prior to the survey, and one third had had more than ten.
- More than 80% of the respondents reported having sexual relations with casual partners during the twelve months prior to the survey. This proportion remained constant between 1992 and 2000.
- They tend to have sex frequently (though the reported level is constant): several times a week for one third of the respondents.
- HIV-positive respondents tend to be more active sexually than those who are HIV negative or have not been tested. In 2000, half of the HIV-positive MSMs (51%) reported more than ten partners during the twelve months prior to the survey (as against 37% of those who were HIV-negative and 23% of those who had not been tested).

On the other hand, lifestyles and sexual practices have changed appreciably, showing an upward trend culminating in 1997.

- The proportion of respondents with a steady partner had increased: from 46% in 1987 to 72% in 2000. However, nearly half of these steady relationships were non-exclusive.
- The proportion of respondents who had practised anal penetration with casual partners

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during the twelve months prior to the survey increased from almost 60% in 1992 and 1994 to almost 70% in 1997 and 2000. However, in relations with steady partners the proportion had remained constant (at around 75%).

- There had been an increase in the frequention of meeting places and pick-up spots. In 2000, 53% of the respondents said they frequented saunas (as compared with 30% in 1987, 53% in 1997), while 37% met partners in parks (as against 24% and 41% respectively) and 26% in public toilets (as against 18% and 27%).

Preventive behaviour and exposure to risk

The incidence of preventive behaviour was measured using two indicators: use of condoms when practising anal penetration and whether or not semen was received into the mouth during fellatio, in the twelve months prior to the survey.

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7 Since 1992, the data have been analysed according to type of partner (steady versus casual).
Figure 7
MSMs: preventive behaviour adopted in the previous twelve months with casual partners (1992-2000)

- No penetration
- Penetration, always with condom
- Penetration, sometimes/never
A significant majority of the respondents also practised “safer sex”, either by abstaining from potentially risky practices, or by always using condoms (Figure 7 and Figure 8). Protective behaviour was most strictly adopted in relations with casual partners: more than 80% of MSMs took no risks when having sex with partners of this type (Figure 7).

However, whatever the choice of prevention method, the level of protection decreased during the period 1994-2000.

- The proportion of respondents who practised anal penetration with casual partners and did not always take protective measures increased from 10% in 1994 to 19% in 2000. More-
over, in 2000, 10% of the respondents said they practised unprotected anal penetration but withdrew before ejaculation as a means of protection.

- The decline in protective behaviour was more noticeable among older respondents.
- Laxity in taking protective measures was particularly evident among respondents who frequented places such as saunas and “backrooms” where sexual encounters take place, or parks and public toilets. The proportion of clients of gay saunas who reported not always using condoms during anal penetration increased from 13% in 1997 to 21% in 2000.
- In relations between steady partners, the range of sexual activities was generally wider and protective measures were less systematically adopted than with casual partners. There had also been a slight decrease in the practice of “safer sex”, beginning in the mid-1990s. However, in most cases, this was due to the fact that both partners knew they were HIV-negative (Figure 8).

Where homosexual couples were concerned, the 1994 survey had shown that 41% of those practising anal penetration were not aware of their HIV status, either because one or both partners had not been tested, or because one member of the couple did not know if his partner had undergone the screening test. The proportion of couples of unknown HIV status had decreased (31% en 2000). Systematic protection using condoms in this situation had improved only slightly (1994: 52%; 2000: 58%).

The preventive behaviour of respondents who were HIV-positive differed appreciably from that of HIV-negative or untested respondents.

- HIV-positive respondents were more likely to have unprotected sex with casual partners than were their HIV-negative or untested counterparts. In 2000, 32% had practised anal penetration without a condom in the twelve months prior to the survey, while the corresponding figures for HIV-negative and untested respondents were 17% and 15% respectively (Figure 9).
- Figure 10, which takes into account only the HIV status of respondents, shows that HIV-positive homosexuals were less likely to practise unprotected anal penetration with their steady partner than their HIV-negative or untested counterparts.
- In the case of HIV-positive respondents, it was evident that unprotected behaviour had tended to increase between 1997 and 2000, regardless of the type of partner with whom they were involved.
Figure 9
MSMs: practice of anal penetration with causal partners without always using a condom, according to the HIV status of the respondent (%)

- untested
- HIV-negative
- HIV-positive
Knowledge and opinions about antiretroviral treatments and post-exposure prophylaxis

There has been an improvement in knowledge about the highly active antiretroviral treatments (HAART). The proportion of respondents who had not heard of them decreased from 25% in 1997 to 15% in 2000. In 2000, 54% of the respondents considered themselves to be well informed in respect of these treatments, while 31% knew of their existence but felt they were poorly informed.
Where post-exposure prophylaxis (PEP) was concerned, only one quarter of the respondents considered themselves to be well informed in 2000, while 45% had never heard of PEP and almost 30% had heard of it but felt they were poorly informed.

An appreciable change in homosexuals’ perceptions of HIV/AIDS occurred between 1997 and 2000, with a large discrepancy between their own behaviour and the behaviour they attributed to others.

- In 2000, 58% thought that, because of the new treatment possibilities, MSMs were less strict about prevention (as compared with 34% in 1997).
- In 2000, 7% thought that they themselves were less strict about prevention because of the new treatment possibilities (as against 5% in 1997).

Use of the screening test and the prevalence of HIV

The proportion of MSMs who have been tested has increased from survey to survey, reaching 80% in 2000. However, there has been an increase in the proportion of respondents with no recent information as to their HIV status: in 2000, 52% of the respondents had been screened in the twelve months prior to the survey, as against 62% in 1994.

In 2000, the reported prevalence of HIV was 2% among those under 30, and 12% among the over-30s.

Dependent drug users

This information has been gathered from the national surveys of users of low-threshold facilities (LTFs)\(^8\) (1993, 1994, 1996, 2000) and from surveys of users of injection rooms in Geneva and Biel (2002).

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\(^8\) These facilities distribute sterile injection equipment and provide other social and health services intended to safeguard the health of drug users who are not ready to undertake a course of treatment or who have suffered a relapse.
Changes in drug use

The information pertaining to LTF users reveals that:

- most inject drugs, though the proportion of LTF attenders who inject drugs is decreasing (85% in 1993, 79% in 2000);
- multiple drug use is very common (approximately 70%);
- heroin is still the substance most regularly used (several times a week for half of the respondents);
- there seems to have been a decrease in the average number of injections per week (19 in 1994, 14 in 2000);
- the number of persons who began injecting drugs recently (in the previous two years) is in decline (30% in 1993, 7% in 2000);
- the number of users undergoing methadone maintenance therapy is increasing (35% in 1993, 56% in 2000).

Exposure to HIV and protective behaviour

In the six months prior to the survey, the proportion of users who had injected drugs with a syringe/needle that had already been used by someone else was relatively low, though the figure seems to have increased slightly in recent years. However, the sharing of injection paraphernalia (the equipment used to prepare the injection) was common (Table 1). This could explain the high level of hepatitis C infection.

Table 1
Risk-taking and protective behaviour, LTF attenders in Switzerland: 1993 to 2000 (%)

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</tr>
<tr>
<td><strong>Sharing of syringe / needle</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>lifetimea</strong></td>
<td>40</td>
<td>* 37</td>
<td>44</td>
<td>45</td>
</tr>
<tr>
<td><strong>during previous 6 monthsb</strong></td>
<td>17</td>
<td>9</td>
<td>11</td>
<td>12</td>
</tr>
</tbody>
</table>

* The difference is not statistically significant.
Table 2
Sexual risk-taking and protective behaviour, LTF attenders in Switzerland: 1993 to 2000 (%)
There has not been any significant change in protective behaviour in sexual relations over the last few years. In 2000, more than two thirds of drug users reported that they always used condoms when having sex with casual partners. In relations with steady partners, protective behaviour was inadequate: just under a third always took protective measures. Moreover, in half of these cases, the steady partner was not a drug user (Table 2).

There seems to have been a decrease in the proportion of women who had resorted to prostitution in the six months prior to the survey. The rate of use of condoms with clients had decreased slightly but was still very high (83% always used a condom in 2000). Proportionally fewer men resorted to prostitution and those who did so were far less likely to protect themselves (Table 2).

Protective behaviour in sexual relations varied according to type of partner. Protective measures were more likely to be taken in relations with casual partners than with a steady one (Table 2). The level of protection also varied in relation to HIV status: far more HIV-positive drug users took protective measures when having sex with their steady partner than did HIV-negative users. The same difference was apparent in casual relationships, though less pronounced. On the other hand, there was a clear lack of protective behaviour in relations

10 It is worth noting that, for both HIV-positive and HIV-negative drug users, the rate of protection with a steady partner was not significantly different, regardless of whether or not the partner was a drug user.
between female drug users who engaged in prostitution\textsuperscript{11} and their clients: only half of them used condoms when having sex for money\textsuperscript{12}. However, this was not true of HIV-negative female drug users, who tended to make even more systematic use of condoms when engaging in prostitution.

The prevalence of HIV and forms of hepatitis

Almost all LTF attenders (94\%) had been tested for HIV at least once (70\% of them during the year preceding the most recent survey) and three quarters (77\%) for hepatitis C:

\begin{itemize}
  \item 11\% reported that they were HIV-positive; the prevalence of HIV has been stable since 1993 (at around 10\%), but it varies from city to city.
  \item 59\% reported that they were HCV positive; the prevalence of hepatitis C was higher among drug users who also had HIV than among those not infected with the virus (87\% and 55\% respectively).
\end{itemize}

\textbf{MALE AND FEMALE PROSTITUTES}

Information concerning prostitution in Europe was gathered as part of a review of the existing literature. Given the distinctly international character of the phenomenon, this information may also shed light on the situation in Switzerland:

\begin{itemize}
  \item Protection rates in the context of professional relationships vary appreciably. They are influenced by the extent to which sex workers are in a position to negotiate, which itself depends on their communication skills and the conditions in which they conduct their business (i.e. the extent to which it is tolerated). Protective behaviour was generally good among female prostitutes (surveys show rates of between 33\% and 100\% for systematic use of condoms) and transvestites/transsexuals (between 70\% and 100\%), but poor among male prostitutes.
  \item Protection rates are distinctly lower in the context of sexual relations with non-paying partners.
\end{itemize}

\textsuperscript{11} 67\% of the HIV-positive female drug users and 44\% of their HIV-negative counterparts had resorted to prostitution at some time; 20\% and 18\% respectively had done so in the previous six months.

\textsuperscript{12} Given the small number of HIV-positive female drug users who had engaged in prostitution in the six months prior to the survey, this difference is not significant; it merely represents a tendency.
The prevalence of HIV infection is generally low among female prostitutes. It is appreciably higher among transvestites/transsexuals and among male prostitutes. In all three groups, it is distinctly higher among injecting drug users.

Migrants

No recent quantitative data is available in Switzerland regarding migrants, of whatever group. Emerging evidence of the impact of the HIV/AIDS epidemic on migrants from the countries of sub-Saharan Africa was the occasion for a rapid assessment of their situation, in particular their knowledge and perceptions of the phenomenon. This assessment revealed a great diversity within this group, a range of beliefs regarding sickness in general and HIV/AIDS in particular, and the difficulties inherent in communicating about sexuality and social relationships in relation to sex. It also revealed the fragility of these groups and the risk of stigmatisation to which they are exposed.

Persons Living with HIV/AIDS

There are three surveys providing information about the protective behaviour adopted by people living with HIV:

- the periodic MSM survey, addressed to homosexuals/bisexuals;
- the periodic LTF survey, addressed to drug users attending low-threshold facilities;
- the Swiss HIV Cohort Study (SHCS), which monitors a cohort of persons with HIV, over sixteen years of age, living in Switzerland.

In addition, there have been two qualitative studies which shed light on how people with HIV cope with being infected and with being a possible source of infection to others and on the problems they face in their sex lives and relationships:

- a study of the sexuality of persons living with HIV/AIDS, undertaken in 1997, to determine

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their sexual problems and the way in which they cope with them;

- a study of the secrecy surrounding HIV/AIDS\(^\text{15}\) undertaken in 2001, investigating the reasons given by persons with HIV to explain their reluctance to disclose their HIV status, and the problems involved in managing this secret.

Please refer to la section 0 for matters relating more specifically to men having sex with other men, and to section 0 for those relating to drug users.

The information gathered from persons with HIV who were monitored as part of the SHCS study showed that most patients live an active love and sex life. During the six months prior to completion of the questionnaire, 55% of all the respondents reported having a steady partner, 19% one or more casual partners, and 6% both a steady partner and casual partners. Patients who had been infected heterosexually were slightly more likely to be in a steady relationship than intravenous drug users and MSMs. The latter, on the other hand, were far more likely to have sex with casual partners or partners of both types.

Of all the respondents with or without a partner/partners, four out of five (81%) reported that in the six months prior to the questionnaire they had always taken protective measures when having sex (or had not had sexual relations), while 12% said that they had not taken precautions. The remaining 7% preferred not to answer the question.

The picture of people with HIV that emerges from the two studies is of individuals torn between two contradictory imperatives.

The fact of having HIV generally leads to considerable changes in a person’s self-image. They are determined largely by the way in which society regards HIV/AIDS and people with HIV/ADS. They are often confirmed by the rejection people with HIV suffer from partners (or potential partners). When a person with HIV is seeking to establish or maintain a loving relationship, declaring their seropositivity becomes a very difficult and sensitive issue. Many people with HIV think that the mere fact of insisting on taking protective measures may draw attention to their condition and cut short the incipient relationship. This being the case, refraining from using a condom may be the person’s only way of safeguarding their personal identity and protecting themselves from frustration and accumulated failure in a vital dimension of social life. Moreover, in established couples the abandonment of protective behaviour may

\(^{15}\) Cf. Godenzi et al in the Bibliography.
result from a person’s need to form a closer relationship and the impression that only this kind of “normalisation” of sexual activity (“normalisation” in terms of the dominant social models) will make it possible to establish a binding relationship with their partner.

**SUMMARY OF BEHAVIOUR PATTERNS IN THE DIFFERENT GROUPS**

Table 3 provides a summary of protective behaviour and risk-taking in the different groups, and of trends in new cases of infection.

**Table 3**

<table>
<thead>
<tr>
<th>Population</th>
<th>Rate of protection</th>
<th>Recent changes in protective behaviour</th>
<th>Notes</th>
<th>Recent trends in new cases of HIV (end 2002)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>General population</td>
<td>medium to high</td>
<td>Possible early signs of a decline</td>
<td>No data for migrants Protection with casual partners &gt; steady partner</td>
<td>Protection of young people &gt; older age group</td>
<td></td>
</tr>
<tr>
<td>Young people</td>
<td>high</td>
<td></td>
<td>After decreasing, number of partners tending to increase again</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSMs</td>
<td>high</td>
<td></td>
<td>Protection with casual partners &gt; steady partner; the opposite is true in the case of persons with HIV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug users</td>
<td></td>
<td></td>
<td>Risks associated with unfavourable social circumstances</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male and female</td>
<td>Lack of data</td>
<td></td>
<td>High among female drug users</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prostitutes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persons living with</td>
<td>high</td>
<td>or</td>
<td>Recent decline in protective behaviour among MSMs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

IUMSP/UEPP
This second part of the report describes the way in which the 1999-2003 programme was implemented, carrying forward the strategy of earlier years. The three intervention levels are covered one by one:

- level I, comprising the STOP AIDS campaigns, which are addressed to the population as a whole, and the HIV/AIDS prevention and sex education measures targeting school pupils;
- level II, comprising the various measures aimed at specific target groups (sex workers, drug users, etc.);
- level III, featuring HIV/AIDS prevention as practised by primary care physicians, an activity based on personal interaction.

LEVEL I: HIV/AIDS PREVENTION IN THE POPULATION AS A WHOLE

The STOP AIDS campaigns

The STOP AIDS campaigns, which have been conducted at regular intervals since 1987, are the most visible element of Switzerland’s prevention strategy. They perform two main functions. The first and most obvious is the transmission of information and the dissemination of preventive messages. The second – underlying – function is to serve as a reminder of the permanence and seriousness of HIV/AIDS to those involved in prevention work, the political circles where decisions are taken, and the general public.

Several changes have recently been made to the way in which the campaigns are planned and followed through. Since 1999, the company responsible for designing the campaigns has been appointed following a tendering procedure, while the creative team which formerly supervised the roll-out of the campaigns has reduced the scope of its activities and is now involved only in the planning phase.
For the 2000-2001 campaign, the method of dissemination based on a series of “communication peaks” was abandoned in favour of a more continuous, less intensive approach, the aim being to achieve greater flexibility. In 2002, the campaign was run in close collaboration with Expo 02, the Swiss national exhibition.

The most recent evaluation covered the 2000-2001 campaign. It reveals a high level of acceptance but also some loss of recognition and visibility, due to changes in the style of the campaign and the media deployed. The evaluation does however show that messages have stuck in people’s minds from earlier campaigns. This finding confirms that, thanks to their continuity – in particular, the permanence of the STOP AIDS logo (featuring a condom) – the campaigns do have a lasting influence, even though some topics or messages make less of an impact than others.

HIV/AIDS prevention and sex education in schools

The promotion of HIV/AIDS prevention and sex education in schools has always been part of the national strategy. The environment in which this level-I activity takes place is complex and extremely diverse. This is due in particular to the federal organisation of the Swiss educational system, the different levels of schooling concerned (mandatory and post-mandatory schooling, with a range of different types of school and curricula), the way in which responsibilities for delivering HIV/AIDS prevention and sex education are allocated, and the profile of the people charged with teaching these subjects.

A survey covering the whole of Switzerland has shown that HIV/AIDS prevention is usually included in sex education, regardless of how formally this is organised, and is based on two principal models:

- an “external” model, whereby sex-related topics are dealt with as part of dedicated courses, generally delivered by specially trained visiting teachers;
- an “internal” model, whereby the teaching is entrusted to school staff members, who include the different aspects of sex education in existing school disciplines.

The “external” model is clearly dominant in the French-speaking part of Switzerland, while the “internal” model is more common in the German-speaking area. Ticino and the bilingual cantons are equally divided between the two solutions.
The principle of sex education and HIV/AIDS prevention is accepted as an aspect of compulsory schooling in most cantons. The legal framework for sex education exists almost everywhere as far as the compulsory years of school attendance are concerned, but this is far less true of post-mandatory education. The existence of a legal basis is in any case not in itself sufficient to make sex education effective: where the responsibility for implementation lies is often unclear.

At primary level (6 to 11 years of age), where sex education is concerned, coverage is good in at least one third of cantons. At secondary level I (attendance compulsory from 11 to 15), most pupils participate in lessons which deal with the topics of both sex education and HIV/AIDS prevention. At secondary level II (post-mandatory schooling), coverage is again very mixed. The schools themselves are responsible for the content of their programmes. Some establishments (or even individual teachers) plan a systematic programme of teaching, while others ascribe only marginal importance to this subject.

The EPSS survey confirms that basic coverage is good, showing that most young people aged between 17 and 20 (roughly 9 out of 10) have had the opportunity to hear about AIDS/HIV or sexuality at least once during their schooldays. However, some received only one lesson on this subject during all the time they were at school. The situation in the German-speaking part of Switzerland is less satisfactory: 42% of respondents reported never having had a lesson on the subject, or only one (as compared with 30% in Ticino and 14% in the French-speaking area). The survey also shows that the topics tackled in the German-speaking part of Switzerland are fewer and less diversified. When the approach to teaching is inter-disciplinary, its actual implementation does not seem to match the theoretical ideal. There is only partial monitoring of the coverage and quality of the teaching of these topics, especially at the post-compulsory level.

Potentially, the two models provide an adequate framework for transmitting information regarding HIV/AIDS prevention. Each has its own particular advantages and limitations.

The “external” model ensures the quality of the interventions (specific training for visiting teachers, possibility of quality control) and an at least minimal level of coverage. The lessons do not depend on the motivation of regular members of staff. The drawbacks of this model are that funding cannot be taken for granted (long-term provision is not assured) and it does not allow teachers to gauge when their pupils are in receptive mood and make the most of such opportunities.
The “internal” model offers more scope for teachers to take advantage of favourable opportunities to raise the issue of HIV/AIDS and sex-related topics. Since the teaching is done by regular members of staff, it is very much less dependent on special resources being allocated. However, it does depend very much on the adequacy of their training, their motivation and the motivation of head teachers (when the latter are responsible for determining the content of the school programme).

In practice, however, the “internal” model seems to be less effective overall in achieving good coverage. There are quite a few factors which militate against the topic of HIV/AIDS being raised in the school setting, and it would be very difficult to monitor the content of such teaching and whether or not it is actually delivered.

**LEVEL II: HIV/AIDS PREVENTION IN PARTICULAR TARGET GROUPS**

Some population groups have characteristics (age, culture, language, exposure to specific risks, difficulties in reaching out to them, poor accessibility of prevention facilities, etc.) which call for prevention measures geared to their particular circumstances. The tables which follow provide a summary of the ways in which prevention measures have been implemented with several of these “special groups”. The tables have been drawn up using information gathered from a number of different evaluations. They state whether the projects are national or local in scope and define the intervention models adopted, the players involved, the services delivered and the coverage achieved. They also set out the principal findings.

**National programmes: information, training/support, outreach work**

There are several national programmes targeting special groups (MSMs, prostitutes of both sexes, prostitutes’ clients, migrants) which share, among other things, the characteristic of being difficult to reach. These programmes generally comprise:

- at national level: training and support measures for the workers involved, and the provision of universally accessible information (telephone hot-lines, web sites) and written documentation;
- at local level: targeted outreach activities, using professionals and mediators. The work of mediation is not restricted to intercultural situations; it is also intended to build bridges between prevention specialists and particular subcultures and may require the involvement of “peers” (persons sharing something of the identity – professional, sexual and/or cultural – of
the target group). This work depends partly on the mobilisation of non-governmental organisations, which often serve as local deliverers of national programmes, while also developing their own projects.

Most HIV/AIDS prevention projects have to contend with the same range of problems as faced by the target groups themselves. This has led them to engage in collaborative and/or complementary ventures with players in the health, social-services and legal sectors, or even to undertake lobbying activities to obtain legal or administrative changes. Networking of this kind has made it possible to fill some of the gaps in the coverage of needs.

The readiness with which these measures are accepted and the high quality of the prevention work performed owe much to the professional and personal qualities of the workers involved and to their commitment. As well as performing their preventive functions, they act as spokespeople for the most marginalised social groups and help to empower them. In the absence of adequately organised and stable community structures, they are the only players likely to give these groups a voice in the social and political system.

**Structures specific to certain groups: low-threshold facilities and general facilities for drug users**

There is no national programme for drug users but they benefit from targeted measures, some delivered by specific facilities (LTFs, treatment centres), others by non-specific structures (pharmacies, prisons). The specific facilities are generally funded by the cantons or municipalities. This diversity of delivery points normally ensures good coverage.

**Groups which are difficult to define: relying on a network of collaborators**

In practice, prevention provision cannot be reduced to specific measures or activities carried out in isolation. It is also important to take into account dynamic factors such as interinstitutional collaboration and referrals which build up a network of provision. In some cases, coverage is provided by the network, rather than by ad hoc interventions. This being the case, the density, diversity and responsiveness of intervention networks – as well as the presence within such networks of a “hard core” of collaborators providing specialised services in the field of HIV/AIDS – are all factors determining the extent to which services are used and how adequate they are.
Young people at risk are a good example. They are not a constant, consistent segment of the population, but are characterised above all by their lack of social integration. They are generally seen as having fallen through the traditional safety net formed by family, school, work and having a place to live. Rejected by society, they are not only difficult to reach, but also difficult to help. From a sociological point of view, they do not fall into any pre-set or consistent category. As such, they are not the object of any specific intervention measure. As there is no HIV/AIDS prevention project officially geared to their needs, these are catered for loosely within the network of collaborators with whom their specific situation may happen to bring them into contact. Prevention work with this group depends on the attention which prevention workers are able to bring to bear on a problem (HIV infection) that is not necessarily the primary reason for their interaction.

Coverage achieved in the prevention field: uneven and selective

The coverage of national territory achieved as a result of the prevention measures is uneven. Although some of the tools adopted are of universal application, most prevention activities are essentially local in scope. This situation may reflect a concentration of need in certain places (focuses of homosexual activity, prostitution and drug addiction are primarily urban phenomena). It may also be the outcome of several factors which hinder the development of prevention activities. In any case, most local or regional players have to contend with a scarcity of resources and must therefore limit their interventions, whether they like it or not. This is detrimental to the coverage of existing needs, particularly the needs of those segments of the population which are most difficult to reach and which require a major investment (of time, human resources and, consequently, money).
### Men having sex with other men (MSMs)

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Intervention methods</th>
<th>Players</th>
<th>Services</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>National MSM programme</td>
<td>• web site <a href="http://www.drgay.ch">www.drgay.ch</a></td>
<td>Swiss AIDS Federation</td>
<td>• anonymous, individual counselling (in the three national languages)</td>
<td>• the whole of Switzerland • accessible at all times</td>
</tr>
<tr>
<td></td>
<td>• outreach workers (sometimes supported by volunteers)</td>
<td>Swiss AIDS Federation and local AIDS offices</td>
<td>• in locations where gays meet anonymously: • anonymous, individual counselling • supply of prevention material</td>
<td>• mainly in urban settings • regular – but not very frequent – presence, varying from canton to canton</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• on the gay commercial scene: • anonymous, individual counselling • supply of prevention material • &quot;consciousness raising&quot; of managers of commercial establishments and their customers</td>
<td>• mainly in urban settings • good overall coverage</td>
</tr>
<tr>
<td>Projects run by NGOs</td>
<td>• telephone help line (Rainbow Line) / German</td>
<td>Pink Cross (co-ordination)</td>
<td>listening; anonymous, individual counselling; guidance to appropriate sources of help</td>
<td>• the whole German-speaking area • line manned six days out of seven</td>
</tr>
<tr>
<td></td>
<td>• telephone help line (Rainbow Line) / French</td>
<td>Vogay / Pink Cross (co-ordination)</td>
<td></td>
<td>• the whole French-speaking area • line manned six days out of seven • service discontinued during part of the reference period, then reorganised</td>
</tr>
<tr>
<td></td>
<td>• telephone help line (Linea gay Ticino) / Italian</td>
<td>Pink Cross (co-ordination)</td>
<td></td>
<td>• Ticino • line manned almost permanently (mobile)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Young Gays support groups</td>
<td>• independent Young Gays groups • local AIDS offices</td>
<td></td>
<td>peer support, building identity • prevention of STIs (secondary objective)</td>
<td>• mainly in urban settings • in German-speaking area: activities on &quot;coming out&quot; days (run by the umbrella organisation Diagonal)</td>
</tr>
<tr>
<td>initiatives in schools</td>
<td></td>
<td>Commission jeunesse et école (Young people and school committee) / Aiuto AIDS Ticino</td>
<td>increasing awareness of the problems of young gays in school settings</td>
<td>• German-speaking area: coverage better in some towns than others • French-speaking area: coverage ensured by a training group • Ticino: pilot initiatives</td>
</tr>
</tbody>
</table>

IUMSP/UEPP
Findings

- Given that the risks of HIV infection are potentially high, the provision of prevention material in establishments where gays meet to have sex is of vital importance. For the time being, this is a completely unregulated situation.

- Generally welcomed by the managers of the establishments concerned (of whatever kind), prevention initiatives are not always as visible as they ought to be. They may lack effectiveness if they are limited to the passive distribution of material.

- Initiatives in places where gays meet anonymously are a way of reaching a mixed population of MSMs who desire anonymity and would not necessarily be accessible elsewhere.

- Among young homosexuals/bisexuals, HIV/AIDS is one of a number of concerns, which also include the need to break out of their isolation, build a support and social-contact network, find positive role models and build their own identity. The community initiatives organised around the prevention of HIV/AIDS do not cover all of these problems. They are based on the assumption that young people have already gained some sense of their identity. Often young homosexuals/bisexuals go through a long period of uncertainty and psychological distress before they make contact with these resources.
### Female sex workers

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Intervention methods</th>
<th>Players</th>
<th>Services</th>
<th>Coverage</th>
</tr>
</thead>
</table>
| National APIS (AIDS prevention among sex workers) programme | • outreach workers  
• cultural mediators | • Swiss Aids Federation  
• NGOs | • counselling, prophylactic material and guidance for migrant prostitutes on accessing the social-services/health-care network | • available in fifteen or so regions  
• good coverage in major urban areas, but uneven elsewhere |
| Projects run by NGOs | • outreach workers  
| | • NGOs | • counselling, prophylactic material and social and health-care services  
• in addition, injection equipment for prostitutes who use drugs and women working in sectors closely connected with prostitution (night clubs)  
• lobbying of the political and administrative authorities | • generally satisfactory in the main urban centres, but patchy elsewhere  
• activities in night clubs are by no means widespread  
• no specific activities targeting escort girls |
| National “Don Juan” project targeting prostitutes’ clients | • outreach workers  
| | • Swiss Aids Federation  
• NGOs | • counselling for prostitutes’ clients | • a few evenings in a limited number of towns (7 in 2000, 6 in 2001, 8 in 2002) |
| | • web site [www.don-juan.ch](http://www.don-juan.ch) | • Swiss Aids Federation  
| | | | • information about HIV and other STIs, self-evaluation of attitudes and behaviour towards prostitutes | • begun in 2003, still in pilot phase |

IUMSP/UEPP
Findings

- The settings in which prostitution takes place are very diverse. A proportion of prostitutes are not reached by prevention initiatives (it is difficult to gain access to those working in "salons", for example).
- The legal situation has a strong bearing on whether workers have access to prostitutes, particularly nationals of foreign countries.
- Access to the target groups is facilitated by at least three factors: the active support of the public health authorities, the co-operation of the managers of sex businesses, and the fact that the prevention initiatives are well established and have a high profile. The effectiveness of the initiatives in fact depends on their being a familiar feature. This makes it possible quickly to establish a relationship of trust with clients, and compensates to some extent for the rapid turnover of foreign sex workers.
- HIV/AIDS prevention is not necessarily a priority concern of sex workers. They generally have to contend with a whole host of legal, social and health problems. HIV prevention is best conducted and most readily accepted as part of the wider framework of services intended to tackle these different problems.
- The effectiveness of these activities depends on long-term commitment, which is incompatible with short-term funding methods.
Male sex workers (MSWs)

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Intervention methods</th>
<th>Players</th>
<th>Services</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>National MSW programme</td>
<td>• outreach workers</td>
<td>• local Aids offices</td>
<td>• information, counselling, psychosocial support, medical care (the latter only in ZH)</td>
<td>• project established in five cities (Zurich, Basel, Geneva, Lucerne and Berne, but discontinued in 2000), which account for a large – or at least the most visible – part of the Swiss “scene” where male prostitution is concerned</td>
</tr>
<tr>
<td>• web sites</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><a href="http://www.malesexwork.ch">www.malesexwork.ch</a></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><a href="http://www.malesexwork.net">www.malesexwork.net</a></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Swiss Aids Federation and the Geneva Aids office</td>
<td>• information, counselling</td>
<td></td>
<td></td>
<td>• the whole of Switzerland</td>
</tr>
<tr>
<td>• accessible at all times</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Findings

- It is difficult to make a reliable diagnosis of the local situation where male prostitution is concerned (settings, extent and development of the phenomenon) in regions where the MSW programme is not established.
- There are small, localised male prostitution “scenes” – of which little is known – in some towns where the MSW programme is not established. Men, often drug users, who solicit clients there are probably not able to benefit from prevention activities appropriate to their circumstances.
- Sexual services are probably available on a paying basis in saunas and sex clubs. However, the attitudes and practices of club managers in respect of these activities are unclear.
### Drug users

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Intervention methods</th>
<th>Players</th>
<th>Services</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local projects run by public authorities (cants of municipalities) or NGOs</td>
<td>“Low-threshold” social/health facilities distributing injection equipment and condoms</td>
<td>public authorities</td>
<td>provision of injection equipment (a total of 3.5 million syringes distributed by LTFs in 2002)</td>
<td>uneven geographical coverage (26 LTFs – 11 with premises for using drugs – in 11 cantons). More LTFs in the German-speaking part of Switzerland, especially the large urban areas</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NGOs</td>
<td>condoms, counselling, referrals to other social/health services, basic medical treatment</td>
<td>a range of services, unevenly delivered</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>premises where drugs can be used (injection rooms, inhalation rooms)</td>
<td></td>
</tr>
<tr>
<td>Public authorities</td>
<td>prisons</td>
<td>cantons</td>
<td>provision of injection equipment and disinfectants, condoms</td>
<td>approximately one third of prison inmates</td>
</tr>
<tr>
<td>Private sector</td>
<td>pharmacies</td>
<td>pharmacists</td>
<td>sales of injection equipment (estimated at 120,000 syringes per month), advice</td>
<td>the main source of supply of syringes in 15 cantons. No recent data on the real extent and quality of supply</td>
</tr>
<tr>
<td>Cantons, physicians in domiciliary practice</td>
<td>treatment facilities, in particular the heroin-assisted treatment programme (HeGeBe)</td>
<td>cantons, physicians</td>
<td>provision of injection equipment (estimated at 94,000 syringes a month under the HeGeBe programme), counselling, condoms</td>
<td>21 centres in 11 cantons for the heroin programme, coverage unknown for other sources of supply</td>
</tr>
</tbody>
</table>

**Findings**

- Switzerland has an extensive, well-established network of facilities involved in preventing the transmission of HIV by injecting among drug users. It is reckoned that 500,000 syringes are provided free of charge or sold each month in Switzerland. The available data (from LTFs) indicate that injection equipment is being provided on a regular basis. However, there is room for improvement in territorial coverage, which is uneven, in terms of both quantity and quality. This is particularly necessary if the aim is to further improve efforts to prevent the spread of HIV and, above all, hepatitis C.
- The measures introduced for national monitoring of syringe distribution in LTFs are viable and provide a useful way of measuring coverage where prevention activities are concerned. There is still no regular monitoring of the supply of syringes by pharmacies, which would complete the picture.
- Activities to prevent the transmission of HIV by the sexual route are inadequately documented in LTFs and still seem to be insufficient.
### Migrants

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Intervention methods</th>
<th>Players</th>
<th>Services</th>
<th>Coverage</th>
</tr>
</thead>
</table>
| National “Migration and Health” project (discontinued in 2001) | • intercultural mediators | • SFOPH  
• NGOs (community associations) | • HIV/AIDS prevention  
• health promotion  
• dependency prevention | • project initially intended for Spanish, Portuguese and Turkish migrants and for asylum seekers; subsequently extended to the Italian, Latin-American, Yugoslav, Tamil and African communities |
| National strategy: “Migration and Health 2002-2006” | | • Swiss Tropical Institute  
• Swiss Red Cross centre of excellence  
• regional centres of excellence administered by NGOs  
• the “Interpret” association | • initial and further training  
• information  
• prevention and health promotion  
• psychological care services (in particular for traumatised asylum seekers and refugees)  
• research  
• interpreting and cultural mediation  
• definition of quality standards | • general-purpose strategy (not specifically geared to HIV prevention) |
| National project: “HIV prevention among sub-Saharan migrants” | • participatory approach (use of existing groupings and associations) | • Swiss Tropical Institute  
• Swiss International Health Centre  
• Swiss Red Cross  
• Migrants’ associations | • HIV/AIDS prevention | • three cantons during the current pilot phase (Vaud, Geneva, Zurich) |
| Local projects | • mediators working in community meeting places | • NGOs  
• local Aids offices | • information, counselling, provision of condoms  
• strengthening of interinstitutional co-operation | |
Findings

- Migrants were the subject of special attention at a very early stage of the HIV/AIDS prevention strategy. The aim was to ensure that they had equal access to prevention services, taking into account their social and cultural characteristics and offering appropriate assistance. The launch of a migration and health strategy providing for all the health concerns associated with the phenomenon of migration represents an important advance. The risk inherent in this overall approach to health policy is that specific activities in the fight against HIV/AIDS could become diluted as part of more general initiatives, or even disappear altogether.

- Without an initiative geared to their specific needs, the HIV/AIDS epidemic will continue to take a disproportionately heavy toll among the population of “sub-Saharan migrants”. The creation of a specific programme endowed with appropriate resources is needed to supplement more general initiatives.
Young people at risk

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Intervention methods</th>
<th>Players</th>
<th>Services</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local projects, which may be non-specific (i.e. not necessarily geared to HIV prevention)</td>
<td>• networking</td>
<td></td>
<td>• counselling on sexual issues (e.g. family planning)</td>
<td>• potentially good coverage ensured by the network rather than by ad hoc initiatives</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• referrals to other players</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Findings

- HIV/AIDS prevention among young people at risk relies on a network of players who have direct access to members of this group. Within this network, workers specialised in HIV prevention ensure the provision of specific services which the other members of the network can make use of.
- Young people at risk are initially identified as such within the educational system. They are then guided towards specific school services or institutions where they are still easily accessible to workers specialising in HIV prevention. This is also the case with young migrants who do not have a residence permit.
- Most young people at risk are characterised by behaviour or circumstances which expose them to the risk of HIV infection. The risks they run may be the result of overconsumption of alcohol, the influence of their culture of origin on sexual behaviour, or thinking it is safe to use the pill rather than condoms.
People living with HIV/AIDS

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Intervention methods</th>
<th>Players</th>
<th>Services</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care of persons with HIV</td>
<td>• consultation</td>
<td>• health-service staff working in public or private treatment centres</td>
<td>• individual counselling (prevention)</td>
<td>• widespread, particularly due to the density of the contact network necessitated by medical follow-up</td>
</tr>
<tr>
<td></td>
<td>• formal procedures implemented in monitoring patients belonging to the Swiss HIV Cohort</td>
<td></td>
<td>• psychosocial support</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• treatment and follow-up</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local projects run by NGOs</td>
<td>• psychosocial specialists</td>
<td>• NGOs</td>
<td>• individual counselling</td>
<td>• in virtually every canton</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Swiss AIDS Federation and local Aids offices</td>
<td>• dissemination of relevant information</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• support</td>
<td></td>
</tr>
<tr>
<td>National projects run by NGOs</td>
<td>• preparation and dissemination of information material</td>
<td>• Swiss AIDS Federation</td>
<td>• individual counselling (via the web)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• web site</td>
<td></td>
<td>• production and provision of information material</td>
<td></td>
</tr>
</tbody>
</table>

Findings

- In the hospital setting, formal procedures, routines and the use of questionnaires designed to elicit the medical history of people with HIV create favourable conditions for targeted prevention counselling directed to the individual.

- There are serious problems in providing information to, and communicating with, migrants with HIV from certain countries. If they are not resolved, these problems are likely to restrict access to medical treatment and, consequently, prevention counselling. Co-ordinated action is required to solve these problems.

- There is a significant risk of people within certain migrant communities being stigmatised and ostracised. This danger is a further reason for ensuring that migrants with HIV have access to health care.

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16 Questionnaire.

17 We refer here only to HIV prevention, not to other activities developed by these branches.
LEVEL III: HIV/AIDS PREVENTION BY PRIMARY CARE PHYSICIANS

A medical consultation is the fundamental type of preventive intervention based on personal interaction (level III). It brings together a doctor who is highly qualified and credible in matters relating to health and a patient whose circumstances, in some cases, may call for repetition and more thorough explanation of the prevention messages addressed to the population as a whole.

Several evaluations have been devoted to HIV/AIDS prevention as practised by primary care physicians (1990, 1995, 2002). They show that doctors are still practically unanimous in ascribing great importance to primary prevention as an aspect of their consultations with patients.

Preventive practices

The quality and effectiveness of the preventive counselling given by doctors depends partly on the care taken in establishing the possibility of exposure to risk when the doctor is taking the patient’s medical history. For the purposes of preventing HIV/AIDS, information regarding a patient’s sexual activity and possible use of drugs is essential.

Investigation of the medical history of a young adult presenting with a non-urgent health problem was the hypothetical situation used to identify the areas doctors would cover in a situation of this kind. Some areas were systematically investigated by almost all the doctors questioned. However, the aspects of the patient’s medical history likely to reveal the possibility of exposure to HIV were less frequently dealt with.

- Use of tobacco and alcohol, physical exercise and professional activity were investigated by more than nine doctors out of ten;
- Drug use and contraception were investigated by roughly two thirds of the doctors concerned (71% and 62% respectively);
- An investigation of the patient’s sexual history/activity was undertaken by only half of the doctors (48%).

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18 General practitioners, specialists in general medicine, specialists in internal medicine, dermatologists, gynaecologists and, in 2000, specialists in infectious diseases.
The doctors who investigated sexual activity were interested above all in the method used to protect against HIV, less in the patient’s sexual orientation and practices.

- 84% of the doctors routinely asked questions about the method used to protect against HIV;
- 57% sought information on the patient’s sexual orientation, 49% on the number of partners with whom he or she had had sex;
- 33% extended their investigation to take sexual practices into account.

Since 1995, there has been very little change in the way doctors take their patients’ sexual histories.

Doctors’ attitudes to investigating the risk of exposure to HIV tend to vary according to the type of patient or the patient’s situation. They are most likely to devote attention to patients whose situations involve an “obvious” risk of contact with HIV (drug users, for example). Although not neglected, patients in more ‘neutral’ situations (young adults, patients coming for a check-up, new patients) are less likely to experience this kind of history-taking. Finally, migrants and patients who have broken off a relationship with their partner are more rarely investigated for risk of exposure to HIV (Figure 11).

Doctors’ behaviour in investigating the possibility of exposure to HIV has changed over the years. In 1990, their attention was focused mainly on the groups conventionally regarded as being at risk. Twelve years later, they are appreciably more attentive to the circumstances of members of the general population (patients requesting contraception, young adults, people coming for check-ups, new patients and – to a lesser extent – migrants). There was, however, a slight slackening between 1995 and 2000 in the efforts made to evaluate risk-taking by homosexual patients (Figure 11).
Figure 11
Proportion of doctors routinely investigating the possibility of exposure to HIV in respect of different types of patient or situation: comparative figures for 1990, 1995 and 2002 (%)

Separated or divorced  | Migrants  | New patients  | Check-up  | Young adults  | Pregnancy  | Request for contraception  | Homosexuals  | STD patients  | Drug users  

| 2002 | 1995 | 1990 |

NB: the “check-up” and “migrants” categories were not included in the 1990 survey; the parameters of the “homosexuals” category were changed after 1990, so that year’s survey result cannot be included in the comparison.

Administration of the HIV test is an opportunity to give advice on prevention. During pre-test counselling, the doctor can explain the time limitations of the test (the ‘time window’), investigate the risks run by the patient, ascertain his degree of knowledge, discuss the consequences of the test, and give advice on what precautions he or she should be taking. Almost
all the doctors (96%) had prescribed at least one test in the six months prior to the survey. Not all issues associated with the test were the routinely covered during counselling:

• only the issue of the test’s validity (the ‘time window’) was always dealt with by more than half the doctors;
• it was still the case that more than one tenth of the doctors never explained the time limits on the test’s validity or did so only rarely;
• one doctor in five failed to investigate the risks run by the patient or did so only rarely;
• one doctor in four did not assess the patient’s knowledge or did so only rarely;
• one doctor in six did not discuss means of protection or did so only rarely.

Between 1995 and 2002, there had been little change in doctors’ behaviour when conducting pre-test counselling (in respect of the frequency with which they covered the different topics).

Half of the doctors (48%) had been consulted at least once in a situation where the administration of post-exposure prophylaxis (PEP)\textsuperscript{19} was an option, 35% in the twelve months prior to the survey. When faced with a situation of this kind, half of them referred their patient to a specialised centre; the others made an analysis of the situation and then decided on the suitability of the treatment on their own initiative or after taking advice.

Involvement of practitioners in the care of patients living with HIV/AIDS

In 2002, a little over half of the doctors (55%) were responsible for the care of at least one patient with HIV at the time of the survey (average 3.8; median 1):

• 6% of the doctors had taken full responsibility for administering a HAART to one or more patients;
• 35% had jointly taken responsibility for at least one HAART;
• 14% were caring for patients with HIV only in their capacity of family doctor.

Extrapolating from the data provided by the sample, between 208 and 533 doctors have been ‘solely responsible’ for a HAART and between 2,420 and 5,902 have received a HAART administered exclusively under the responsibility of a general practitioner.

\textsuperscript{19} Administration of a HAART-type treatment very soon after probable exposure to HIV
Despite the heavy involvement of doctors in providing such care, one practitioner in eight (12%) still thinks it ‘natural to refuse to care for a patient with HIV in order to protect his personal safety and that of his colleagues’. This attitude is in slight – but steady – decline (17% in 1990 and 14% in 1995).

**Care of patients with HIV in the doctor’s consulting room**

Almost all the doctors who had administered HAARTs were very careful in providing information prior to such treatment. By so doing, they enabled their patients to give genuinely informed consent. Once the treatment had begun, the vast majority of the practitioners kept themselves informed of side effects (94%), the problems posed by the complexity of the treatment (84%), and patient compliance (88%). On the other hand, only two thirds took an interest in the impact of the treatment on the patient’s family life and work (61% and 66% respectively).

Doctors who were caring for patients with HIV in one capacity or another did not devote equal attention to the different aspects of their daily lives:

- Between two thirds and three quarters kept themselves regularly informed of the social, professional, emotional and sexual lives of their patients who were living with HIV, and of their habits where protection was concerned.
- Just under half showed concern lest their patients were suffering financial problems.
- A third of the doctors enquired into the sex lives of their patients, and a quarter into their emotional lives and issues relating to protection, only when they first took responsibility for their care. Consequently, they failed to gather information regarding the development of a health problem which is long term, and some repercussions of which do not appear immediately.
- 12% and 7% respectively of the doctors never sought information about the emotional and sex lives of their patients, and 22% were not concerned about the financial problems their patients might encounter (Figure 12).
Figure 12

Frequency with which doctors caring for patients with HIV enquired into different aspects of their lives

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Not Inquired</th>
<th>At Start of Care</th>
<th>Regularly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social life</td>
<td>78</td>
<td>20</td>
<td>4</td>
</tr>
<tr>
<td>Working life</td>
<td>70</td>
<td>26</td>
<td>3</td>
</tr>
<tr>
<td>Protection of partner(s)</td>
<td>69</td>
<td>27</td>
<td>3</td>
</tr>
<tr>
<td>Emotional life</td>
<td>66</td>
<td>22</td>
<td>12</td>
</tr>
<tr>
<td>Sex life (covering)</td>
<td>61</td>
<td>32</td>
<td>7</td>
</tr>
<tr>
<td>Financial problems</td>
<td>44</td>
<td>34</td>
<td>22</td>
</tr>
</tbody>
</table>
SUMMARY OF IMPLEMENTATION AT THE THREE LEVELS: COVERAGE

Table 4 provides a summary of the extent of the coverage ensured by prevention activities at each of the three levels.

Table 3
Summary of the coverage ensured by prevention activities at the three levels

<table>
<thead>
<tr>
<th>Level</th>
<th>Target group</th>
<th>Coverage</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>General population</td>
<td>++</td>
<td>Good visibility and acceptance. The campaign logo conveys the essence of the prevention message.</td>
</tr>
<tr>
<td></td>
<td>Pupils (≤16 years)</td>
<td>+</td>
<td>Virtually complete, but of variable intensity and quality.</td>
</tr>
<tr>
<td></td>
<td>Pupils (&gt;16 years)</td>
<td>+/ -</td>
<td>Uneven. Depends on the good will of head teachers.</td>
</tr>
<tr>
<td>II</td>
<td>MSMs</td>
<td>+</td>
<td>Prevention activities concentrated mainly in urban areas.</td>
</tr>
<tr>
<td></td>
<td>Young MSMs</td>
<td>+/-</td>
<td>Still insufficient where young gays are concerned.</td>
</tr>
<tr>
<td></td>
<td>Drug users</td>
<td>+/++</td>
<td>The distribution and sale of syringes are concentrated in urban areas, and facilities are still inadequate in some cantons. Activities to prevent the spread of HIV by the sexual route are less widespread.</td>
</tr>
<tr>
<td></td>
<td>Female sex workers</td>
<td>+/-</td>
<td>Several segments of the milieu in which prostitution takes place are still inaccessible to outreach workers.</td>
</tr>
<tr>
<td></td>
<td>Male sex workers</td>
<td>+</td>
<td>Initiatives concentrated in a few urban areas.</td>
</tr>
<tr>
<td></td>
<td>Migrants</td>
<td>-</td>
<td>HIV/AIDS prevention is diluted by a wide-spectrum approach to health issues. Some particularly vulnerable groups (e.g. migrants from sub-Saharan Africa) are probably still not being reached by prevention activities geared to their perceptions and needs.</td>
</tr>
<tr>
<td></td>
<td>Young people at risk</td>
<td>+/-</td>
<td>No specific prevention measures. The care provided depends heavily on workers in related fields (education, health, social services) networking together.</td>
</tr>
<tr>
<td>Level</td>
<td>Target group</td>
<td>Coverage</td>
<td>Comments</td>
</tr>
<tr>
<td>-------</td>
<td>--------------------</td>
<td>----------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Persons with HIV</td>
<td>+/-</td>
<td>Potentially very wide coverage: a large proportion of people with HIV are cared for by doctors. But coverage is inadequate in some population groups (migrants, for instance). If the subject of sexuality is addressed in a consultation setting, obstacles may be encountered. Recourse to systematic procedures (common in hospitals) makes it easier to raise the subject. They are rarely used by primary care physicians, whose responsiveness to the problems raised by their patients is still the main guarantee of the effectiveness of the prevention activity.</td>
</tr>
<tr>
<td>III</td>
<td>Primary care</td>
<td>+/-</td>
<td>Preventive activity by primary care physicians is potentially good. However, there are still gaps in systematic investigation of the risks run by patients and in pre-test counselling.</td>
</tr>
</tbody>
</table>
DYNAMICS OF THE EPIDEMIC

This chapter provides an analysis of the present state of the epidemic. It is based on the behavioural data gathered in various population groups, reviews of the literature relating to a number of specific groups, and the data provided by the epidemiological monitoring system for HIV and s.

The general population can be regarded as well informed on the issue of HIV/AIDS and on ways of taking precautions against infection. This is explained by the intensity, continuity and wide coverage of the media campaigns, the school-based activities and, more generally, the degree of social mobilisation achieved.

Since 1987, there has been a profound change in people’s behaviour, reflected in the increasing adoption of protective measures. Although not the same in all age groups, levels of condom use are generally high. The situation began to stabilise in 1992. The most plausible interpretation of the most recent data (2000) is that this stability is being maintained. It would not be appropriate to speak of a decline. Prudence is nevertheless called for, given recent epidemiological developments (increases in new cases of HIV and s, a recrudescence of the epidemic internationally). Also of concern is the existence of small subgroups of the general population which are not represented in the surveys due to their marginalisation, the fact that it is impossible to reach them by telephone or their poor knowledge of the Swiss national languages – as a result of which their behaviour is not adequately documented. Finally, there are always individual exceptions to the general trend.

The most recent data for protective behaviour among young people (the SMASH survey), together with the figures for condom sales, show no signs of a decline, but tend to confirm the general stability. Gathered in 2002, these data relate to a period characterised by renewed interest in HIV/AIDS in the press, and by SFOPH media information and new campaigns which, beginning at the end of 2001, gave warning of the recrudescence of the epidemic in industrialised countries and drew attention to the disaster occurring in the developing world.
Data for the behaviour of specific groups present a varied picture.

Among men having sex with other men (MSMs), since 1997 there has been a decline in the protective measures adopted in relations with casual partners, a stabilisation of protective behaviour with steady partners (though still at an unsatisfactory level, due to inadequacies in the protective strategies adopted by couples), and an increase in the number of sexual partners. Even though protection levels have remained generally high, this decline no doubt fore-shadowed the recent increase in new cases of HIV infection in this group.

Among intravenous drug users, the recent slight (though not significant) decline in avoidance of sharing injection equipment and the continuing inadequate level of protection in sexual relations might have been expected to lead to an increase in new infections, particularly in those urban areas where the level of sharing is still high. However, for the time being this is not confirmed by the epidemiological data.

Where people living with HIV are concerned, the 2001 target rate for protective behaviour in sexual relations (90%) set by the national HIV/AIDS programme has not yet been achieved.

Finally, there is a lack of recent data for migrants (even those from sub-Saharan Africa) and persons engaging in prostitution. Where migrants are concerned, there is a real need for data concerning their knowledge and behaviour, as the epidemiological development shows that a significant proportion of the new cases of HIV infection by the heterosexual route are occurring among persons of sub-Saharan origin or their sexual partners. In the case of female and male sex workers, international data indicate high levels of protection by condom, and a low prevalence of HIV among professional prostitutes. The situation is less clear-cut, and even worrying, in other sectors of prostitution.

The recent trend in new notified cases of HIV infection must be interpreted in the context of the changes in behaviour, which may also allow some hypotheses for the future to be sketched out.

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20 This tendency became statistically significant in 2000.

21 This was the only population “group” for which a protection rate target was set.

22 However, we do not know whether these persons contracted HIV in Switzerland or in their country of origin.
The first question that arises is the agreement between behavioural data and data deriving from the HIV monitoring system. The two sets of data do in fact agree quite closely: the decrease in risk behaviour likely to transmit HIV was followed several years later by a decrease in new infections, while changes in behaviour among MSMs and drug users foreshadowed the new cases of HIV we are now seeing in these two groups. This being the case, monitoring of behaviour in these groups needs to be continued and should be extended to other specific groups (migrants of sub-Saharan origin, male and female sex workers), as it is complementary to the monitoring of HIV and other STIs. Together, the two activities lay the basis for a “second generation” monitoring system, as recommended by the WHO/UNAIDS.

A second issue is the possibility of the epidemic spreading to large segments of the general population; in other words, becoming generalised. The data for new infections show an increase among heterosexuals (the largest increase proportionally). However, the importance of this new finding needs to be set in context. Heterosexuals make up the majority of the population and it is legitimate to expect that, after a certain time, the number of infections within this group will increase (in number but not greatly as a proportion). In fact, the proportion of the population infected (8 out of every 100,000 inhabitants) is very well below the rate which would put Switzerland in the group of countries where infection is generalised. New cases of heterosexual infection are still concentrated mainly in small population groups (migrants of sub-Saharan origin, partners of persons already diagnosed as having HIV, etc.) and specific groups such as MSMs and drug users. Switzerland’s epidemic is therefore of the concentrated type.

Finally, we need to consider the significance of the recent recrudescence of new cases of HIV infection. Some of these cases are truly recent (primary infections). Others have been discovered at a later stage – or even, in a large and growing proportion of cases, with the appearance of full-blown AIDS. It also needs to be stated that the HIV/AIDS epidemic consists of a number of subepidemics (in different population groups), or even of localised outbreaks focused on a core of persons exhibiting at-risk behaviour patterns. In several specific population groups (MSMs, intravenous drug users), the prevalence of HIV is high, but still stable. Here, HIV is endemic and there could be a recrudescence of truly epidemic proportions – albeit restricted to one or another of these groups – in the event of a decline in protective

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23 1% among pregnant women in large urban areas.

24 As observed in the Lausanne region, where a series of new cases of HIV of a very particular subtype emerged among a group of drug users.
behaviour. Nothing is known of the distribution of HIV and its prevalence in certain sub-Saharan African communities. Consequently, there are no valid grounds for interpreting the new cases in these communities as the beginning of an epidemic.

Potentially, there are a number of “bridges” over which the infection could cross on a larger scale into the “general population”\(^25\), i.e. to persons not belonging to a specific population group (e.g. the sexual partners of injecting drug users, or the partners of bisexual men). There is a need to remain attentive to this issue. However, it has to be said that these bridges have existed since the beginning of the HIV/AIDS epidemic and that the high levels of protection found among the general population and in specific groups have prevented a massive spread of the infection – though there are cases of HIV among heterosexuals in which the sole pertinent characteristic as far as the infection is concerned is the fact of their having had sex with multiple partners. So long as this generalised “safety net” of protection is maintained, it is unlikely that we shall see a general recrudescence of the epidemic. On the other hand, it is possible that, for a long time yet, there will be fluctuations in the number of new cases, or even that we shall see a stabilisation of the number of new cases at a level higher than that achieved at the end of the 1990s.

**Dynamics of the implementation of the national programme**

**Progress and institutionalisation of the HIV/AIDS strategy**

The national “HIV and AIDS – 1999-2003” programme fits in with the perspectives set out in the 1993 publication “HIV Prevention in Switzerland” and takes into account the development of the situation since that time. As well as respecting the fundamental values on which the publication is based, the programme covers such themes as health promotion, “normalisation”, the international background, highly active antiretroviral therapies (HAART), international co-operation and quality assurance.

This programme is a public policy, implemented within the Swiss federal framework. The emphasis is on subsidiarity and encouragement. It mobilises a large number of players, who intervene at different levels (national, cantonal and regional), perform their activities in various fields and act in accordance with their own procedures. Many activities are undertaken independently (steering the work in a particular direction, deciding whether or not to embark on

\(^{25}\) Insofar as these persons fail to adopt prevention measures.
collaborative ventures, etc.). The general principles of the programme can be summed up as follows:

- the emphasis is on building on what has already been achieved and sustaining existing activities;
- for those working in the HIV/AIDS field, it sets out clear aims and objectives, with explicit pointers on how to achieve them;
- it nevertheless leaves open the questions of how competences, measures and specific funding should be allocated/shared;
- it guides local players in their activities and helps them with their planning;
- it lends legitimacy to the measures and funding brought to bear at the regional level.

Background to the implementation of the national programme: participation and consensus

The national programme for 1999-2002 was drawn up following a wide-ranging consultation involving federal authorities, the cantons, intercantonal bodies responsible for co-ordinating public policy, the institutes of social and preventive medicine, and non-governmental organisations. The involvement of players working in the HIV/AIDS field was an important factor in ensuring the programme’s compatibility and co-ordination with existing activities.

There is a broad consensus among the various players in support of the SFOPH’s strategy. Nationally and in cantons where studies have been conducted, the “coalition” formed by the main players in the HIV/AIDS field at the federal, cantonal and NGO levels plays a preponderant role. It wields de facto authority in drawing up and implementing health policy in this field.

There is every indication that the general public is very supportive of the health policy developed in the field of HIV/AIDS. People’s acceptance of the STOP AIDS campaign is remarkable. Its visibility remains high. More than 90% of the population want it to continue. The measures adopted to prevent HIV/AIDS among drug users (in particular the provision of sterile injection equipment) have met with approval from almost 90% of the persons questioned (89% in 1997).

Disagreements overcome

The initial period of implementation of the national programme was marked by disagreements and misunderstandings between the main players at the national level (SFOPH/Swiss AIDS Federation). The problems had to do mainly with the volume and distribution of the resources allocated by the SFOPH to the bodies involved in prevention, and with the leadership role
played by the SFOPH, which some parties perceived as being in decline. These problems are now (2003) settled. The SFOPH has renewed its efforts in support of prevention work and has done some intensive lobbying on this subject. It has undertaken to clarify the ambiguities which existed with regard to roles and competences. It has decided to reassert its leadership by fully restoring the visibility of the STOP AIDS campaign and strengthening its collaboration with the Swiss Aids Federation and its contacts at cantonal level.

The national leadership role of the SFOPH
Over and above the tasks referred to in the national programme, the SFOPH plays a leadership role – which is both political and symbolic – in laying down guidelines for the prevention strategy and reminding people of the importance and continuing relevance of HIV/AIDS as a public health priority. This facet of the SFOPH’s activity is important in giving regional players legitimacy in terms of public-health policy in their relationships and negotiations with the regional authorities and institutions which fund them. The STOP AIDS campaign is an essential component in this national leadership role. It makes the population aware of the acuteness and permanence of the problem of AIDS and legitimises the activities undertaken in response to it.

The Swiss Aids Federation also occupies a position of vital importance in the constellation of players. Active at the national and regional levels, it represents and defends the interests of persons living with AIDS (PWAs) and other marginalised groups, implements prevention activities designed for their benefit, and ensures that the social and ethical imperatives of health policy in the AIDS field are respected. Even though part of its funding comes from individual cantons, the Swiss Aids Federation’s management, training, co-ordination and, more generally, its political support and direction are derived from the national level.

Dynamism in the cantons
On the whole, the cantons are doing a satisfactory job of implementing the national programme. The only negative point is that in some cases some players are finding it more difficult to perform their tasks or to obtain funding.

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26 The following areas are mentioned on page 41: framework for political decision-making; monitoring of the epidemic; product safety; information; instructions and recommendations; co-ordination; networking and knowledge transfer; international co-operation; innovation, start-up and sustainability; crisis and risk management.

27 Persons living with AIDS.
The specific points noted in the chapter on implementation in respect of certain groups or settings apply equally at the cantonal level.

- In the area of treatment and diagnosis, the objectives of the national programme are pursued independently.
- The prevention of HIV/AIDS among drug users has been integrated into general health policy relating to drug use. It is delivered partly on a national, partly on a regional – or even local – basis. It has been institutionalised in the framework of the activities undertaken in the field of drug dependence.
- The school situation is characterised at regional level by complexity and diversity. In this area, there is a clear need to “keep up the pressure” to consolidate or extend existing achievements, at least in some cantons. This means renewing the motivation of the players concerned, which requires symbolic input from the national leadership.
- The biggest differences between cantons are evident in the broad and not very sharply defined area of prevention, advocacy and involvement with particularly vulnerable groups. Here, the situation depends on autonomous decisions taken by local players.

Public goodwill in the fight against HIV/AIDS and the potential for successful prevention

The general public is very positive in its support of prevention work. This attitude is evinced in a real willingness to collaborate in prevention activities, provided that players specialised in HIV/AIDS take the initiative and bear the costs. This is borne out by isolated instances such as the assistance provided by public bodies not directly involved in HIV/AIDS prevention or the co-operation of night club managers. Contrary to the implications of the apparent pessimism surrounding the issue, this goodwill is an asset which could be more widely and systematically drawn on for the purposes of prevention.
**General Situation: Behaviour Patterns and Cases of VIH**

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<th>Conclusions</th>
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<td>&gt; In the general population, and particularly among young people, the signs are that preventive behaviour has now stabilised. However, the situation is more variable in certain population groups: there has been a decline in protective behaviour among MSMs and a similar tendency is observable among drug users. Moreover, in all the groups that were surveyed there are subgroups whose members are significantly more exposed to risk. New cases of HIV are increasing, particularly cases where the infection has been transmitted by the homosexual and heterosexual routes. Persons of sub-Saharan African origin account for a large proportion of the cases of transmission by the latter route. However, we have no recent data for behaviour patterns among migrant groups. Generally, there is a satisfactory level of agreement between the results of behavioural monitoring and those of biological monitoring (actual cases of HIV).</td>
<td>&gt; It is necessary to maintain the prevention initiatives addressed to the general population and to young people. Those addressed to particularly vulnerable groups and subgroups need to be strengthened. As the strategy for combating AIDS has so far proved effective and protection levels remain high, what is required is not a change of direction but appropriate adjustments. &gt; The prevention strategy should continue to be organised around the three levels of intervention, with activities and content appropriate to each level. &gt; A monitoring system needs to be maintained in the form of a long-term second-generation system, combining HIV monitoring with monitoring of behaviour. The system for monitoring other STIs also needs to be improved. &gt; Accurate targeting of prevention activities is not possible without a good knowledge of the groups and subgroups which are particularly vulnerable. Consequently, it is important to maintain the research effort in public health and the social sciences.</td>
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CONCLUSIONS AND GENERAL RECOMMENDATIONS

Conclusions

> Though worrying, the increase in new cases of HIV does not signal a fundamental change in the nature of the HIV/AIDS epidemic in Switzerland, which is still of the concentrated type. For the foreseeable future, AIDS will continue to be an endemic public health problem.

Individual risk management is a reality. As well as the use of condoms, risk management may involve undergoing the HIV test and, between steady partners, negotiated agreements to refrain from taking precautionary measures. However, observation shows that the risks involved are not always adequately taken into account.

Moreover, it is too often the case that people discover they are HIV positive only when they are diagnosed as having full-blown AIDS.

> Though small, the proportion of persons infected with HIV who do not always use condoms when having sex is far from negligible.

Recommendations

> The population should be informed of the epidemiological situation and of relevant behaviour patterns, but without arousing undue anxiety or creating attitudes of stigmatisation.

> Access to good-quality condoms (whether purchased or provided free of charge) needs to be further improved by establishing co-operative relationships with the players concerned (producers/distributors, supermarkets and pharmacies, commercial establishments, low-threshold and treatment facilities serving drug users) (Levels I, II and III).

> People need to be better informed about the HIV test at level II (specific population groups) and level III (individual counselling), and encouraged to take the test if they are in high-risk situations and would benefit, if necessary, from treatment at an early stage.

> Measures should be introduced to encourage persons living with HIV to adopt protective behaviour more consistently. This requires understanding of the reasons for their not taking precautions and calls for initiatives at levels II and III (raising of the issue in the groups most directly affected, the right setting, adequate counselling).
On the whole, those involved in prevention work – particularly at regional level – have adapted well to the changing situation. In many cantons, existing partnerships have been consolidated. In some cantons, however, the situation is more difficult because of uncertainties regarding the long-term funding of prevention activities geared to vulnerable groups.

The effect of the national programme has been to raise expectations – at cantonal level – of clear leadership and resolute support on the part of the SFOPH. Those active at cantonal level would also like to see a clearer definition of roles and better planning, of the kind mentioned, though not set out in detail, in the national programme.

The SFOPH should make more effort to identify problem situations and provide the necessary support.

A strong presence on the part of the SFOPH and the STOP AIDS campaign is necessary to support the dynamic implementation of the national programme as a whole. The SFOPH has taken steps in this direction as a result of the consultation on the 2004-2008 HIV/AIDS campaign.
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<td>&gt; The climate for the introduction of the national programme has been very favourable, with a broad consensus and support from the various players and the population generally. The programme benefits from the dynamism generated in earlier years. In cities and cantons, there is a willingness to co-operate on the part of players whose principal role is not in the field of HIV/AIDS (public services, professionals working in non-healthcare-related areas, the private sector, etc.), particularly in prevention activities. In other sectors – treatment, risk reduction among drug users – developments are occurring independently, but in a way which is fully compatible with the programme objectives.</td>
<td>&gt; Players in the HIV/AIDS field (SFOPH, Swiss Aids Federation, cantonal organisations) should take the initiative in exploiting the readiness to co-operate of other partners and encourage them to play a part in prevention work.</td>
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<td>&gt; There are unexploited possibilities for prevention activity, particularly in the development of networking:</td>
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<td>▪ appropriate links on web sites</td>
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<td>▪ identification of persons with specific needs in relation to HIV/AIDS by professionals in various fields and their referral to specialised agencies (particularly important in the case of young people at risk and migrants)</td>
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<td>▪ ensuring that services co-operate and complement one another by improving the flow of information through the network, etc.</td>
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**Present Coverage and Priority Needs**

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<td>&gt; At prevention level I, the national campaigns and sex education measures have achieved a good degree of coverage. However, the intensity and quality of the initiatives remain uneven.</td>
<td>&gt; It is necessary to continue the campaigns and aim to achieve total coverage where sex education is concerned, since school is a compulsory stage in the lives of all young people (including migrants and young people at risk). Attention needs to be paid to the quality of sex education.</td>
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CONCLUSIONS AND GENERAL RECOMMENDATIONS

Conclusions

> At prevention level II (particular groups), the coverage is uneven:

- good in the case of intravenous drug users, albeit varying from canton to canton
- relatively good in the case of MSMs (though it could be improved, particularly where young people are concerned and in places where MSMs meet to have sex)
- still inadequate in the case of sex workers
- inadequate in the case of migrants from countries where there is a high or growing prevalence of HIV
- inadequate in the cases of persons living with HIV who belong to the various special groups.

Recommendations

> All the cantons need to be encouraged to improve access to injection equipment in structures of all kinds (low-threshold and treatment facilities, pharmacies).

> Prevention work with MSMs needs to be much strengthened by establishing cooperative relationships with the circles concerned (associations, managers of commercial establishments, educational workers).

> Prevention programmes targeting sex workers need to be strengthened, particularly in the case of migrants and drug users, and co-operation needs to be established with the circles concerned (persons working in the social and medical fields, managers of commercial establishments).

> Prevention activities need to be strengthened in the various migrant communities, particularly those of African origin.

> Since persons living with HIV do not constitute a distinct social group, it is important that specific activities promoting both prevention and access to counselling and health care be conducted in all the particular groups (MSMs, drug users, migrants, etc.).
Conclusions

> At level III (individual counselling by professionals, mainly in the medical, educational and social fields), the opportunities for prevention are still underexploited. Yet it is at this level that it is possible to reach vulnerable individuals (e.g. migrants), persons belonging to particularly exposed groups (e.g. MSMs) or those whose behaviour puts them at risk (e.g. clients of male and female prostitutes) and give them advice suited to their personal circumstances.

At this level, it is also possible to improve coverage of the population as a whole in a lasting way, if professionals make the provision of advice/counselling part of their routine.

Recommendations

> More effort needs to be made to encourage certain professionals – doctors in particular – to tackle issues of sexuality and HIV/AIDS prevention more systematically with their patients/clients.

> It is necessary to ensure that the issue of HIV/AIDS and other STIs, and the subject of sexual health generally, is included in the basic and further training of professionals working in the health, education and social fields.
### POLICY IN THE FIGHT AGAINST HIV/AIDS

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<td>&gt; The positive results obtained to date in combating AIDS, which are also observable in neighbouring countries, probably depend more on the general characteristics of the policies adopted than on the specifics of their implementation or the details of their content.</td>
<td>&gt; It is necessary to maintain what seems to be the common core of every effective policy:</td>
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<td>▪ the political will to act</td>
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<td>▪ a liberal (non-repressive) approach to prevention activity and a concern to avoid discrimination</td>
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<td>▪ consistency between activities and continuity of activity</td>
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<td>▪ an on-going effort to raise awareness, both of the state of affairs and of the means employed to deal with it</td>
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<td>▪ on-going vigilance and social advocacy.</td>
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<td>&gt; The SFOPH needs to retain its leadership in this field and act as guarantor of the policy (its role should combine monitoring, coordination, encouragement, and advocacy of its continuation in the long term). To do this, it should delegate most of the implementation to its partners in the field and pursue a policy of giving financial support to projects of national and/or supracantonal scope or promoting projects designed to fill significant gaps.</td>
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