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All the behavioral data has been taken from the prevention program evaluation unit at the Lausanne University Institute of Social and Preventive Medicine.
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index of abbreviations</td>
<td>4</td>
</tr>
<tr>
<td>Appendices</td>
<td>4</td>
</tr>
<tr>
<td>I  Summary of the current situation</td>
<td>5</td>
</tr>
<tr>
<td>II  Overview of the HIV epidemic and behaviors linked to HIV/AIDS</td>
<td>8</td>
</tr>
<tr>
<td>1 Sources and methods</td>
<td>8</td>
</tr>
<tr>
<td>2 Findings</td>
<td>10</td>
</tr>
<tr>
<td>Trends</td>
<td>10</td>
</tr>
<tr>
<td>Men having sexual intercourse with men (MSM)</td>
<td>14</td>
</tr>
<tr>
<td>People contaminated through heterosexual intercourse</td>
<td>18</td>
</tr>
<tr>
<td>Injecting drug users (IDU)</td>
<td>20</td>
</tr>
<tr>
<td>3 Discussion</td>
<td>22</td>
</tr>
<tr>
<td>Preliminary comments on the method used for new positive tests</td>
<td>22</td>
</tr>
<tr>
<td>Current trends</td>
<td>22</td>
</tr>
<tr>
<td>4 Conclusions</td>
<td>24</td>
</tr>
</tbody>
</table>
I Summary of the current situation

Epidemiological situation
Switzerland has managed to maintain HIV infection at the stage of an epidemic affecting mainly specific groups of the population. Nevertheless due to a lapse in prevention and protective measures, the epidemic may spread more widely. In Switzerland the fight against AIDS aims mainly to prevent this kind of negative development.

The total number of new diagnoses of HIV has decreased slightly in Switzerland since 2002. However, this trend does not apply to "men having sexual intercourse with men" (MSM), for whom the number of positive tests has increased significantly, whilst decreasing for heterosexuals. A detailed analysis of notifications of HIV shows that in Switzerland, as in other western countries, MSMs tend to take less precautions.

The three ONEs
Switzerland applies the "Three principles" set by UNAIDS:
1) The national HIV and AIDS program provides a national framework to fight against AIDS together.
2) On a national level, the Federal Public Health Office (OFSP) is responsible for the strategy and planning for the fight against AIDS in Switzerland. Swiss Aid against AIDS (ASS)1, a private body, plays an important role in practical operations. Strategy definition and operations control are the responsibility of the Federal Commission on AIDS related issues (CPS)2, a non parliamentary commission founded by the Federal Council in 1983.
3) On a national level, there is also a common follow-up and evaluation system. The OFSP monitors epidemiological developments. Monitoring of behavioral factors and evaluation of the implementation of the program are mandated by the OFSP and carried out by the Lausanne University Institute of social and preventive medicine. Current monitoring is adapted to the UNAIDS second generation monitoring system

National HIV and AIDS program 2004 - 2008
In 2003, the Federal Council adopted the fourth PNVS, to run from 2004 – 20083. This program is chiefly the work of key figures in the area of HIV and AIDS. It thus provides a common basis for the fight against AIDS: this work becomes fully effective if all those involved invest their efforts in a commonly-defined strategy based on consensus. The national objectives, which are compelling for the federal administration, provide reference points for the work of others.

Three main tasks in the fight against HIV/AIDS
1. prevent new infections through prevention campaigns
2. guarantee access to advice and therapy for the people concerned
3. avoid discrimination against of people affected and promote solidarity

Current prevention priorities
- Adjust the information intended for the general public because HIV infection has changed from being a fatal illness to a treatable (though incurable) illness. It is therefore necessary to send out prevention messages to the general population in order to encourage health: STOP AIDS has become LOVE LIFE STOP AIDS.

1 www.aids.ch
2 www.ekaf.ch
3 www.bag.admin.ch/aids
- Focusing and concentrating information on the largest target groups because the risk of infection is much greater for them than for the general population or for young people: intensive prevention targeting high prevalence groups or those with increased vulnerability must be continued in order to avoid the uncontrolled spread of HIV amongst these populations.

- Improving personal advice, because the HIV test is not a preventive measure in and of itself, but only if it is accompanied by appropriate advice.

The Swiss HIV cohort study (SHCS), guarantor of quality of therapy
The Swiss HIV cohort study (SHCS), guarantees the quality of therapy. Therapy is available for anyone who knows of their HIV-positive status.

Conclusion
The national HIV and AIDS program 2004 - 2008 is having an effect on the Swiss AIDS protection system. Following the projects and actions undertaken in the first third of this period, there is hope that both the slight decline in use of precautions - due to the shock effect wearing off and the removal of the threat of death - in particular for the most vulnerable groups, and the increase in new diagnoses of HIV infection, may be permanently stabilized. The weaknesses and faults of the work carried out so far are well known. Prevention must and can be improved in each of its three areas, with the aim of reducing the number of new diagnoses of HIV infection to below the level of the year 2000.

The next few years will be devoted mainly to improving personal prevention advice, initial and ongoing professional training for the professions in contact with HIV and AIDS, the needs of people living with HIV/AIDS, and to the situation in prisons. At the same time, we are working on a system of external evaluation and setting in place foundations for the future.

This report gives a summary of the current situation of work done and challenges. Additional information is available on our website:

www.bag.admin.ch/aids
Health ministers come and go. It’s always the same message. Stop AIDS

STOP AIDS 2003 campaign poster
II Summary of the HIV epidemic and behaviors linked to HIV/AIDS

The total number of new diagnoses of HIV has decreased slightly in Switzerland since 2002. This tendency does not apply however to "men having sexual intercourse with men" (MSM), for whom the number of positive tests has increased significantly, whilst decreasing for heterosexuals. A detailed analysis of HIV notifications shows that in Switzerland, as in other western countries, MSMs tend to use precautions less often.

The number of HIV positive tests increased considerably in 2002, in particular in two categories: MSMs and heterosexual migrants from countries with a high HIV prevalence(1). This increase did not continue in 2003 and 2004, but the number of new positive results remained high. Proportionately, the different methods of transmission remain stable and no significant change has been recorded for the other epidemiological factors studied(2).

The increase in new positive tests for MSMs followed a regular trend in diminished use of precautionary measures for this population, which was observed as of 1997. The use of preventive measures in the injecting drug using population has remained stable.

The general situation does not appear to have changed significantly in 2005: according to the quarterly statistics published by the OFSP, the total number of positive HIV tests did not increase in the first nine months of the year(3).

Half (40.3%) of males testing positive were in the MSM category. This figure is all more the significant, given that in Germany, where MSMs are by far the category the most affected by HIV, the number of positive tests increased by 20% during the first six months of 2005(4).

1 Sources and methods

This chapter is based on the notifications of HIV positive tests sent to the OFSP by confirmatory laboratories before 30th September 2005 (laboratory notifications) and the corresponding additional notifications sent by GPs.

Data from the behavior monitoring system (5) is also presented in this chapter (see also, chapter VI, 22), which is now fully adopted as part of monitoring in Switzerland. This data is for the general population (young people aged 17 to 20), MSMs and injecting drug users.

From an epidemiological point of view, the amount of information from laboratory notifications is more or less limited to demographic information regarding gender, age and home canton. Other information as to the probable means of infection, nationality or stage of the illness, can be obtained only from the additional notifications. Additional notifications do not necessarily correspond to laboratory declarations (table 1), which means that it is not always possible to determine directly the number of HIV tests for each group in the population; in this case the number is an estimate. This is the case when additional notifications do not indicate which group the person falls into (e.g. means of infection or nationality).
Table 1
Positive HIV tests in Switzerland. Confirmatory laboratory notifications (with the proportion of females affected) and number of additional GP notifications per year for the test (with the proportion of main means of infection).

<table>
<thead>
<tr>
<th>Test year</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory notifications</td>
<td>597</td>
<td>582</td>
<td>631</td>
<td>792</td>
<td>757</td>
<td>742</td>
<td>529</td>
</tr>
<tr>
<td>Proportion of females</td>
<td>36.7%</td>
<td>39.0%</td>
<td>35.8%</td>
<td>39.5%</td>
<td>40.8%</td>
<td>35.8%</td>
<td>32.4%</td>
</tr>
<tr>
<td>Additional notifications</td>
<td>459</td>
<td>425</td>
<td>470</td>
<td>560</td>
<td>643</td>
<td>675</td>
<td>420</td>
</tr>
<tr>
<td>Proportion of MSMs</td>
<td>24.8%</td>
<td>25.4%</td>
<td>22.2%</td>
<td>24.0%</td>
<td>20.8%</td>
<td>23.4%</td>
<td>33.3%</td>
</tr>
<tr>
<td>Proportion of heterosexuals</td>
<td>55.0%</td>
<td>56.7%</td>
<td>55.0%</td>
<td>54.4%</td>
<td>57.3%</td>
<td>59.6%</td>
<td>52.2%</td>
</tr>
<tr>
<td>Proportion of IDUs</td>
<td>14.1%</td>
<td>13.6%</td>
<td>15.4%</td>
<td>11.8%</td>
<td>15.8%</td>
<td>11.1%</td>
<td>10.5%</td>
</tr>
<tr>
<td>Others/do not fall into any category</td>
<td>6.1%</td>
<td>4.3%</td>
<td>7.4%</td>
<td>9.9%</td>
<td>6.1%</td>
<td>5.9%</td>
<td>4.1%</td>
</tr>
</tbody>
</table>

1Results for the first nine months
2MSMs: males having sexual intercourse with males; IDUs: injecting drug users

In order to present figures for the trends of the different subgroups with these trends corresponding to the total number of laboratory notifications for the corresponding gender and year of test, the data had to be extrapolated as a percentage from the additional notifications. These are only estimations and not actual figures for the number of additional notifications received. In order to apply this procedure, it was assumed that the additional notifications were representative of the general situation.

The analysis is based available notifications before 30th September 2005. In order to make direct comparisons with statistics from preceding years, the figures for 2005 were multiplied by a factor of 1.36 (to extrapolate a figure for 12 months with a slight correction in order to take into account notifications for the initial period arriving later). These figures are therefore estimations since it is assumed that the tendency observed in the first nine months will remain the same until the end of December.

From the year 2000 onwards, data is available from notifications showing the breakdown of recent infections and older infections (between 92% and 96% according to the means of infection). This data may include a preceding negative test result or the presence of a primary infection (initial acute phase of HIV infection, which is often accompanied by flu-type symptoms(6)). When the date of the preceding negative test result is known, the infection can be situated in the middle of the period between the negative test and the new positive test. "Recent infection" includes cases where a primary infection has been diagnosed as well as those where the presumed time of infection is less than six months before the HIV diagnosis.
2 Findings

Trends
On 30th September 2005, Swiss notification laboratories had notified 529 HIV positive test results. If it is assumed that the situation did not change significantly before 31st December 2005, it is possible to estimate the total number of HIV positive tests at 720 for 2005, which is once again lower than the figure for the preceding year (cf. table 1 and figure 1).

![Figure 1](image1.png)

Positive HIV tests in Switzerland Laboratory notification, by test year and gender

<table>
<thead>
<tr>
<th>Number of tests</th>
<th>unknown gender</th>
<th>females</th>
<th>males</th>
<th>cases expected before the end of December</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test year</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2005: data up to the end of September</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The proportion of females, which was on the increase until 2003, has been decreasing for the past two years and stood at 32.4% in 2005.

The number of additional notifications sent by GPs has continued to increase significantly since 2002, contrary to laboratory notifications (cf. table 1). This result does not represent an actual increase in HIV tests carried out; it arises from the measures undertaken to increase the number of additional notifications from GPs. The HIV positive test rate with an additional notification has increased to over 90% by 2004, which has improved the reliability of information.

Table 2 shows the geographical distribution of the new HIV positive tests. Contrary to the procedure used for the quarterly statistics published in the newsletter, the notifications not mentioning home cantons (14.7% in 2005) have been attributed to a geographical area according to their laboratory catchment area (simulations). Without this correction, the figures for the different cantons would have been too low.
Table 2
HIV positive tests in 2005 (extrapolated over 12 months) by home canton / region\(^1\). The 77 cases (14.6\%) for which the home canton was not given have been attributed proportionally according to the laboratory catchment areas (estimate ranges are arrived at based on 25 simulations).

<table>
<thead>
<tr>
<th>Region</th>
<th>Corrected number of notifications</th>
<th>Estimate range</th>
<th>Rates (for 100 000 inhabitants)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zurich</td>
<td>190</td>
<td>185-197</td>
<td>15.4</td>
</tr>
<tr>
<td>Vaud</td>
<td>107</td>
<td>105-110</td>
<td>16.9</td>
</tr>
<tr>
<td>Geneva</td>
<td>94</td>
<td>91-98</td>
<td>22.5</td>
</tr>
<tr>
<td>Bern</td>
<td>63</td>
<td>57-67</td>
<td>6.7</td>
</tr>
<tr>
<td>Basle City</td>
<td>37</td>
<td>33-44</td>
<td>20.2</td>
</tr>
<tr>
<td>Plateau</td>
<td>71</td>
<td>61-79</td>
<td>5.4</td>
</tr>
<tr>
<td>French-speaking Switzerland</td>
<td>57</td>
<td>52-60</td>
<td>6.2</td>
</tr>
<tr>
<td>Eastern Switzerland</td>
<td>37</td>
<td>34-41</td>
<td>2.9</td>
</tr>
<tr>
<td>Central Switzerland</td>
<td>38</td>
<td>35-41</td>
<td>5.0</td>
</tr>
<tr>
<td>Tessin and Grisons</td>
<td>18</td>
<td>18-20</td>
<td>3.6</td>
</tr>
<tr>
<td>Abroad</td>
<td>7</td>
<td>7-15</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>719</td>
<td></td>
<td>9.9</td>
</tr>
</tbody>
</table>

\(^1\) Plateau: AG, BL, SO; French-speaking Switzerland: FR, JU, NE, VS; Eastern Switzerland: AI, AR, SG, SH, TG; Central Switzerland: GL, LU, NW, OW, SZ, UR, ZG

The cantons comprising large urban areas, like Geneva, Basle-City, Vaud and Zurich, show a larger number of new HIV positive tests per number of inhabitants. Greater variations compared to the year before were found in the canton of Zurich (increased from 151 to 190), followed by the cantons of Vaud (decreased from 138 to 107) and Bern (decreased from 92 to 63).

Distribution by means of infection changed significantly between 2004 and 2005: the proportion of MSMs increased from 23.4\% to 33.3\%, whilst the proportion of heterosexuals decreased from 59.6\% to 52.2\% (cp. table 1). This is a new development, since between 2002 (the year when the number of HIV positive tests increased significantly) and 2004, the categories most affected by new HIV diagnoses were more or less the same.

The increase in the proportion of new diagnoses in MSMs is even more striking if the results for males and females are separated. The proportion of MSMs increased from 36.5\% of males testing positive in 2004 to 49.3\% in 2005. This figure is the highest ever recorded since additional GP notifications were introduced in 1988.

After extrapolating the relevant figures, it is possible to have an approximate idea of the trends for actual figures (cf. figure 2). For men, the MSM category has increased significantly, from 174 in 2004 to 240 in 2005 (+ 37\%).
However, the number of new HIV cases has diminished for heterosexual males and females (cf. figure 2). The number of HIV positive tests for injecting drug users (IDUs) and in the "Others" category has remained stable for the past few years.

The proportion of foreigners with HIV positive tests has increased again to 55.5% in 2005. The tendency noted over the past ten years in Switzerland was therefore unchanged in 2005. This increase was not however evenly distributed for different nationalities: at the top of the list are European citizens (from 11.0% to 15.7%) The number of Sub-Saharan Africans decreased (from 27.1% to 22.9%).

STOP AIDS 2004 campaign poster in Russian, aimed at migrants (in 16 languages)
The nationality of people testing HIV positive has varied enormously according to the category concerned over the last few years (cf. table 3 for 2005). In the MSM and IDU categories, the people affected are mainly Swiss (around 60%) or people from European countries. Around one third of the heterosexuals are Swiss and 37% sub-Saharan Africans.

Table 3
Nationality (grouped regionally) of people diagnosed HIV positive in 2005 according to means of infection

<table>
<thead>
<tr>
<th></th>
<th>MSMs</th>
<th>Heterosexuals</th>
<th>IDUs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number1 (%)</td>
<td>Number1 (%)</td>
<td>Number1 (%)</td>
</tr>
<tr>
<td>Switzerland</td>
<td>140 (58.6 %)</td>
<td>130 (34.7 %)</td>
<td>43 (56.8 %)</td>
</tr>
<tr>
<td>European countries</td>
<td>46 (19.3 %)</td>
<td>53 (14.1 %)</td>
<td>10 (13.6 %)</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td>3 (1.4 %)</td>
<td>139 (37.0 %)</td>
<td>10 (13.6 %)</td>
</tr>
<tr>
<td>Asia</td>
<td>10 (4.3 %)</td>
<td>21 (5.5 %)</td>
<td>3 (4.5 %)</td>
</tr>
<tr>
<td>Others</td>
<td>41 (17.1 %)</td>
<td>33 (8.8 %)</td>
<td>9 (12.0 %)</td>
</tr>
<tr>
<td>Total</td>
<td>239 (100.0 %)</td>
<td>376 (100.0 %)</td>
<td>75 (100.0 %)</td>
</tr>
</tbody>
</table>

1 Number of notified HIV tests extrapolated over 12 months
2 MSMs: Males having sexual intercourse with males; IDUs: injecting drug users

In the MSM category, the number of Swiss nationals diagnosed HIV positive has changed considerably since 2002 (between 100 and almost 150 per year). In the same category, the number of Europeans has continued to increase over the past few years (reaching 46 in 2005 after extrapolation). The number of non-European foreigners (mainly South Americans) is beginning to increase (cf. figure 3). Amongst people infected through heterosexual intercourse, the number of Europeans has increased slightly each year since around 2001. The number of Swiss nationals and sub-Saharan Africans has significantly decreased compared to 2004.

Figure 3
Positive HIV tests in Switzerland
Estimation of the number of HIV infections diagnosed in males having sexual intercourse with males (MSM) and heterosexual people infected by region of nationality

<table>
<thead>
<tr>
<th>MSM</th>
<th>Heterosexual men</th>
<th>Heterosexual women</th>
</tr>
</thead>
<tbody>
<tr>
<td>CH</td>
<td>CH</td>
<td>Sub-Saharan Africa</td>
</tr>
<tr>
<td>Others</td>
<td>Sub-Saharan Africa</td>
<td>CH</td>
</tr>
<tr>
<td>Europe</td>
<td>Europe</td>
<td>Europe</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Test year

1 The additional notifications have been extrapolated for the total number of laboratory notifications.
2005: The results of the first nine months were extrapolated over the whole year.
Men having sexual intercourse with men (MSM)

As already stated, the number of new HIV positive tests for MSMs increased by around 37% in 2005. In absolute terms, this increase is similar for Swiss nationals, Europeans, and Asians or Americans (+18, +19 and +28 cases respectively). There has however been a more marked increase for foreigners than for Swiss nationals (Swiss: +15%, Europeans: +70%, Asians or Americans: +127%), because the number of new cases for this group reached a much higher level.

In the cantons of Geneva and Basle-City and in the three cantons of the Plateau (cp. table 2), the increase in the number of new HIV positive tests for MSMs was above average. In French-speaking Switzerland (except for Geneva), no increase has been recorded.

Over the past few years, the distribution by age of HIV positive MSMs has not changed significantly (cf. table 4). The median age is fairly constant at 37 years. MSMs are no older than heterosexuals or male injecting drug users (IDUs) when diagnosed, although this was the case a few years ago(7).

STOP AIDS 2002 campaign poster

Table 4
Median age\(^1\) for people diagnosed HIV positive from 2001 to 2005 by means of infection\(^2\) and gender.

<table>
<thead>
<tr>
<th></th>
<th>MSMs</th>
<th>Heterosexuals</th>
<th>IDUs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>males</td>
<td>Females</td>
<td>males</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^1\) By median, it is understood that half of the people are younger than the given value, and half older
\(^2\) MSMs: Men having sexual intercourse with men; IDUs: injecting drug users
Amongst the new HIV positive tests for MSMs for whom the time of infection is known (after 2001), 31% would appear to have been infected during the six month period preceding the HIV diagnosis. During the period under review, this rate increased from 21.3% to 42.3% (table 5). Extrapolating for 2005 gives an increase of almost 40 more new infections than in 2004, which means that in the MSM category almost two-thirds of the total increase in HIV positive tests are due to recent infection.

Table 5
Rate of recent Swiss HIV infections by means of infection and test year.

<table>
<thead>
<tr>
<th>Test year</th>
<th>MSM</th>
<th>Heterosexuals</th>
<th>IDUs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number1 (%)</td>
<td>Number1 (%)</td>
<td>Number1 (%)</td>
</tr>
</tbody>
</table>

Date of infection in the six month period preceding the HIV diagnosis (evaluation based on a previous negative test or primary infection diagnosis). Extrapolation over the total number of laboratory notifications. 2005: data for the first nine months was extrapolated over the whole year.

2 MSMs: Men having sexual intercourse with men; IDUs: injecting drug users

Since 2001, sexually transmissible infections (STI) have been diagnosed in the two years preceding HIV diagnosis for almost 14% of MSMs testing HIV positive. This rate increased from 9.1% in 2001 to 20.7% in 2005 (table 6). The number of cases may have doubled in 2005. STIs include gonorrhea (46%), syphilis (40%), chlamydial infections (22%), and other infections (condyloma, hepatitis B and herpex simplex at a total of 14%).

Table 6
Estimation of the number of people diagnosed HIV positive having contracted a sexually transmissible infection within the two years preceding the HIV positive test. Distribution by means of infection and test year.

<table>
<thead>
<tr>
<th>Test year</th>
<th>MSM</th>
<th>Heterosexuals</th>
<th>IDUs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number1 (%)</td>
<td>Number1 (%)</td>
<td>Number1 (%)</td>
</tr>
</tbody>
</table>

1 Extrapolation for the total number of laboratory notifications. 2005: data from the first nine months has been extrapolated over the whole year

2 MSMs: Males having sexual intercourse with males; IDUs: injecting drug users

For 74.9% of the 679 additional notifications concerning MSMs (after 2001), data is available concerning the number of sexual partners over the last two years. In 44.9% of cases, the men concerned say they have had at least five partners over the last 24 months. This rate is higher for MSMs with a STI (73.5%), or for whom the HIV infection is recent (56.7%).

Repeated surveys were carried out amongst MSMs in Switzerland in 1992, 1994, 1997, 2000 and 2004 using a questionnaire inside gay magazines.

In 2004, the questionnaire was also proposed on the internet. These surveys showed changes implying a greater exposure to risks of HIV infection.
The median number of sexual partners (over the last 12 months) has thus considerably increased, from 5 in 1994 to 7 in 2004.

Preventive behavior during the last 12 months is measured using two indicators: the use of condoms during anal penetration according to type of partner (stable or casual) and unprotected anal penetration with one or more partners of differing or unknown HIV status. The second indicator allows an estimation of the general level of exposure to risk within the population of respondents (regardless of partners in sexual activity).

Generally, the data from the 2004 survey confirms the trends observed as of the latter half of the 1990s (Figure 4). The proportion of respondents engaging in anal penetration with casual partners is rising: it rose from 56% in 1994 to 73% in 2004. Having reached its lowest level in 1994 (9%), the proportion of respondents not systematically using condoms has been rising steadily: it stood at 13% in 1997, 18% in 2000 and 20% in 2004 (Internet: 23%). In the 'paper' sample, this trend can be observed independently of the age of respondents. However, in the Internet sample, an big difference can be observed for the level of exposure to risk between respondents aged less than 30 (27%) and those over 30 (21%). This high level of risk amongst the under-30s is seen more particularly in the behavior of young adults under 20: 40% of them never use condoms with casual partners during anal penetration, as opposed to 24% of 20-29 year-olds.

With stable partners, the practice of anal penetration has also increased, from 70% in 1992-94 to 80% in 2004 (Figure 4). However, no major change is observed for preventive behaviors with respect to protection. Taking into account alternative protection strategies (for example mutual faithfulness), a majority of couples do not systematically use condoms during anal penetration. This proportion varies enormously according to the HIV status of both partners, but remains relatively high in all cases. For example, in 2004, the HIV status of one of the two partners is unknown in 40% of stable relationships (Internet: 57%) and 43% of these couples did not systematically use protective measures for anal penetration (Internet: 55%).
**Figure 4**
Proportion of respondents having practiced anal penetration during the last 12 months (as a %) and proportion of these respondents having had unprotected relations, by type of partner and age group

<table>
<thead>
<tr>
<th></th>
<th>With stable partner</th>
<th>With casual partners</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Overall</td>
<td>Overall</td>
</tr>
<tr>
<td>Internet</td>
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<td>Under 30</td>
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<td>Over 30</td>
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% of respondents having practiced anal penetration during the 12 months preceding the survey
% of respondents practicing anal penetration having had unprotected relations.
* printed questionnaire only
In spite of the slackening off of preventive behaviors with casual partners, the general level of exposure to risk (at least one unprotected anal penetration with a partner of different or unknown HIV status) has not worsened since the end of the 1990s. After a slight increase between 1994 (11%) and the year 2000 (14%), it remained stable in 2004 (13%). No significant difference is observed for respondents of different ages. On the Internet, the value of this indicator is considerably higher (17%) for all age groups: amongst under-30s, 13% of respondents to the printed questionnaire had been exposed to risk, as opposed to 17% of respondents on the Internet. A similar gap can be observed for over-30s (13% as opposed to 16%).

People contaminated through heterosexual intercourse
The steep rise in the number of people contaminated through heterosexual intercourse in 2002, particularly affecting those from sub-Saharan Africa, continued until 2004 but at a reduced rate (cf. figure 2). In 2005, the number of new cases dropped for the first time, for males and for females (after extrapolation, 375 cases as opposed to 442 in 2004, viz. 15%). This trend corresponds to the fall in the proportion of people infected through intercourse (from 59.6% to 52.2% in 2005) mentioned above.

The drop in the number of new HIV positive tests was particularly significant for Swiss and sub-Saharan African heterosexuals (37 fewer cases in each category after extrapolation). However, the slight increase observed over the last few years for European heterosexuals has continued (cf. figure 2).

Since 2003, the median age of heterosexual males at the time of HIV diagnosis has increased from 36 to 41 years. The age of females has remained relatively stable since 2001 (except for a temporary rise in 2003) at 31-32 years. For males, the proportion of the over-35s age group has increased significantly, whilst that of under-35s has decreased.

For 17% of heterosexuals declared HIV positive since 2001, the infection probably occurred in the six month period preceding the positive HIV test. In this category, contrary to that of MSMs, no trend can be observed; variations in the level can be seen, in the 13% to 19% range (cf. table 5).

For around 7% of heterosexuals diagnosed HIV positive since 2001, a STI had been diagnosed in the two years preceding the positive HIV test. In this case also, no trend can be observed for the period under review (cf. table 6). Gonorrhea (17% of STIs for this group) and syphilis (25%) are found more often than for MSMs. In 22% of cases, the STI was a chlamydial infection. "Other STIs" is the largest category with 41%.

In the category of people contaminated by heterosexual intercourse, data is available for the number of sexual partners over the last two years for 73.6% of the 1542 HIV positive tests having been subject to an additional notification (after 2001). In the majority of cases (81.2%), the number of partners was a maximum of five (and only one partner in 44.0% of cases). As for MSMs, there is a correlation between having more than five sexual partners and a STI diagnosis (18.3%) of cases with a STI, 10.6% of those without an STI).

In 74.8 cases, information is available enabling classification sexual partners from the last ten years according to HIV risk. Partners from countries with a high HIV rate are mentioned by far the most often (63.1%), followed by casual partners (16.4%), partners of known HIV status (8.9%), and injecting drug using partners (7.2%).
There are however considerable differences according to the nationality of the person diagnosed HIV positive: partners from a country with a high HIV rate are cited first by Swiss nationals (in 44.5% of cases), then casual partners (28.3% for males and 18.3% for females). Sub-Saharan Africans mention almost exclusively partners from a country with a high HIV rate (89.2%).

The last survey of the general population’s (17-45 year-olds) sexual behaviors was carried out in the year 2000(10). For young people, the use of condoms remains high: in the year 2000, 69% of 17-20 year-olds had used them in their new stable relationship (Figure 5); the use of condoms with casual partners is systematic for 76% of them (Figure 6). Learning prevention methods through sex education at school (almost universal in Switzerland) seems to work well.

**Figure 5**
Proportion of young people (17-20 year-olds) with a new stable partner during the year and use of condoms with this partner (1998-2000)

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<tr>
<td>% new stable partners</td>
<td>% use of condoms</td>
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\*Slight drop compared to 1997, which seems to have been exceptionally high.
Figure 6
Proportion of young people (17-20 year-olds) with casual partners in the last 6 months and use of condoms in this context (1987-2000)

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<tr>
<td>% with casual partners</td>
<td>always using condoms</td>
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Injecting drug users (IDUs)

Aids: stop Injecting drugs. Or use only sterile syringes. Sterile syringes: on sale in all pharmacies. STOP AIDS

Warning of the Federal Office for public health: the use of drugs puts your health at risk and is a criminal offence.

STOP AIDS 1994 campaign poster

The notifications of HIV positive tests for IDUs do not make it possible to establish a clear trend since 2001. This group was also spared the general increase seen in 2002. A temporary increase was recorded in 2003 (from 93 to 120 cases). In 2004, the number of cases went back down to 82.
In keeping with the trend observed from the time that additional notifications came into force, the median age of male IDUs at the time of HIV diagnosis has been constantly rising since 2001. This rise is explained firstly by a higher incidence in the 40-45 age bracket. No similarity has been observed since 2001 for female injecting drug users.

For 27% of HIV positive diagnoses for IDUs since 2001, the infection probably occurred less than six months before the positive test result. The number of recent infections doubled between 2001 and 2003, before returning to its 2001 level (cf. table 5).

For IDUs, doctors had only rarely diagnosed a STI in the two years preceding the HIV diagnosis (between 3 and 7 cases per year after 2001, cf. table 6). Since there are few cases, it is impossible to determine a trend.

For 83.3% of notifications showing the date of last drug use, this was less than a year before HIV diagnosis. It may therefore be assumed that most of the people concerned were still drug addicts at the time of diagnosis (this was the case for 72.3% of the 360 notifications concerning IDUs after 2001). The median length of drug use before HIV diagnosis was 11 years for this group, whilst it was between six and seven years before 1995.

In the notifications mentioning the frequency of shared syringes, 28.8% of IDUs said they often shared syringes, 59.6% occasionally and 11.6% never.

Surveys carried out with drug users visiting centers providing new syringes (1993, 1994, 1996, 2000, next survey planned for 2006), show that preventive behavior has become more regular(10).

The proportion of drug users having used a syringe or needle already used by someone else recently - in the six months preceding the survey - is fairly low, at around 10%, with a possible tendency to increase over the past few years (9% in 1994, 11% in 1996, 12% in 2000).

However, sharing equipment used to prepare injections is far more frequent and this could be a possible explanation for the high rate of hepatitis C infection reported. Shared use of spoons and filters decreased slightly between 1996 and 2000 (in 2000, 51% had shared spoons and 38% filters during the preceding 6 months; the figures for 1996 were 68% and 46% respectively).

Users exposing themselves to risk of infection by injecting themselves using equipment which has already been used by someone else (called syringe/needle sharing here) can be differentiated from those who do not. They are slightly younger and are mostly female. They are in less good health, often living in precarious conditions (unemployed, homeless, without professional training) and they have often spent some time in prison over the preceding two years. They mostly use and inject cocaine and inject themselves more often.

The use of protection during sexual intercourse has not changed significantly over the last few years and is still insufficient, especially with stable partners. In the year 2000, over two-thirds of drug users systematically protected themselves during casual sexual intercourse during the 6 months preceding the survey. The opposite is observed for stable relationships: slightly less than one third of individuals systematically protected themselves. In half of the cases, the stable partner is not a drug user.
The proportion of females having practiced prostitution during the last 6 months seems to be decreasing. The rate of condom use with clients is decreasing slightly but remains very high (83% systematic condom use in 2000).

3 Discussion

Preliminary comments on the method used for new positive tests

The figures in this report were obtained by extrapolating the situation on 30th September 2005. They are therefore not final figures. This method was chosen for the sake of clarity, because it is thus possible to make direct comparisons with preceding years. The experiment showed that the difference between the estimated total (of around 720 new cases in 2005) and the final total will probably not exceed around twenty cases. Final figures will be available in 2006.

The same trends were observed in a parallel survey, which was also aimed at the last few years but taking twelve months (from 1st October to 30th September) as its period of reference.

Current trends

The new documented changes taken from the analysis of the data on HIV published in 2004 can be presented in the following way(11). These new changes have not had any direct impact on the total number of HIV positive tests. The increase in the number of new HIV positive tests for MSMs is the most important change for the period under review. This change has also been documented in Germany(12). This increase comes as no surprise since a slight but steady decrease in preventive behaviors in this population has been observed since from the end of the 1990s, in Switzerland but also in Germany and in France. At the same time, a decrease in the proportion of females diagnosed with HIV has been observed. This decrease is not due to a reduction of the number of infections but is the indirect result of the rise in the number of cases for MSMs.

The age of males contaminated by heterosexual intercourse and male injecting drug users has been increasing for a few years. No parallel has been observed for MSMs. In the latter category, the median age at the time of the first positive diagnosis has remained unchanged at 37 years for the past few years, as in France, for example(14).

The rise in age at the time of HIV diagnosis could indicate that the risk of infection has lessened during the period of exposure to the HIV virus. For example, the risk of infection could diminish if the HIV prevalence is reduced, which is nonetheless unlikely. This risk could also diminish due to better protective measures, which nonetheless prove to be insufficient in the long term. For sexually active people, more consistent condom use could be envisaged (amongst other alternatives), for IDUs less syringe sharing, which would delay the time of infection. This hypothesis is borne out by the fact that for IDUs, drug addiction has predated HIV diagnosis by a longer time period since the year 2000 than in the middle of the 1990s. Also sharing injecting equipment has not increased and there has been a general decrease in the number of injecting drug users. The increase in age may also indicate that heterosexual males are protecting themselves more than they have done in the past few years, whilst this hypothesis does not hold good for MSMs.
An STI has been diagnosed in the two years preceding HIV diagnosis far more often for MSMs than for heterosexuals and IDUs. The number of MSMs concerned has increased significantly over the past few years. This phenomenon has also been observed in the neighboring countries around Switzerland(15-19). The male/female ratio in the laboratory notifications of Neisseria gonorrheae infections has also seen a marked increase since 1997. Moreover, syphilis diagnoses for males, made by Swiss dermatology clinics, has increased sharply since 2001. This increase was far more noticeable for MSMs than heterosexuals(20). It has recently been ascertained that lymphogranuloma venereum reappeared in MSMs in 2003, in Switzerland and in the rest of western Europe, although it had practically disappeared in industrialized western countries(21,22). All these factors lead us to believe that MSMs are having more and more unprotected sexual intercourse and that this is leading to an increased risk of HIV infection.

The analysis of notifications mentioning the number of sexual partners also confirms that there is a link between the increase in new HIV positive tests for MSMs and unprotected sexual intercourse. The rate of people saying they have had sexual intercourse with five or more partners is far higher for MSMs than heterosexuals. In these two categories, the number of partners is higher for people having been diagnosed with a STI during the two years preceding the HIV diagnosis. For MSMs, this number is also higher for recently infected males, than for males probably infected more than six months previously.

In the category of people contaminated by heterosexual intercourse, there is a high rate of people probably having been infected by a partner from a country with a high HIV rate. However, this rate varies considerably according to the person's nationality. For Swiss nationals, it is 45% but 90% for people from sub-Saharan Africa. In the latter case, it can clearly be concluded that intercourse leading to infection occurred mainly - either in the country of origin, or in Switzerland - between two people of the same nationality. For Swiss nationals, it is more difficult to make an interpretation, given that it is not known whether the person was infected in Switzerland or abroad. Swiss males, for whom a STI diagnosis was made in a Swiss polyclinic, did however often state that they were infected during a trip abroad(23).

Since 2001, the proportions of recent infections for new positive HIV tests has varied between 17% and 31% according to the means of infection. Generally speaking, this proportion should be higher due to the fact that primary infections often go unnoticed(24) or notification of previous negative tests has not been given. This hypothesis is confirmed in France, where a serologic test to determine recent infections has been in use since 2003(25). Data taken from the medical file and laboratory notifications point to the same changes and timescale. A laboratory test similar to the French serologic test has been in use in Switzerland since July 2005 in the context of the "CH.A.T" survey (CH=Switzerland, A=Aids, T=Transmission Survey(26)). The information thus gathered will allow for a more reliable analysis of current changes in HIV epidemiology.

The proportion of recent infections is higher for MSMs and IDUs than for heterosexuals. This is due to the fact that for the latter, HIV status only is diagnosed more frequently than AIDS when the first symptoms appear(27). It could be concluded that there are more heterosexuals than MSMs or IDUs who do not know (or who prefer not to know) that unprotected sexual intercourse carries a risk of infection. Another explanation could be that a large proportion of HIV positive heterosexuals are migrants, who, for different reasons, have HIV tests less frequently than Swiss nationals.
For MSMs, the number of recent infections has been continually increasing since 2001, with a particularly marked increase in 2005. Is this high figure due to an increase in the number of tests? This is not possible due to the fact that the increase is only found for MSMs and it is not very plausible that only this category of people is having more tests. In addition the number of MSMs coming to anonymous screening centers has remained the same, at almost 7%, over the past few years.

4 Conclusions

This information taken from notifications of HIV positive tests clearly shows that our country is affected by the world HIV epidemic. For example, the change in heterosexual cases shows that Switzerland, like its western European neighbors, has been affected since the latter half of the 1990s, by the rapid changes in the epidemic in Southern and Asian countries. Migrations, and trips abroad made by Swiss nationals, are the main causes of this phenomenon.

The data currently available shows the link between the changes in the HIV situation in Switzerland and other western European countries. This information leads to the conclusion that the measures aimed at reducing the risk of HIV infection or STIs are not being implemented, particularly by MSMs. With respect to lymphogranuloma venereum, it would appear that direct contact between MSMs from different countries is the main reason for the reappearance of this disease in MSMs in all western countries, even in North America, a region which as been affected only recently. HIV notifications only rarely mention contamination, which does not allow us to determine how far this explanation can also be applied to HIV. This is one aspect which should be able to be examined more thoroughly by means of the CH.A.T. survey mentioned above.
III National response to the AIDS epidemic

5 The Three ONEs

Switzerland applies the “three ones” principles drawn up by UNAIDS:
1) In the PNVS (national HIV/AIDS programme) it has a common national framework for combating AIDS.
2) At the national level, strategic and conceptual management of the fight against AIDS is in the hands of the OFSP. The ASS, a private organisation, plays an important role in operational implementation. Matters concerning definition of strategy and supervision of implementation are dealt with by the CFS, an extra-parliamentary committee set up by the Federal Council in 1983.
3) There is a common system for monitoring and evaluation at the national level. The OFSP provides monitoring of epidemiological development. The monitoring of behaviour indicators and the evaluation of implementation of the programme are carried out, on instructions from the OFSP, by the IUMSP (university institute of social and preventive medicine) at Lausanne University. Monitoring is currently in line with the UNAIDS second-generation surveillance system.
On 26 November 2003, with a view to World AIDS Day on 1 December, the Federal Council adopted the fourth national HIV/AIDS programme (PNVS), in force for the period 2004 – 2008. This programme is mainly the work of players in the HIV/AIDS field who discussed its content at workshops. It was then submitted to a very wide-ranging consultation and finalised according to the various written positions adopted and discussions undertaken during consultation conferences. Thus it constitutes a common basis for combating AIDS; this work is most effective if all the players direct their activities according to a strategic plan developed jointly and based on consensus. One of the main achievements of the new programme is that, apart from the joint effort at the level of content, certain roles and competencies for implementing national objectives were negotiated right from the programme’s development stage. The national objectives, which are binding on the Federal administration, constitute markers for the work of the other players.
Three main tasks in combating HIV/AIDS

For the past twenty years there has been a consensus on the three main tasks involved in combating HIV/AIDS:

1. stopping further HIV infection by prevention;
2. ensuring that the people concerned have access to counselling and treatment;
3. preventing discrimination against the people concerned and promoting solidarity.

Figure 7

The main areas of activity in the national HIV/AIDS programme for 2004 – 2008 (hatched area = sectors of application of the programme)
Since the beginning of the prevention of AIDS, Switzerland has successfully followed the approach that has meanwhile been summed up in the formula "CNN" (Condoms, Needles, Negotiating skills).

In its current activities on prevention, Switzerland takes as its model the UNAIDS policy position paper entitled "Intensifying HIV Prevention". It already applies many of the principles set out in this document. The other principles serve as a guide for the current adaptations of work on prevention. An auto-evaluation gives a view of this.\(^5\)

It is only by continuously investing in HIV prevention that there will be success in future in preventing a generalisation of the HIV/AIDS epidemic in Switzerland. It would only be possible to guarantee and maintain the success prevention has had so far if protection behaviour continues to maintain a high level in the general population for all sexual relations except those within a mutually faithful couple with no HIV. It is then necessary for the target groups that are particularly concerned or vulnerable to be reached by prevention messages over a period of time. And the level of cases of new infection by HIV declared each year must be brought down to below the figures for 2000.

Evolution in protection behaviour

In the light of the data gathered in Switzerland for the evaluation of the AIDS prevention strategy, on protection behaviour, on the evolution of knowledge and ideas among various groups of the population, it appears that the population is on the whole well informed about HIV/AIDS and the means of protection. This is due to the intensity, the continuity and the wide coverage of the media campaigns, the activities carried out in schools and, more generally, social mobilisation. As early as 1987 we were able to observe a considerable change in behaviour in the direction of greater protection. Although unequal depending on age group and type of partner, the level of condom use is generally high. We can see an example of this in the evolution of protection with occasional partners.

\(^5\) http://www.suchtundaids.bag.admin.ch/imperia/md/content/aids/99.pdf
Figure 8

Proportion of persons having had one or more occasional partners in the six months preceding the survey and the use of condoms in these situations, for the age-groups 17-30 years (1987-2000) and 31-45 years (1989-2000)
Source: prevention programme evaluation unit (UEPP), Lausanne

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<th>17-30 years</th>
<th>31-45 years</th>
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<tr>
<td>with occasional partner</td>
<td>always with condom</td>
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This increased prevention behaviour has been stable since 1992. The most probable interpretation of recent data (2000) is that this stability is continuing – there is no evidence of falling back. One must nevertheless be prudent in the present epidemiological context (recent increase of new cases of HIV and STIs, international context of a recrudescence of the epidemic). Nor should the overall evolution blind us to the existence of substantial individual variations.

The most recent data on protection behaviour among young people (SMASH study\textsuperscript{6}) and the evolution in the sale of condoms do not show any sign of a decrease in protection and confirm the tendency to stability. This data was gathered in 2002 and refers to a period marked by the re-launch of the topic of HIV/AIDS in the press, by communications from the OFSP, and by the campaigns which, from the end of 2001 onwards, have warned against an upsurge of the epidemic in industrialised countries and have drawn attention to the disaster occurring in developing countries.

\textsuperscript{6} Swiss Multicenter Adolescent Study on Health; see (30)
**Figure 9**

Marketing of condoms in Switzerland (estimation: more than 80% of the market)
Source: prevention programme evaluation unit (UEPP), Lausanne

*in millions of units*

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**The prevention of HIV improves protection behaviour without altering sexual behaviour**

The evaluation of the HIV/AIDS prevention strategy in Switzerland shows firstly that this prevention results in the global population improving its behaviour in terms of protection, and secondly that it does not actually change sexual behaviour. Thus the number of occasional partners has not increased in the 17-30 years age-group. HIV prevention has not resulted in earlier sexual activity among young people and the number of abortions among this population has not increased while, at the same time, condom use has increased in general terms.

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**Is prevention worth it?**

Without proper treatment, infection by HIV leads, in 8 to 12 years on average, to full-blown AIDS. It then causes death by deficiency of the immune system, in 10 to 30 months. Currently in Switzerland people who have been diagnosed as being infected by HIV are treated using antiretroviral medicines before the symptoms of AIDS appear. To do this, the state of the immune system is assessed in the laboratory and an indication is established. Retroviral medical treatment costs on average 20 000 Swiss francs per year. Taking into account the 6 000 people who currently need treatment, the immediate cost amounts to 10 million Swiss francs per year.

If in one year 500 people become infected with HIV, the cost of their treatment for an average of ten years would amount to 10 million Swiss francs per year, on the basis of current costs. We must nowadays start from the principle that treatment lasts a lifetime with the possibility of a few interruptions.
The argument that medicines will be cheaper in the future does not stand up by analogy with other chronic diseases. In the history of medicine, progress in research and the development of medicines has very rarely resulted in a new generation of medicines that are more effective and cheaper.

A simple calculation shows that if people infected by HIV need medication for just five years at current prices, it is worth spending 100,000 Swiss francs to prevent a single case of infection, not counting the economic losses, the human suffering caused and the years of living that are lost.

A study by the Swiss national fund for scientific research (FNS) estimates the cost of prevention at 55 million Swiss francs for 1998. In comparison, the immediate cost of infection by HIV was estimated at 143 million Swiss francs for the same year. The indirect cost caused by the disease and deaths were in the order of 275 million Swiss francs (24).

A recent American study recommends investing public money in the combination of campaigns directed at the general population and prevention among target groups because of their efficiency and effectiveness. On the other hand, HIV testing programmes among the general population should be dropped because the cost far outweighs the benefits (31).
Conclusion: the combination of media campaigns directed at the general population and more detailed information directed at the targeted groups at risk, including an offer of counselling and voluntary HIV testing, is worthwhile. The recommendation to test the general population, however, is not very effective and is very expensive.

The three levels of communication in prevention

The prevention of HIV (based on action at three levels):
1. Information for the general population (wide-ranging action): everyone living in Switzerland should be informed regularly about HIV/AIDS and about the possibilities of protection.

2. Information and motivation specific to a number of target groups (wide-ranging action and in-depth action): people whose behaviour puts them at risk, who are part of a group in which prevalence is high, or who are at risk because of their living conditions (and are therefore vulnerable) receive targeted information and their motivation in favour of prevention is encouraged.

3. Individual prevention action and counselling (in-depth action): decentralised information services, encouragement in favour of prevention and counselling are offered on an individual basis or in specific ways to individuals.

This model is based on knowledge of the fact that, for very many people, information on infection by HIV, possible routes of transmission (and those that are not) and the possibilities for protection have a sufficiently preventive effect in that these people are seldom exposed to such risks. For people whose behaviour puts them at risk and for people whose living conditions place them under the threat of an increased risk of infection by HIV, "general public" messages do not provide them with enough information, or enough encouragement in favour of prevention, or enough support in changing their behaviour. Individual counselling is for people whose questions and problems (uncontrollable fear of AIDS, difficulties with using a condom, questions about HIV testing, relational problems, etc) call for individual clarification and solutions. The prevention messages therefore need to be communicated, placed in context and adapted according to the level and the individual.

The LOVE LIFE - STOP AIDS campaign

The STOP AIDS campaign – 1987-2004
Since 1987, with the STOP AIDS campaign, the OFSP and the ASS have been regularly informing everyone living in Switzerland about HIV/AIDS and the possible means of protection.
The STOP AIDS campaign fulfils three functions:

1. it informs the entire population and encourages protection;

2. it sends out a visible political signal – AIDS is a problem of national importance that must be taken seriously;

3. it creates a rallying point for the prevention of AIDS, motivates the people involved in prevention work, and supports them in their efforts at local level.

The STOP AIDS campaign is the best-known prevention campaign in Switzerland – between 70 and 80% of the people asked said they remembered it (spontaneously or otherwise)\(^7\).

\(^7\) Post-tests for the STOP AIDS campaigns in 1995, 1997, 1999 and 2001 (representative surveys).
The STOP AIDS campaign affects the three elements in the chain – “increase awareness” – “change attitudes” – “influence behaviour”. Most of its action operates at the first two levels:

1. awareness – making and keeping people aware of AIDS; this is essential in assimilating information;

2. behaviour – encouraging a positive attitude towards the prevention of AIDS and using a condom; to achieve this, the message must be remembered and must be convincing.

By the message it puts across, the campaign also confirms and reinforces the desired prevention behaviour. The path from the assimilation of information to a change in behaviour is a long one, demanding a constant reminder of the campaign's messages and continuation of the campaign. In addition, between seventy and one hundred thousand young people reach sexual maturity each year, making them new targets for the campaign.
New challenges
The prevention work of STOP AIDS has been very effective over the past eighteen years. Use of a condom and the STOP AIDS brand name are both widely established in society. However, we are now faced with new challenges:
- The general public's perception of the present threat posed by HIV/AIDS has lessened in intensity, at least since it has been possible to treat HIV. AIDS nevertheless remains a potentially fatal disease. The long-term success of treatment is uncertain, and medical treatment can have unpleasant side effects. The people affected often suffer from isolation and various mental disorders, so maintaining the population's awareness of HIV/AIDS and making the rising generations reaching sexual maturity aware of the fact that they will have to live with HIV in the years to come remain specific challenges.
- Faced with this situation, fewer resources are available for HIV prevention. This situation falls within the context of general financial cut-backs on the part of the public authorities. It is also a consequence of familiarisation with HIV/AIDS. Substantial amounts are not spent on such a long-standing issue.
- Lastly, the STOP AIDS campaign is also intended to make the younger generation aware of an issue that is supposedly well-known and to adopt an intelligent position in an increasingly sexually-oriented advertising environment.

From STOP AIDS to LOVE LIFE
The STOP AIDS campaign is reacting to these challenges by taking a new direction:
- according to the principle of encouraging good health, it puts sexual health at the centre of the campaign;
- by its positive provocation, the campaign creates news, and increases the emotional loading of the messages and the involvement of the target groups;
- by combining positive messages with specific advice on behaviour, the campaign increases its relevance;
- AIDS cannot be eradicated yet, and this decreases the credibility of the STOP AIDS brand name. Since 2005, LOVE LIFE – STOP AIDS has enabled us to continue a natural development of the brand name.

Production of the campaign
a) Creative concept
For the message for our 2005-2008 campaign, we are using the highest common denominator – the thing that links all the segments of the target groups is in fact their identical desire for a carefree love-life. This is a universal, unfailing desire. We make that a reality in the heart of our campaign by launching an appeal to LOVE LIFE and STOP AIDS. LOVE LIFE reflects straightforward behaviour for the future by symbolising a positive experience of sexuality.

b) Standard messages
To increase the meaning of the 2005-2008 campaign, standard messages will be communicated. These should pass on knowledge and at the same time provoke specific action as well as sometimes offering explicit help. In doing so, attention is being paid to the widespread application of the rules for safer sex, concentrating on the two most important rules – no penetration without a condom, and avoiding mouth contact with sperm or blood. In this way we give the target public understandable advice on behaviour so that they can protect themselves effectively. To increase their detailed knowledge of the rules for safer sex, these phrases are included in most of the means of communication. A "call to action" is also used as a standard feature, in the form of an Internet site (www.lovelife.ch) and a consultation hotline.
Specific information and motivation of the target groups

The risk of infection by HIV is not the same for everyone in a given population. Personal, social and situational factors may influence individual vulnerability to infection by HIV.

Belonging to a social group with a high prevalence of HIV (homosexuals, intravenous drug users, migrants from countries where prevalence is high), the absence of access to means of prevention (condoms, clean injection equipment), forced or dependent relations (eg sex workers (male and female)), loss of control (alcohol, other drugs), mental factors (pleasure in taking risks, indifference), and lack of access to information (language) are factors that may increase the risk of HIV being transmitted.

It is essential and wise to specifically designate those groups who are particularly at risk from infection by HIV and to communicate with them specifically about prevention. There is however a risk of this creating stigmatisation, and so participation, differentiation and sensitivity are essential conditions for work in prevention. We need to develop and create appropriate methods and prevention action for and with these groups.

At present, the need for prevention concerns as a priority:
- homosexuals and other males (including adolescents) who practise unprotected anal penetration (MSM and Dr Gay projects)
- migrant women from countries where the prevalence is high, and their partners (see Chapter 11, Afrimedia project and information film)
- intravenous drug users (see below)
- sex workers (male and female) (APiS and MSW projects)
- the clients of prostitutes (male and female) (Don Juan project) and tourists travelling to endemic regions without using protection

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8 www.aids.ch/f/ahs/praevention.php#FAQ3 and www.drgay.ch
9 www.aids.ch/f/ahs/praevention.php#FAQ9
10 www.aids.ch/f/ahs/praevention.php#FAQ9 and www.malesexwork.ch
In view of their potential in terms of prevention, people infected by HIV/AIDS also call for more extensive action.

For all these target groups there are specific prevention programmes and projects, described on the homepages mentioned. Below, as an example, is a description of the programmes for intravenous drug users. The Afrimedia project for migrant women from sub-Saharan Africa and the information film for migrants are described in Chapter 11.

Lastly, there are places where people exposed to a high risk of HIV infection are widely represented, including prisons, institutions for hospital aid for young people and detoxification establishments.

Reducing the risks for intravenous drug users

In the mid-Eighties, Switzerland had to face the facts; offers of help to drug addicts were only reaching a small number of them – the ones who wanted to stop. This was the era of the liberalisation of drug-taking (Needle-Park in Zurich, Kocherpark in Bern, etc). Drug addicts were living in terrible mental and physical conditions, overdose deaths reached record proportions, and many people were being infected by HIV or hepatitis viruses. To deal with this, low-threshold offers were set up, at first mainly in the towns concerned, for drug addicts with no willpower to kick the habit. These offers were supposed to enable drug addicts to get over their addiction with as little damage as possible in physical, mental and social terms. And therefore to survive.

The "four pillars" policy was developed as a political concept in the early Nineties in order to reduce drug-related problems. It includes four areas for action that have come to constitute the foundation of national policy on drugs – prevention, treatment, risk reduction, and control/repression.

Within the framework defined by its statutory mandate, the OFSP undertakes to reduce drug-related problems in the following areas:

- coordination of collaboration between the Confederation, the cantons and the municipalities;
- primary and secondary prevention;
- treatment (abstinence, substitution, prescription);
- reduction of risks;
- information and documentation;
- continuous training for specialised personnel;
- research;
- promotion of quality.

If we want to prevent drug users contracting HIV, hepatitis or other infectious diseases, prevention has to be extended to sexual behaviour. In Switzerland, low-threshold reception centres hand out injection equipment and condoms. Condoms are also available at contact points for drug users who are prostitutes. In all these services, information can be obtained on taking drugs hygienically. In 2002, 28 low-threshold centres offered a syringe exchange programme and 13 had consumption areas where the drugs addicts brought in with them could be consumed under supervision and in hygienic conditions (mainly by injection, but also by inhalation).

The various offers for the treatment of drug addiction pursue the objectives of supporting social integration, promoting physical and mental health, and making it possible to break addiction. To achieve these objectives, the Confederation is involved in residential treatment directed towards abstinence and substitution treatment (methadone, heroin and buprenorphine).

Substitution treatment comprises medical and psycho-social action. It is one of the standard therapies in the range of action in Switzerland and in many other countries. During this treatment, the illegal heroin is replaced (hence the name substitution) by a long-acting opiate prescribed by a doctor. It is usually methadone that is used, and occasionally buprenorphine. Under strictly supervised conditions, substitution is also possible using the original product, in which case the treatment involves prescribing heroin.

Nowadays this mainly involves reducing risks, finding a balance between the interests of the people directly concerned (secondary prevention), the interests of society at large (policy on public order) and what society expects (policy on drugs). The basic objective of the work carried out in this field must be to promote the social integration of the people who have managed to emerge from the illegal drugs scene, above all by the promotion of health based on a global notion of health.

9 Treatment – the Swiss HIV cohort study (SHCS) as an assurance of treatment quality

It may be considered that in Switzerland all the people who know they are HIV positive have access to antiretroviral treatments (except certain migrant populations, for example illegal immigrants). However, it often happens that infection by HIV is diagnosed only when the patients complain of difficulties that subsequently turn out to be symptoms or the early stages of AIDS. This is why counselling and screening programmes must be set up for the groups in which HIV infection is frequent. It is not merely a matter of improving prevention through counselling – it also involves adequate treatment for HIV infection at the right time. A number of pilot projects are currently being assessed, such as the Checkpoint project in Geneva – this is a counselling and screening centre for homosexual men that has been operational since early 2005.

Apart from access, the quality of the treatment is important for the people concerned – patients monitored as part of the Swiss HIV cohort study (SHCS) can benefit from leading-edge knowledge on the subject. Thanks to the cohort study, medical science is constantly improving treatment methods and medical treatment. We do not have sufficient proof, but we have reliable indicators to be able to state that the investment of three million Swiss francs per year in research made by the Swiss national fund for scientific research (FNS), compared with expenditure of some 10 million Swiss francs on treatment – see Chapter 8 entitled “Is prevention worth it?”, is a valuable operation that allows the discovery of new knowledge and ensures the quality of treatment. A further point is that older forms of HIV treatment are not less expensive than recent treatments. Poor treatment also encourages the appearance of resistant viruses, which represent a potential danger to public health if they spread. The quality of life of patients and therapeutic success are also reduced. The CFS is currently studying various possibilities for raising the level of all the antiretroviral treatments in Switzerland to that of the Swiss HIV cohort study, for the good of the patients concerned and for the good of public health.

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13 www.shcs.ch
14 www.snf.ch
Poster for the 2000 STOP AIDS campaign
10 Solidarity

Various studies have shown that there is no systematic discrimination – apart from in the field of insurance – against people living with HIV/AIDS in Switzerland. However, many people concerned report difficulties encountered at their place of work, in dealings with insurance companies, and in their private lives. That means that the promotion of solidarity must remain an important aspect of work concerning HIV/AIDS, as indeed provided for in the new Federal Constitution.

Poster for the 1991 STOP AIDS campaign

11 Some of the highlights of the first two years of implementing the 2004-8 national HIV/AIDS programme

Strategic management of the work

The OFSP has stepped up its collaboration with the ASS, a non-governmental organisation based in Zurich, by focusing on the twelve objectives of the programme. The results of this work are more specific contracts and clear instructions in agreement with the objectives determined and the reference markers. At the same time the OFSP has been trying to establish contact with the cantons' bodies (canton medical officers and health directorates), institutionalised in the form of an annual visit to the cantons. Each person in the AIDS section team is responsible for a group of cantons, knows the respective people in charge and implementation of the work on AIDS, and acts as the link between the cantons and the OFSP in terms of requirements and expectations. This initiative on the part of the OFSP, which constitutes the second objective of the PNVS – national cooperation – has been welcomed and appreciated by the cantons and will be continued in the form of annual visits.
Exhibition

The OFSP and the ASS work with much commitment and energy on the management of knowledge. Firstly, a substantial quantity of knowledge about HIV/AIDS has been and is being produced worldwide that should be systematically analysed so that the tasks to be carried out correspond to the current state of knowledge. Secondly, it is important to make it possible to use the quantity of documents collected between 1988 and 2003 by AIDS Info Doc Suisse after the organisation closed down at the end of 2003 and continue this work in the form of "AIDS documentation" at the OFSP. To mark the twentieth anniversary of the ASS and of a number of regional branches, an exhibition has been organised at the Bärengasse museum in Zurich (annexe of the Swiss Museum), and a document serving as a catalogue for the exhibition published, to mark the event. Thanks to this project it is possible to consult a substantial quantity of material illustrating twenty years of work in the AIDS field incorporated in the history of contemporary Switzerland that can be preserved for the future.
CHAT survey – an in-depth prospective survey at the time of diagnosing new cases of infection by HIV

"It is by talking to people recently infected by HIV about the circumstances of their infection that the most is to be learned about prevention". This statement has often been heard at the CFS – no-one contests it – but until now nobody thought it could be done. A year-long feasibility study started on 1 July 2005, called "the CHAT survey" (CH= Switzerland, A= AIDS, T= Transmission Survey<sup>15</sup>), in the form of a mandate given to the St-Gallen Canton Hospital. New laboratory tests now make it possible to determine, during HIV testing, if infection took place less or more than six months earlier. As part of the CHAT survey, for a period of one year, each blood sample will be put through this procedure. The purpose of the study is to establish whether it is possible, through the GP, to contact patients infected less than six months earlier and to talk to them. If this proves to be possible, a certain number of elements in the study should be included in the obligatory declaration system and thereby help to further improve knowledge of the HIV epidemic in Switzerland and provide foundations for more closely targeted measures of prevention.

Minimum standard for prevention in gay establishments

The minimum standard for prevention regarding HIV in gay establishments that make "on-the-spot" sexual activity possible has been developed in collaboration with the managers of gay establishments, the OFSP and representatives of non-governmental organisations (ASS, Dialogai and Pink Cross) – they were consulted when it was being drawn up. In legal terms, the minimum standard constitutes a personal undertaking to include the requirements it contains in the very foundations of the establishment's management. Signature of the minimum standard attests to the compulsory nature of the standard for the signatory, but does not give the national authorities any direct means of sanction. The cantons, however, on the basis of Article 21 of the Epidemics Act (EpG), can declare the minimum standard obligatory in the eyes of the law by virtue of the distribution of responsibilities between the national level and the cantons with regard to combating transmissible diseases. This means that the cantons can sanction failure to abide by the minimum standard in terms of prevention of HIV by closing the establishment.

The minimum standard covers the following four points:
1. Hygiene
2. Condoms and lubricants available free of charge
3. Information material
4. Posters

Afrimedia project

The message, benefits and care in the prevention of HIV/AIDS must be accessible to migrants (male and female) from sub-Saharan Africa. That is the aim pursued by Afrimedia<sup>16</sup>, an OFSP project administered by the Swiss Tropical Institute and the Swiss Red Cross.

Qualified mediators from sub-Saharan countries provide this varied target group with information and make it aware of different services and benefits that exist in the field of HIV/AIDS. They help in combating certain taboos and in preventing the stigmatisation of these population groups in relation to the HIV/AIDS phenomenon.

<sup>15</sup> http://www.suchtundaids.bag.admin.ch/imperia/md/content/aids/survaids/2.pdf
The work on awareness uses the networks that already exist within the target group – religious communities, hairdressing salons, associations, bars, etc. The mediators (male and female) also rely on leaders of opinion through direct communication work with members of the target group, to create a knock-on effect in order to reach as many people as possible.

An information film on HIV/AIDS for migrants
The OFSP has produced a DVD entitled "LOVE LIFE - STOP AIDS: an information film about HIV/AIDS for migrants", available in 16 languages, each in one version for women and one for men.

The 12-minute film provides basic information on HIV/AIDS. Two doctors – one male and one female – give explanations throughout the film on the main aspects of the disease, such as methods of transmission and situations in which there is no danger. They also explain how people should protect themselves and others, and how to use a condom properly. This information is accompanied by pictograms. Each film starts with an introduction by people belonging to the same language community as the target public and concludes with some good advice.
IV The main obstacles encountered and action necessary for achieving the objectives

12 Some good news …
The trend towards a general drop in the number of heterosexual contaminations is cause for satisfaction. In 2005, 90 Swiss men and 40 Swiss women were diagnosed as being HIV positive; however, it is only among women that this drop is evident (from 75 in 2002 to 40 this year).

In 2002, female migrants to Switzerland from sub-Saharan Africa – people from countries where prevalence among adults may be as much as 30% or even higher – have contributed substantially to the increase. The number of declarations of HIV concerning this group of the population dropped slightly in 2005 – perhaps as a result of the work carried out under the Afrimedia project. It should not be forgotten that prevalence remains high among people in this group.

13 And some bad news …
In 2002, apart from heterosexual men and women from sub-Saharan countries, the substantial increase in new infections declared concerned above all Swiss men who had had sex with other men (MSMs). In 2005, this increase only affected homosexuals. For the first time, in addition to Swiss men, men of other nationalities were concerned – from Europe, mainly Germans and Italians, and non-European countries, particularly South Americans. Another disturbing fact is that the number of new infections (during the last six months before the test) is over-represented among homosexuals.

Switzerland is not alone in this. For the first part of 2005, Germany has announced a 20% increase in the incidence of HIV affecting homosexuals almost exclusively. It seems that the changes in behaviour observed in the "Gay Survey 2004"(8) are not surprisingly resulting in more infections by HIV. Given that the prevalence of HIV on the active gay scene should be estimated at more than 10%, the probability of meeting a partner who is already infected is 30 to 40 times greater than among the heterosexual population. Since prevalence is so high, a slight relaxation of protection behaviour results in new cases of transmission of HIV.

14 Current priorities for prevention
The three-level reference model on which prevention is based, the levels being information directed at the general population, information targeted at specific groups, and individual counselling, is not at issue, but at each of these levels there is potential for improvement:
– adjustment of the information directed at the general population;
– focusing on the most important target groups and providing in-depth information;
– improvement in individual counselling.

15 Information directed at the general population
Antiretroviral medicine has been available since 1996, and as a result infection by HIV has ceased to be a fatal disease and is now considered a disease that can be treated (but not cured!) by medicine; thus the threat of death connected with AIDS no longer exists. Consequently it has been necessary to formulate prevention messages directed at the sexually active population in terms of the promotion of good health. This change in information strategy was reflected in the change in the eighteen-year-old STOP AIDS campaign, which in spring 2005 became the LOVE LIFE - STOP AIDS campaign (see Chapter 8: The "LOVE LIVE - STOP AIDS" campaign).
The OFSP and the ASS are convinced that it is possible to continue to motivate the population to protect itself against HIV with this new slogan. The large-scale telephone survey to be carried out in 2006 will provide additional data that it will be possible to compare with the data from the last survey in 2001.

Schools have a significant contribution to make to informing the "general public"; their task consists of ensuring that the state of knowledge among young people leaving school is at the same level as that of the general population after twenty years of receiving information about AIDS. The AIDS theme is included in all syllabuses. The inter- and sometimes intra-cantonal differences are enormous. Sex education broaches the subject of AIDS in more or less detail.

Conclusion: Continuation of the LOVE LIFE – STOP AIDS campaign and information accessible in all schools is still the best way of preventing a general epidemic of HIV!

Leaflet directed at young people

16 Information directed at target groups
Among the Swiss population there are three specific groups of people among whom 10% or even more are infected with HIV. The prevalence of HIV is very high among homosexuals, intravenous drug users, and migrants (male and female) from sub-Saharan Africa. The risk of infection is much higher among these groups than among the general population or among young people. These groups therefore need targeted prevention programmes and more information about HIV/AIDS. The problem is slightly different among prostitutes (both male and female) – they are particularly exposed and vulnerable because of their professional activity and the high number of partners likely to infect them. There is no indication in Switzerland of a high number of sex workers being infected by HIV. For the remainder, prevention programmes are needed on the same lines as those for the three other groups targeting this population and their clients. Beyond that, there are fears in the European Union that opening up to the countries of eastern Europe will result in a substantial increase in risks in this area.

Conclusion: In-depth prevention targeted at groups with a high prevalence or greater vulnerability should be pursued in order to prevent the uncontrolled spread of HIV among these populations.
Reasons for the substantial increase among homosexuals

It seems obvious, on the basis of this data and other national and international studies, that one single cause cannot be the source of the increase observed in this target group. With a view to short- and medium-term measures, the OFSP has drawn up a number of hypotheses, supported by data but not (as yet) checked, that could explain the worrying situation among homosexuals.

1. The Internet offers new possibilities for contact: many men no longer visit establishments on the gay scene but arrange meetings using the Internet. These men are not reached by local preventive activities.

2. Sexual behaviour, according to the "Gay Survey 2004", has changed considerably – the annual number of partners has increased, as has sexual activity as a whole and the frequency of anal sex in general, and unprotected anal sex in particular.

3. Thanks to the success of antiretroviral treatment (ART), people infected by HIV are now living longer. In view of the still high level of new cases of infection, the number of homosexuals infected by HIV is continuing to increase as is, consequently, the probability of meeting a partner who is already infected.

4. If treatment is properly programmed, we may hope to reduce infectiousness by means of ART, but it would appear that this positive effect is more than cancelled out by an increase in risky behaviour.

5. The level of knowledge seems to be falling steadily, particularly as regards the effectiveness of means of protection. Strategies for reducing risks, based on erroneous data and suppositions, are increasingly being adopted by people in this target group. Also, fewer people now know people among their acquaintances who are affected by HIV or are living with or have died of AIDS.
The combination of these five hypotheses could provide an explanation for the increase in the incidence of sexually transmitted infections (STIs and HIV) among homosexuals compared with the incidence among the general population.

**Preventive measures among homosexuals**
The offer on the gay scene has changed. Places for going out are concentrated in the Lake Geneva area (Lausanne and Geneva) and in Zurich. The other towns have lost their popular meeting places, restaurants and discotheques. In Zurich, there are as many places offering "on-the-spot" sexual consumption (saunas, darkrooms, etc) as in all the rest of German-speaking Switzerland. That is why the OFSP decided to concentrate the Confederation's human and financial resources on prevention among homosexuals living in these regions. A Task Force directed by the OFSP has also been set up. The professionals working with the ASS, the regional branches involved and the people in charge of places for sexual encounters collaborate closely within the Task Force and coordinate the measures adopted. The next wave of the LOVE LIFE - STOP AIDS campaign in spring 2006 will include messages directed at men who have sex with other men, in order to reach those who are not accessible on the gay scene. The information available on the Internet will be reinforced and counselling on the Internet (e-Streetworking) developed. New posters, advertisements and leaflets still to be devised should increase the visibility of prevention messages in places for going out on the gay scene. In October 2005, in agreement with the people in charge of places for sexual encounters, the minimum standards for prevention (see Chapter 11) were reinforced. The OFSP asked these people to take on additional responsibilities in respect of the activities taking place on their premises.
17 Individual counselling

Each year in Switzerland approximately 5% of the adult population undergoes an HIV test, which corresponds to 300 000 tests per year. Unfortunately, a number of studies show that appropriate counselling before and after testing is far from being standard – it constitutes an exception, although it is established that a test in itself has no preventive value if it is not accompanied by an appropriate counselling interview. There is therefore no need for more tests per year, but for tests with a better indication and more quality counselling. The CFS and the OFSP have published new recommendations for doctors\textsuperscript{17}.

The development of an IT tool in the form of a questionnaire (on the Internet) likely to provide the doctor or other person providing counselling with the necessary information on the risks the patient is taking and what information the patient needs to be given (a number of studies have shown that most doctors do not know or do not want to ask the questions that would make a suitable anamnesis of the sexual risks possible) may constitute an improvement in the effectiveness of prevention at this level. Regular interviews between doctors and HIV patients as part of the accompaniment of antiretroviral treatment (and additional offers as appropriate) should help to make prevention more effective. Indeed people already infected with HIV can make a substantial contribution to halting the spread of HIV.

Conclusion: in Switzerland, it is the level of individual counselling by doctors and social and health workers that is the least well developed. There is considerable potential here for improvement, but it would take significant investment and the release of new resources.

18 Results

General trends and encouraging developments among certain specific groups show that the national programme to combat HIV/AIDS 2004-2008 is being successful. It confirms more particularly that the effectiveness and efficiency of the combination of general information for the public and measures directed at specific groups highlighted by a recent American study (31) is also valid in Switzerland. The increase in cases of infection among homosexuals is not a surprise – for a number of years, publications from the major capitals of Europe and surrounding countries have pointed to changes in behaviour and an increase in sexually transmitted infections and cases of transmission of HIV. It is the scale of the phenomenon that is surprising.

Analysis of the data confirms that Switzerland is not an island. The success and failure of HIV/AIDS prevention in neighbouring countries and the country of origin of migrants entering Switzerland are reflected in the country's statistics on HIV. That is why not only prevention work among migrant African women in Switzerland is one of our priorities, but also national solidarity and support for international activities in the AIDS field. There will no doubt be a demand from certain quarters for more testing or compulsory testing, for example among asylum-seekers, but this would not constitute a solution. Firstly, there is nothing to indicate that a significant proportion of the cases of infection by HIV among the non-Swiss population concerns female asylum-seekers and, secondly, compulsory testing has not proved conclusive in any country. More voluntary testing could have a preventive effect if it were to be accompanied systematically by appropriate counselling for people whose behaviour puts them at risk.

It should also be emphasised that the success of prevention among intravenous drug users depends entirely on the maintenance of programmes to reduce risks, and these are the responsibility of the cantons and municipalities. The prescription of heroin and methadone and needle exchange programmes ensure effective protection among this population. Given that prevalence is also very high among drug users (between 10 and 30%), any let-up in what is available for reducing risks rapidly results in new cases of infection.

\textsuperscript{17} see www.bag.admin.ch/dienste/publika/bulletin/2005/f/BU39_05f.pdf
The fact that out of 1542 additional declarations concerning people infected by heterosexual transmission, 44% (ie 680 people) declared that they had had just one partner over the previous two years provides food for thought. Obviously the risk is greater for anyone who has sex with a number of different sexual partners; however, remaining faithful to a single partner also presents a risk if that single partner is not faithful in turn.

Because of reduced human and financial resources, the projects connected with the achievement of certain objectives of the national programme have had to be frozen. The following projects have however been made a priority for the next few years of activity:
- the project on elementary, continuous and on-going professional training;
- the project on people living with HIV/AIDS;
- the situation in prisons (project on drugs, AIDS and hepatitis in the prison environment).

The shift of energy and working forces towards topics left pending until now, and targeted commitment to improving individual counselling on prevention has only been made possible by specific circumstances – the current stages of certain projects now require less resources that the earlier stages of design and launching.

The prevention programme evaluation unit (UEPP) of the university institute of social and preventive medicine (IUMSP) at Lausanne University has developed, for the duration of the current PNVS, a system of monitoring that corresponds to the demands of UNAIDS (Second Generation Surveillance System(32) – see Chapter VI). On instructions from the OFSP, UEPP is implementing the monitoring and constantly supplying new information. An external evaluation of the programme is also scheduled for the final third of the duration of the programme, probably in cooperation with a number of international organisations.

The monitoring and the external evaluation will supply the foundation for examination of the programme looking forward to 2009 and beyond. At the same time the CFS is working on the definition of the 2010 challenges which are also to be taken into consideration in the next programme.

Conclusion: The national programme to combat HIV/AIDS for 2004 – 2008 is having an effect on the AIDS scheme in Switzerland. The projects and measures adopted in the first third of its lifetime give reason to hope that the slight decline in protection behaviour – due to a degree of familiarity and to the disappearance of the threat of dying – in particular among those groups that are most vulnerable, and the increase in the number of new cases of infection by HIV being diagnosed could be stabilised durably. It is known that there have been shortcomings and weaknesses in the work carried out so far. Prevention must and can be improved in each of these three areas, the objective being to reduce the number of new cases of infection by HIV being diagnosed to below the level for 2000.

The coming years will be devoted mainly to improving counselling for individual prevention, professional training (elementary, continuous and on-going) for professionals in contact with HIV/AIDS, the needs of people living with HIV/AIDS, and the situation in prisons. At the same time we shall be devising the external evaluation and drawing up strategies for the future.
V  Support necessary from partners for development in the country

This chapter is not covered by Switzerland, in accordance with the instructions given by the Executive Director of UNAIDS on 8 November 2005 informing donator countries that it was not necessary for them to supply information on their programmes of international cooperation on AIDS.

VI  Framework for monitoring and evaluation

The national strategic plan for HIV/AIDS defined in the national programmes has been assessed regularly since 1986. The evaluation studies are used not only to report on the use made of public funds, but also to judge policies, programmes, projects and other measures in order to detect significant changes in a given field and to deduce the consequences. They also provide foundations for decision-making making it possible to implement suitable correctives. The long-term monitoring of indicators of the processes and results of the AIDS prevention strategy, and in particular the monitoring of sexual behaviour and injection behaviour in repeated surveys among various groups of the population, is an important part of the evaluation process and is carried out on a continuous basis by the prevention programme evaluation unit (UEPP) of the university institute for social and preventive medicine (IUMSP) at Lausanne University. The next survey of drug users is to be carried out in 2006 and surveys among the general population and men who have sex with other men in 2007. An external evaluation, probably in conjunction with international organisations, will be held at the end of the 2004-8 programme. The monitoring and external will provide the foundation for examination of the programme with a view to a consecutive programme for the years 2009-13. At the same time, the CFS is working on the definition of the 2010 challenges, which will also be taken into consideration in the next programme.

19  Objectives of the evaluation

The national strategic plan for HIV/AIDS throws up a number of questions – Is the strategic plan valid? Does it achieve its objectives? How is it received and implemented by the players concerned? The evaluation was designed from the outset as being external, global, continuous and centred on use. The mandate covered the following points:

- Assess all the component parts of the strategic plan continuously; this includes evaluation of a number of pilot schemes directed at groups of the population defined in the field of prevention or training the personnel involved.
- Give rapid, valid answers, with information allowing an identification of the factors of success or failure, to be able to make the necessary corrections to the strategic plan.
- Monitor the emergence of conflicts and specific problems raised by prevention, and identify elements for improved management.
- Explore the characteristics (exposure to risk, access to information, capacity to adapt behaviour, etc) of certain sub-groups of the population that are particularly exposed, to make it easier to devise suitable intervention and to be able to accompany changes.
- Compensate for the lack of basic routine data.
- Maintain a degree of flexibility in the design of the evaluation so that it is possible to integrate new requests.
- Circulate the results of the evaluation to all the players concerned (politicians, prevention officers, researchers, professionals involved, target groups, the general public, etc) in an appropriate form.
20 Organisation of the evaluation
The evaluation took place in successive stages – seven up to 2004 – each lasting between one and four years. Each stage comprised between ten and twenty quantitative or qualitative studies. The studies are complementary and selected in such a way as to allow a validation of the results by triangulation. The studies may cover the various components of the prevention strategy. Some have analysed the implementation of the national programme for combating HIV/AIDS as a whole, while others have covered specific interventions or the media and institutional context; the level of information and sexual behaviour and protection habits have been studied at some length among various groups of importance for prevention (the general population, homosexuals, intravenous drug users, young people, migrants, etc).

The studies may be divided into three categories according to the type of information they provide for the prevention strategy. Firstly there are the measurements of trends carried out by means of repeated studies. Studies of this kind may cover attitudes, behaviour and the use of means of protection, and they have been carried out among the general population since 1987 even before the launch of the STOP AIDS campaign, among homosexuals (also since 1987) and among intravenous drug users (since 1993). Monitoring of sales of condoms, based on marketing statistics, is also included in these measurements of trends, as is the study of the evolution of prevention activity on the part of doctors. The second category covers "studies on a specific theme seen from various points of view over a period of time". The programmes for prevention and sex education in schools have been studied in this way, being considered successively from the viewpoints of their implementation, their reception by pupils and teachers, and lastly their content and institutional anchorage. The situation of prevention among migrants has been studied as regards needs, the implementation of prevention activities, and results in terms of attitudes and prevention behaviour. The implementation of the national programme to combat HIV/AIDS has also been studied in this way. The third category is that of single studies investigating a particular topic in depth or to obtain a rapid report on the situation. Examples here include a study on the sexuality of people who are HIV positive, a study on institutional discrimination, a study of the role of parents in prevention, and a study on the clients of prostitutes. The evaluation of the prevention strategy is managed centrally by a team at the prevention programmes evaluation unit of the IUMSP that is responsible for the conception, methodological development, organisation, performance and supervision of the studies, supervision of their quality, and summing up and making use of the results.

Each study ends with conclusions and recommendations. At the end of each stage in the evaluation, the team draws up a summary report indicating the main points to be learned from the various studies, produces a summary, and lists a number of general conclusions and recommendations on the results, the context, and the implementation of the prevention strategy.

21 The results of the evaluation and their use
The results of the evaluation are the information it provides on the context, implementation and effects of the prevention strategy. These results, produced by the various studies and summaries carried out by the evaluation team, are firstly and without delay submitted to the OFSP and to the other players involved in prevention and discussed with them. They are then included in scientific publications – reports on studies and summaries, articles in science journals and presentations at congresses. This information on the situation of prevention is used by the OFSP for steering the strategic plan and by the various players involved in prevention. As this information comes from an outside scientific institution, it contributes to confirming and scientifically validating the strategic plan adopted and thereby contributes to its political and social acceptance and hence also to the continuation of its financing.
The evaluation has also made it easier to make the necessary alterations to the strategic plan and adjustments to prevention policy have been implemented as a result of recommendations made by the evaluation. Thus an exemplary policy of non-discrimination in the workplace has been instituted in the national administration on the initiative of an inter-departmental group on AIDS. The assessors have been integrated into think tanks on the strategic plan (the STOP AIDS campaign "creative team", working parties of women, young people, drug users, etc), and this has made it possible to put the results and recommendations into thinking on practice.

22 The future of the evaluation

The long-term monitoring of indicators in the process and the results of the AIDS prevention strategy, carried out as part of the overall evaluation set up in 1987 by the prevention programme evaluation unit (UEPP) of the institute of social and preventive medicine at Lausanne University, constituted from the outset one of the components of Switzerland's response to the epidemic (33-36).

In Switzerland, the monitoring of sexual and injection behaviour by means of repeated surveys among various groups of the population – carried out since 1987 until recently as part of this evaluation – corresponds in fact to the behaviour section ("behavioural surveillance") of a second-generation surveillance system. This behavioural surveillance has not yet, however, achieved the same level of institutionalisation as the biological surveillance of HIV, in that it has not yet become a routine activity, with fixed periods for gathering data.

Over the period from 2004 to 2008, the OFSP wanted to consolidate this scheme and ensure long-term follow-up for its strategic plan to combat HIV/AIDS (37). It instructed the UEPP to propose a surveillance and monitoring system for Switzerland, incorporating the UNAIDS recommendations on second-generation surveillance systems, to make a long-term contribution to the evaluation of the strategic plan to combat AIDS, and to define its continuous and periodic elements.

The populations used for the behavioural surveillance are the general population, young people, men who have sex with other men (MSMs), intravenous drug users (IVDUs), migrants, and prostitutes (male and female).

General population and young people: Since 1987, a survey conducted by telephone on sexual behaviour among 17 to 45 year olds in relation to HIV/AIDS (regular telephone survey to assess AIDS prevention in Switzerland – EPSS) is carried out regularly 18 (38, 39). It is planned to drop this survey specific to HIV/AIDS in the medium-term and to include in the Swiss survey on health (ESS), which is held every five years 19, a sexuality module which would include a number of core questions (core questionnaire). The next AIDS-specific survey is scheduled for 2007, the same year as the ESS that will contain the new sexuality module. Carrying out these two surveys at the same time will make it possible to calibrate the module. Subsequently, it is planned to ensure that the sexuality module is retained in the ESS.

Men who have sex with other men (MSMs): since 1987, there has also been a regular survey 20 among MSMs in Switzerland (41) in connection with HIV/ AIDS. This is carried out using a questionnaire inserted in gay magazines, circulated by associations and, more recently, also put on the Internet.

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19 This involves people aged between 15 and 75.  
The survey will be repeated in 2007, then at intervals of three to five years.

**Intravenous drug users**: since 1993, a national survey has been carried out regularly\(^{21}\) (42, 43) among people using low-threshold centres where one of the main missions is to provide injection equipment. The survey will be repeated in 2006, then at intervals of three to five years. A module of specific questions on the consumption of intravenous drugs and needle sharing has also been included in the Act-Info core questionnaire\(^ {22}\) on treatment statistics.

**Migrants, in particular those from countries where the AIDS epidemic is generalised** (44): this sector of the population is small and varied but produces a not inconsiderable proportion of new cases of HIV diagnosed among heterosexuals. The secondary analysis of data gathered in the EPSS and ESS surveys is supplemented by the work of one or several groups of experts on those populations most exposed to HIV/AIDS, which meet at regular intervals to examine the situation of the evolution of behaviour within these populations. This group functions as an alert system.

**Prostitutes (male and female) and their clients**: this group also is small and varied, and represents a "gateway" for the transmission of HIV to the general population, and the same secondary analysis system is used for data gathered from the general population (EPSS and ESS) concerning prostitutes' clients and the regular consultation of a group of experts.

Other sources of data may be used on an ad hoc basis if they contain indications concerning sexual behaviour or drug injection, as for example surveys on the health of adolescents.

Table 7 sums up the main components of the second-generation supervision arrangements in Switzerland, indicating the level of achievement of WHO recommendations on this type of supervision in countries where the epidemic is concentrated.

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<table>
<thead>
<tr>
<th>UNAIDS recommendation</th>
<th>Level of compliance of the arrangements proposed in Switzerland with the recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Surveillance of STIs and other biological risk factors</td>
<td>Achieved: compulsory declaration of new cases of infection by gonorrhoea and chlamydia by laboratories and declaration of hepatitis (A, B and C) by doctors and laboratories + compulsory declaration by laboratories and introduction of an additional declaration by doctors of cases of syphilis, and the introduction of an additional declaration by doctors of cases of gonorrhoea starting in 2006</td>
</tr>
<tr>
<td>2. Notification of cases of infection by HIV/AIDS</td>
<td>Achieved</td>
</tr>
<tr>
<td>3. Monitoring of HIV in donated blood</td>
<td>Achieved</td>
</tr>
<tr>
<td>4. Surveillance of HIV and behavioural surveillance in sub-populations with risk behaviour</td>
<td>Achieved (biological: in the declaration system with transmission groups; behavioural: in regular surveys among MSMs and drug users with auto-declaration of HIV status). No biological samples taken as part of surveys.</td>
</tr>
<tr>
<td>5. Surveillance of HIV and behavioural surveillance in &quot;gateway&quot; groups</td>
<td>Partly achieved (biological: in the declaration system, for clients of prostitutes; behavioural: in regular surveys among drug users whose partners are not users, bisexuals, the general population, and clients of prostitutes)</td>
</tr>
<tr>
<td>6. Transverse study on behaviour among the general population</td>
<td>– Achieved</td>
</tr>
<tr>
<td>7. Sentinel surveillance of HIV in the general urban population</td>
<td>– Not achieved</td>
</tr>
</tbody>
</table>
Conclusions
The behavioural surveillance system set up as part of the evaluation since the end of the Eighties corresponded broadly to the behavioural element of a second-generation surveillance system. In the period 2004-2008, extension of the scheme will make it possible to better correspond to the WHO recommendations. These amendments take the following elements into account:

- **calibration necessary when transferring to another instrument**: carrying out an EPSS\(^{23}\) and an ESS simultaneously (in the same year) in 2007 will allow a fine analysis of the differences due to the characteristics of the instruments and will provide a solid foundation for the interpretation of long-term trends;
- **improvement in the surveillance of STIs from 1 January 2006 onwards** with the re-introduction of the compulsory declaration by laboratories and the introduction of an additional declaration by doctors in cases of syphilis, and the introduction of an additional declaration by doctors in cases of gonorrhoea;
- **maximum use to be made of existing information without using additional instruments**: this is why emphasis is being placed on EPSS and ESS data on prostitution and migrants;
- **concentration of efforts on groups in which prevalence is high** (MSMs and drug addicts) by maintaining specific instruments;
- **paying attention to unexpected changes**: (lightweight) alert systems proposed in respect of prostitutes and migrant populations constitute a supplement to the information gathered by the instruments (EPSS and ESS) covering the general population at the same time as offering a precaution against developments which would otherwise slip through because of limitations in the methodology applied\(^{24}\);
- **integration of concern for cover**: the various instruments in the proposed scheme are not designed to supply representative data at the level of the cantons\(^{25}\), but they make it possible to follow developments in the general population and in the groups that are actually or potentially important in the evolution of the epidemic.

Beyond 2008, there will be the matter of continuity of the surveys among the ad hoc populations (MSMs and drug users), and the frequency of carrying them out. The experience of working with groups of experts operating as an alarm system will have to be reassessed to determine the value of using this type of scheme for small populations that are hard to access.

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\(^{23}\) And MSMs as appropriate.

\(^{24}\) Cover limited to the population reachable by telephone and capable of being interviewed in one of the national languages.

\(^{25}\) They are nevertheless representative of the language areas.
Poster for the 2003 STOP AIDS campaign
Reference List


