Syntagma GmbH
Politikanalyse, Evaluation & Beratung

Review of the Swiss HIV Policy by a Panel of International Experts

Study on behalf of the Swiss Federal Office of Public Health

Expert Report

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List of Abbreviations

AHS	Swiss Aids Federation (Aids-Hilfe Schweiz)
ART	Antiretroviral therapy
CHF	Swiss Franks
EFTA	European Free Trade Association
EKAF	Swiss National AIDS Commission
EU	European Union
FSW	Female sex worker
HAART	Highly active antiretroviral therapy
HIV	Human immunodeficiency virus
IDU	Injecting drug user
NGO	Non-governmental organisation
NHAP	National HIV/AIDS Programme
MSM	Men having sex with men
MSW	Male sex worker
SFOPH	Swiss Federal Office of Public Health
SHCS	Swiss HIV cohort study
STI	Sexually transmitted infection
UN	United Nations
VEGAS	Association of Gay Establishments (Verein Gaybetriebe Schweiz)
VCT	Voluntary Counselling and Testing strategy
WHO	World Health Organisation
ZAH	Aids Help Zurich (Zürcher Aids-Hilfe)

0 Abstract

The panel of international experts, commissioned by the Swiss Federal Office of Public Health (SFOPH) to review the current Swiss HIV Policy, has come to the following conclusions concerning the three questions it was mandated to examine:

1. How can Switzerland minimize HIV transmission?

- Put the effort where the virus is: gay men and other men having sex with men (MSM), migrants from Sub-Saharan Africa, intravenous drug users (IDUs).
- Embed HIV prevention activities in a broader strategy of sexual health.
- Combine non-medical and medical prevention.

2. How can Switzerland assure timely testing of persons infected with HIV, referral for treatment and support services as well as continuity of care?

- Develop and implement a coherent HIV testing strategy.
- Continue to promote Voluntary Counselling and Testing (VCT) and strengthen Provider Initiated Counselling and Testing (PICT).
- Further improve continuity of care by creating incentives both for doctors and patients.

3. What would be the best governance in the Swiss HIV policy system in terms of division of labour, resources and incentives?

- Support and facilitate the creation of a Swiss Gay Men's Health Organisation.
- Assist existing organisations in making better use of innovative potential and mobilisation capacity of affected groups.
- Diversify the partnerships between the SFOPH and civil society.
- Strengthen the leadership role and capacity of the SFOPH (e.g. reformulation of mandates, structural support for civil society organisations).

1 Introduction

1.1 Mandate and Aim of the Expert Report

The current HIV policy of the Swiss Confederation is based on the National HIV/AIDS Programme 2004-2008 (NHAP) (SFOPH 2003). In March 2008, this programme was extended for two years – i.e. until 2010. According to the NHAP 2004-2008, the HIV policy in Switzerland focuses on three core fields and three levels of intervention. The core fields read as follows: 1) preventing the spread of HIV, 2) treatment and counselling in HIV infection and AIDS as well as 3) solidarity with individuals at risk of infection and those with HIV and AIDS. The three levels of intervention of the NHAP 2004-2008 comprise the following tasks: 1) information for the general population, 2) information and motivation of target groups and 3) individual prevention and counselling (SFOPH 2003). With the extension of the programme until 2010, the three levels of intervention were renamed as axes and the third axis was changed as follows: 3) preventing HIV transmission in serodiscordant couples (www.bag.admin.ch, August 2009). With respect to the National HIV/AIDS programme beyond 2010, the Swiss Federal Office of Public Health (SFOPH) decided to commission an independent assessment of the current HIV policy by an international expert panel. This decision was motivated by the fact that problems and issues in the field of HIV have fundamentally changed since the mid-1990s with the introduction of highly active antiretroviral therapy (HAART) (Rosenbrock et al. 2000). HIV is no longer a rapidly fatal condition in Switzerland. Since the mid-1990s risk-behaviour has changed (Dubois-Arber et al. 2001), and decision-makers have become less willing to provide funds for prevention (Neuenschwander et al. 2005). This raises the question as to whether the current „policy design" (Knoepfel et al. 1997) defined by the NHAP is still able to provide effective strategies for prevention, treatment and governance, or whether it must be changed.

The final outputs of this review consist of two reports: (i) a comprehensive scientific background report containing a description and analysis of the current state of affairs in the field of HIV policy in Switzerland (Plüss et al. 2009); (ii) a summary report containing the expert panel's recommendations for a future Swiss HIV policy (this document). The expert report provides recommendations in the areas of surveillance, primary prevention, treatment and care, positive prevention as well as governance. It is addressed to the programme managers of the SFOPH and its partners as well as other interested specialists in the field of HIV policy.

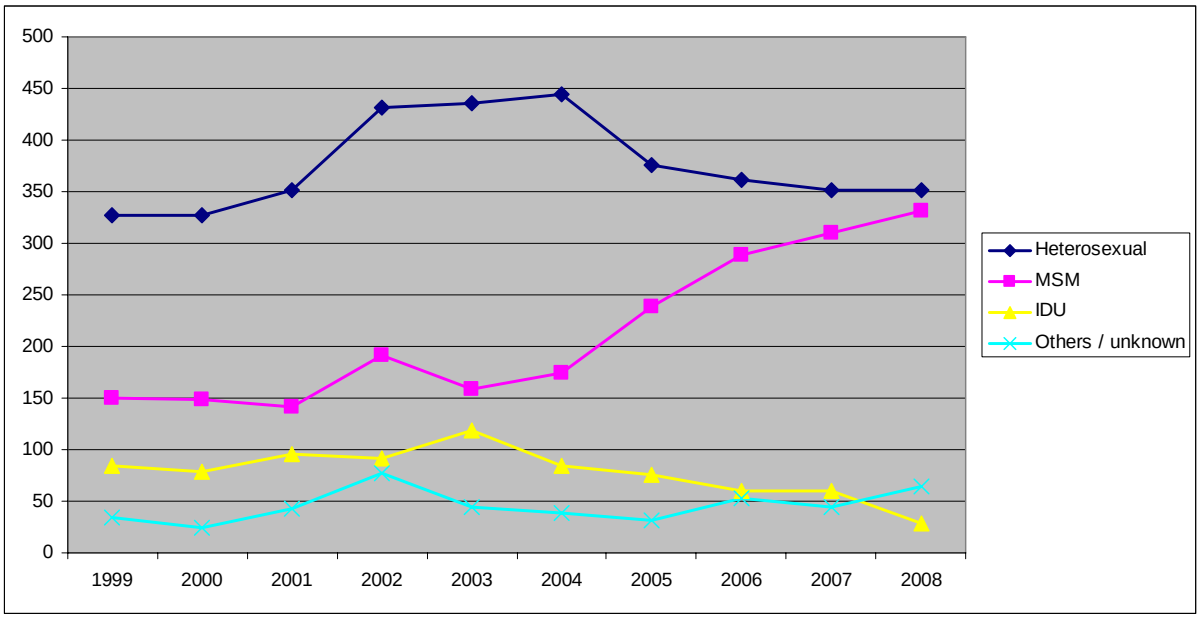
1.2 Switzerland in the International Context

In 2007, an estimated 33 million people were living with HIV globally. Around 2.5 million infections occurred in 2007 with 1.7 million (68%) of these in Sub-Saharan Africa (www.who.int, May 2009). However, HIV infection also remains a major public health issue

in Europe, with evidence of continuing transmission of HIV in many countries. Case reporting data from 2007 show that the number of newly reported HIV diagnoses in the WHO European Region continues to rise. Between 2000 and 2007, the annual HIV notification rate in Western Europe has almost doubled, from 39 to 75 per million population (www.eurohiv.org, May 2009). In the countries of the European Union (EU) and the European Free Trade Association (EFTA), the predominant mode of HIV transmission is sex between men, followed by heterosexual contact. Around 40% of newly diagnosed heterosexually transmitted infections are reported to involve people originating from countries with generalized HIV epidemics although this proportion varies between countries.

Compared with other countries in Western Europe, the reported number of newly diagnosed HIV-infections in Switzerland is rather high. In relation to the overall population, it is comparable to France, Luxemburg, or the UK, but three times higher than Germany or Austria (www.eurohiv.org, May 2009). Between 2000 and 2008, the number of new HIV diagnoses rose by approximately one third in Switzerland. Until 2004, this increase was seen mostly in people who acquired HIV through heterosexual contact (figure 1). Thereafter, the number of new diagnoses due to heterosexual transmission declined and then stabilized, while the number of new HIV diagnoses in men having sex with men (MSM) sharply increased and has almost doubled since 2004. So, the total number of yearly HIV diagnoses remained more or less constant since 2002 (760 diagnoses on average), but the proportions of heterosexual and homosexual transmission changed dramatically.

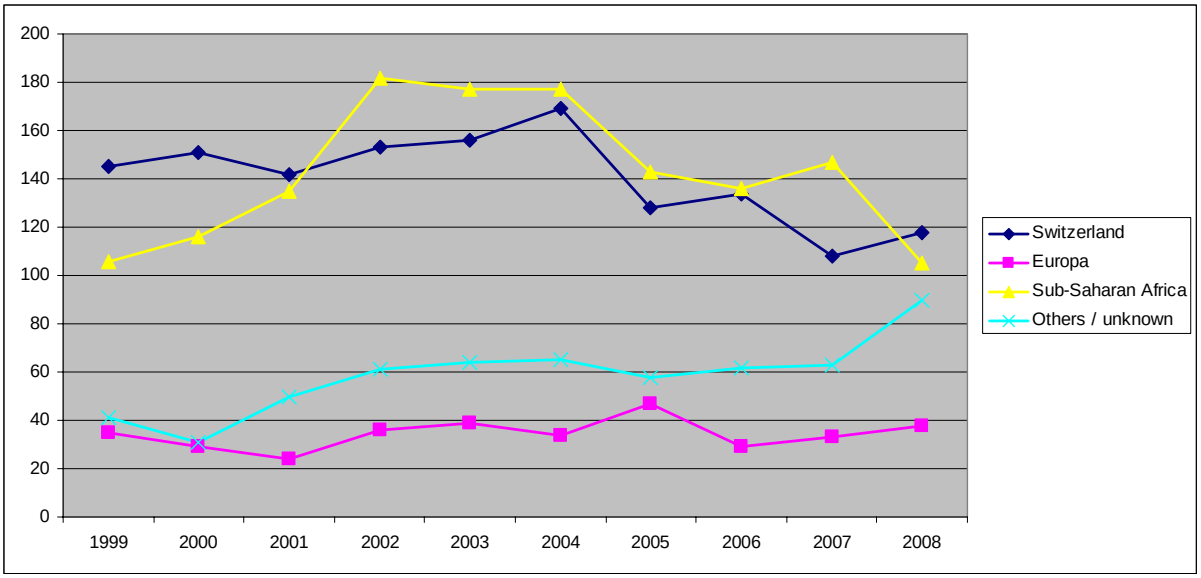
Figure 1: Number of new HIV diagnoses according to ways of transmission (1999-2008) (Source: SFOPH)



An analysis of the countries of origin shows that HIV infections frequently involve persons from countries with high HIV prevalence – mainly Sub-Saharan Africa – as seen in other European countries. The proportion of Sub-Saharan African migrants among the total number of newly diagnosed persons amounts to 23% on average (1999-2008). In this group, HIV was

mostly acquired through heterosexual contact. Consequently, within the number of new diagnoses due to heterosexual transmission the proportion of Sub-Saharan African migrants account for 38% on average (1999-2008) (figure 2).

Figure 2: Heterosexual transmission group: Number of new HIV diagnoses according to region of origin (1999-2008) (Source: SFOPH)



Switzerland faces the same challenges as most other Western European countries. On the one hand, the number of new HIV diagnoses in MSM is still rising, while the number of heterosexual cases has leveled off since then. On the other hand, trends in migration show that traveling has become easier and less expensive in the past 10 to 20 years which leads to changing migration patterns and increased population mobility. For instance, circular migration and frequent visits in the home country are becoming more feasible. So, the fact that migrants from high prevalence countries living in Switzerland are financially able to make frequent visits home could contribute to a further increase in new HIV diagnoses.

1.3 Research Questions

The SFOPH has identified three main questions with respect to the functioning of the Swiss HIV system. These three questions relate to the fields of prevention, treatment and governance. The SFOPH seeks answers to these important questions so that it can develop an effective programme from 2010.[1] During the course of the review, the original questions were reformulated without loosing their intentions as follows:

[1] Minutes of the meeting of the 16th of September 2008, Fachstelle Evaluation und Forschung, H. Brunold.

1. **How can Switzerland minimize HIV transmission?**
2. **How can Switzerland assure timely testing of persons infected with HIV, referral for treatment and support services as well as continuity of care?**
3. **What would be the best governance in the Swiss HIV policy system in terms of division of labour, resources and incentives?**

1.4 Design and Methods

To review the current situation in relation to the three research questions and to formulate recommendations, a panel of internationally renowned experts was convened. The expert panel was chaired by Prof. Dr. Rolf Rosenbrock (Wissenschaftszentrum Berlin) – a renowned and internationally recognized scholar active in the field of HIV policy since the very beginning of the epidemic. The further panel members were Calle Almedal, former Senior Adviser at UNAIDS, Prof. Dr. Jonathan Elford, holding the chair in evidence-based healthcare at City University London, Dr. France Lert, director of the unit on Epidemiology of the social and occupational determinants of Health, at INSERM, and Dr. Srdan Matic, head ad int. of the communicable diseases unit of the European Office of the World Health Organisation. Prof. Dr. Daniel Kübler, political scientist at the University of Zurich and member of the Swiss AIDS Commission, was the Swiss representative on the expert panel. The expert panel was supported by a team of scientific collaborators (lic. phil. Larissa Plüss and lic. phil. Kathrin Frey), based at Syntagma Ltd. Horgen (Switzerland) working under Prof. Dr. Daniel Kübler. Additional support was provided by Axel J. Schmidt (MD, MPH), scientific coordinator of the European MSM Internet Survey (EMIS) located at Robert Koch Institute in Berlin.

The review had three phases. The *initial phase* (November 2008 – March 2009) comprised the development of the scientific basis for the assessment. First of all, the expert panel defined the relevant assessment criteria relating to the three questions under investigation. The panel then asked its research team to collect and analyse data to assess the current state of affairs in the field of HIV policy in Switzerland. The results of this research constitute the scientific basis of the review and are synthesised in a separate scientific background report (Plüss et al. 2009).

In the *second phase* of the project (April – July 2009), the expert panel read the scientific background report and held meetings with selected actors involved in the implementation of the Swiss HIV policy. These meetings took place in the beginning of May 2009 in Berne and Zurich and 13 people working in the field of surveillance, prevention, therapy and treatment of HIV in Switzerland were interviewed.[2] The expert panel then answered the three research questions and formulated recommendations for a Swiss HIV policy which are included in the present expert report.

[2] The list of the participants to these meetings is provided in the appendix.

The *third phase* (August – October 2009) consisted of a validation of the expert report by the participants in the meetings, whose feedback was incorporated into the final version of the report. The final outputs, the scientific background report and the expert report, were completed in October 2009.

1.5 Structure of the Expert Report

This report starts with some of the points considered by the expert panel concerning the context in which a new Swiss HIV/AIDS programme is to be formulated, which presents a number of challenges (chapter 2). In the following chapters, the expert panel provides concrete and comprehensive recommendations in the fields of surveillance (chapter 3), primary prevention (chapter 4), treatment and care (chapter 5), positive prevention (chapter 6) as well as governance (chapter 7).

2 From AIDS to HIV

Over the last 28 years since the first AIDS cases were reported, the conditions and possibilities of dealing with an HIV infection, its treatment and the strategies for prevention have changed substantially.

In the early years, with AIDS being a fatal disease and no medical treatment available, prevention activities focused on influencing individual behaviour by public campaigns and structural prevention. Within the approach of "a new public health", innovative concepts mainly based on the social sciences were developed in close collaboration with organisations of the groups mainly affected, above all the gay community (Rosenbrock et al. 2000: 1610). These concepts aimed to strengthen people's motivation for preventive behaviour and protect the civil rights and dignity of people living with HIV.

This period of high AIDS visibility and public attention was followed by a phase of declining interest in the issue (Rosenbrock et al. 2000: 1613). In Western Europe, the feared health catastrophe did not occur. This is partly due to the success of the primary prevention policies that were implemented in close collaboration with, and often by, the most affected groups. With the availability from the mid-1990s of highly active antiretroviral therapies (HAART), the AIDS fatality rate was substantially reduced. Survival times were extended dramatically and HIV turned into a "normal" chronic disease. At this point in time, the role of clinical medicine grew considerably. An important focus lies now on secondary prevention – on easier access to testing, early detection and treatment. The medicalisation and rather clinical management of HIV infection as a chronic disease led to a shift towards individualisation among people living with HIV. The formerly strong communities – especially the gay com-

munities – became weaker and their form and structure changed.

The transition from AIDS to HIV coincides with a substantial change in prevention approaches. Over the last ten to fifteen years, there has been a shift from community based structural and behavioural prevention (with a focus on primary prevention) to health care based "medical prevention" (with a focus on "test and treat" that has an impact both on secondary and on primary prevention). These two approaches have always been in competition in the history of HIV. However, for future success it is necessary to combine both approaches to benefit from their distinct advantages. A coherent policy is needed which connects primary prevention with secondary prevention and treatment.

As a consequence of the changing patterns of HIV infection, the link between HIV and other sexually transmitted infections (STIs) is becoming more relevant, since HIV and other STIs mutually increase their infectivity. Hence, a comprehensive prevention approach must integrate the broad field of STIs and include both HIV- and STI-prevention in an overall strategy for sexual health.

The intention of the expert panel is to contribute to the formulation of a future Swiss HIV policy that is able to take on these challenges. The concrete guidelines and recommendations for a Swiss HIV policy, provided in the following chapters, are suggestions made by the expert panel to help achieve this goal.

3 Surveillance

In Switzerland, there are three types of surveillance: epidemiological, behavioural, and clinical surveillance. Epidemiological surveillance is carried out by the Swiss Federal Office of Public Health (SFOPH) and consists of the centralised collecting of positive HIV test results which the screening laboratories are obliged to report anonymously. The reported results are complemented by a set of anonymised clinical information (probable route of transmission, stage of disease and CD4 count). Behavioural surveillance is conducted by the Institute of Social and Preventive Medicine (IUMSP) of the University of Lausanne and includes regularly repeated surveys in the general population and among MSM and injecting drug users (IDUs), as well as continuous monitoring of annual condom sales and syringe distribution. Clinical surveillance – for individuals already infected with HIV – is an essential part of the Swiss HIV cohort study (SHCS) which started in 1988 and enrols about half of the total number of HIV-positive persons aged 16 years and older and collects information about HIV-associated diseases, antiretrovirals and other medication, laboratory parameters and basic demographical data.

This chapter provides general recommendations for surveillance as well as more specific suggestions for the three different areas of surveillance – epidemiological, behavioural, and clini-

cal. With respect to all kinds of surveillance it should be clear, that surveillance can only provide an approximate picture of the epidemic and its dynamics.

3.1 General Recommendations

3.a It is necessary to improve the exchange of information between the different actors in the field of surveillance.

Effective collaboration and exchange of information between all actors in the different areas of surveillance are essential for the functioning of the Swiss HIV system. A working group called SurvAIDS has already been established in 2004. This working group comprises different stakeholders of the Swiss surveillance system – such as the SFOPH, the IUMSP, the SHCS and the Swiss Aids Federation (Aids-Hilfe Schweiz, AHS). In the beginning, the group members met four times a year; since 2008, the meetings take place twice a year. This exchange of knowledge has to be sustained. However, the flow of information between the SHCS and the other fields of surveillance is not sufficient. Gaining easier access to anonymised data of the HIV-positive persons enrolled in the SHCS would broaden the knowledge of other relevant actors in the field and could improve the numerous prevention activities. The expert panel recommends that these communication channels be strengthened.

Within the SFOPH, the exchange of information and knowledge is additionally hampered due to the separation of the AIDS section and the Infectious Diseases section. Effective cooperation and coordination between these two sections has to be established within the SFOPH.

3.b Surveillance of STIs other than HIV has to be expanded.

Since 2000, the number of reported STIs in Switzerland has risen continually – after a decline in the 1990s (Low 2007). The number of new cases of chlamydia infections doubled between 1999 and 2005. The number of gonorrhoea infections tripled between 1999 and 2006. With regard to syphilis, comparisons are more complicated because of disparate notification procedures (SFOPH 2008b). Syphilis surveillance was stopped in 1999 because of the high workload and initiated again in 2006. During this time, the number of syphilis cases is presumed to have tripled. Because of this increase, a new Swiss surveillance system was adopted in 2005 and compulsory anonymous registration for gonorrhoea and syphilis infections was introduced. Registration for chlamydia infection was already compulsory.

However, according to representatives of the SFOPH, the surveillance of STIs other than HIV is not adequate. Since HIV and many other STIs mutually increase their infectivity, the link between these infections is crucial. Hence, the surveillance of other STI infections – in combination with HIV – should be expanded for both the general population and groups at elevated risk for STI and HIV.

3.c Contextual factors for risk taking behaviour should be integrated into surveillance activities.

With regard to effective prevention strategies, it is of particular importance to know the relevant contextual factors for sexual risk taking. Which are the typical risk taking situations? Where and when do they take place? Which are the most important variables that influence risk taking? What roles do alcohol, drug use and mental health problems play? Is there an association with mental health problems which would weaken protective behaviour? How is the national level of HIV infections related to other societal issues like suicide rates, clinical depression, other STIs, general risk taking behaviour and the number of prescribed psychoactive drugs?

For example, Ciesla and Roberts (2001) found that HIV-positive individuals were 1.99 times more likely to be diagnosed with major depressive disorder than HIV-negative individuals. Certainly, the question still remains if these mental health problems are related to the severity of the disease or if they in fact weaken protective behaviour. However, there is a lack of Swiss data about the relation between HIV infection and mental health, and especially between HIV exposure and mental health, a potentially important link for primary prevention. The SHCS collects data regarding psychiatric treatment of the enrolled persons and started recently gathering data on depressive disorders. Regarding other contextual factors for risk taking behaviour, an adaptation of the surveillance activities has already taken place as well. Since 2007, the IUMSP additionally enquires individual strategies for risk minimization (such as serosorting or strategic positioning) in its regularly repeated surveys among MSM.

As Switzerland has a relatively high prevalence of HIV, it is important to identify locally the contextual and structural factors for risk taking behaviour and use this knowledge for the formulation and targeting of preventive strategies.

3.2 Recommendations for Epidemiological Surveillance

3.d It is necessary to monitor the general testing behaviour of the Swiss population.

In Switzerland, as in most if not all countries, only positive HIV test results are anonymously collected and centralised by the SFOPH. The general testing behaviour, in the general population and particularly among vulnerable groups, is not recorded regularly and systematically. The Swiss Health Survey provides information on testing behaviour, but it is only conducted every five years. The IUMSP also enquires testing behaviour in surveys among the general population, MSM and IDUs. Furthermore, through specific testing institutions like the checkpoints in Zurich and Geneva, there is some information available on the testing behaviour of

particular target groups. But this information as well is not systematically collated or centralised.

Given the evidence presented to them, the members of the expert panel concluded that the increase in the number of new HIV among MSM in Switzerland could reflect both an increase in the rate of transmission (i.e. incidence) as well as an increased uptake of HIV testing. However, at present it is not possible to exactly examine overall trends in the uptake of HIV testing in Switzerland. Consequently, negative HIV test results have to be recorded as well as the positive test results. The SFOPH is presently pushing for such an action – this effort must be sustained and put into practice.

3.e The HIV incidence rate should be estimated.

The SFOPH should consider estimating the HIV incidence rate (i.e. the rate of HIV transmission) for the different groups affected. The increase in the number of HIV diagnoses in any one group could be explained by a number of factors including increased incidence, increased uptake of testing, changing patterns of migration and improved notification and case reporting. Robust estimates of HIV incidence are therefore needed to ascertain whether the rate of HIV transmission among MSM, for example, is changing. HIV incidence could be estimated using laboratory data on recent HIV infection combined with information on testing behaviour of the target groups.

3.3 Recommendations for Behavioural Surveillance

3.f Behavioural surveillance has to be continued and put on a sustainable basis.

In Switzerland, behavioural surveillance was initiated in 1987 by the SFOPH, implemented by the IUMSP and presently comprises regularly repeated surveys among the general population, MSM and IDUs, as well as continuous monitoring of annual condom sales and syringe distribution. With the overall decrease in new AIDS cases since the advent of HAART, there has been a decrease in the perceived need for information on trends and in available funding for data collection and analysis. As a consequence, the repeated HIV-related behavioural survey among the general population was recently dropped and replaced by a specific sexual behaviour module in the Swiss Health Survey that is conducted every five years (Dubois-Arber 2008).

As behavioural surveillance provides crucial information for primary and secondary prevention, further cutbacks have to be avoided. As a minimum, behavioural surveillance in the groups most affected by HIV has to be conducted regularly. The established structures and processes should be put on a sustainable basis.

In general, the expert panel appreciated the quality of the behavioural surveillance delivered by the IUMSP – especially with respect to the data on MSM (Balthasar et al. 2008a, 2008b, 2005). The behavioural surveillance data operated as an early warning system by showing that the level of protection among MSM has decreased since the mid-1990s (Balthasar et al. 2008a). The expert panel strongly recommends that the "gay survey" is continued and provides even more detailed data and analysis with respect to the context of sexual risk taking (see recommendation 3.c).

Furthermore, the expert panel appreciates that the researchers at the IUMSP increasingly participate in European research projects (e.g. Dubois-Arber et al. 2003b).

3.g It is necessary to improve behavioural research among migrants.

Empirical evidence shows that in the last few years, barriers for migrants to access the Swiss health service have been reduced due to the establishment of several effective low-threshold[3] institutions. However, a rapid assessment of the situation of migrants (Zuppinger et al. 2000) revealed a range of difficulties in communicating about sexuality, social relationships and sex. So, it is necessary to improve behavioural research among migrants to understand factors which could potentially foster or impede prevention strategies and to provide a useful insight into sexual behaviour and risk taking in this population as well as into their broader social background.

As there has been a decrease in the number of new HIV diagnoses among Sub-Saharan Africans since 2002, it was decided to stop the survey among migrant women for the moment. As a consequence, a sentinel behavioural survey was recently conducted in a University obstetrics and gynaecology outpatient clinic. Dubois-Arber et al. (2008) conclude that this seems to be a promising way of recruiting migrant women and obtaining data on their sexual behaviour. However, results of this study are not yet available.

3.h It is necessary to improve behavioural research among sex workers.

A recent study on the Swiss sex market shows that HIV prevalence among sex workers is presumably higher than in the general population, since IDUs and migrants are represented in this group to a much greater extent (Bugnon et al. 2009: 49). Around 70% of the sex workers have a temporary or permanent residence permit and approximately 15% are migrants without a residence permit.

The population of sex workers is generally very mobile which makes it difficult to precisely monitor the incidence of HIV and other STIs. In Switzerland, there is a lack of data concerning their behaviour and their general health conditions, including intravenous drug use, as well as a better estimate of the HIV prevalence in this group. So, the expert panel suggests

[3] The term „low-threshold" is a specific Swiss expression and is synonymous with „easy access".

that more knowledge on the structure, the general health conditions and the behaviour patterns of this population should be sought and behavioural research should be improved in this field.

3.4 Recommendations for Clinical Surveillance

3.i Clinical surveillance should generally be supported and sustained.

Clinical surveillance is operated by the SHCS, a prospective multi-centre cohort study established in 1988. Drawing on the comprehensive database of the SHCS, numerous studies and publications have been produced. The expert panel was impressed by the high quality and the productivity of the research based on the SHCS. The cohort study is financed by research grants from the Swiss National Science Foundation which currently amount to CHF 3 million per year (SFOPH 2005: 11). Since the SHCS provides valuable and comprehensive information on HIV-positive individuals, these research activities have to be sustained.

3.j The expert panel recommends the improvement of knowledge transfer between the SHCS and the prevention specialists.

Within the SHCS, a large amount of data on individual characteristics and on the medical history of HIV-positive persons is available. In the past, this information has been used mainly by clinicians in order to answer clinically relevant research questions, yielding in the production of peer reviewed scientific articles. However, other research questions, with particular relevance to HIV prevention and prevention needs, are not routinely incorporated, and social scientists do not participate in planning and evaluating the cohort. Behavioural and sexual issues have remained underdeveloped in the SHCS and could be addressed both from a scientific and a public health point of view. More emphasis should be placed on the transfer of such information to prevention specialists and community representatives in order to facilitate the formulation of sound prevention strategies. Furthermore, a close collaboration with prevention specialists and community representatives would enable the SHCS to implement secondary prevention measures within its setting. So, the communication channels between the fields of prevention and treatment have to be expanded and put on a sustainable basis.

3.k Within the Swiss HIV cohort, additional emphasis should be placed on behavioural surveillance.

To further develop the enormous potential of the cohort data, the SHCS should integrate social scientists and community representatives into its organisational structure to investigate sexual and non-sexual risk taking as well as preventive behaviour among people living with HIV. Behavioural research could also provide information on missed opportunities for testing and therefore lead to an improved testing policy. Such social science research programmes

within the SHCS could be mandated by the SFOPH or the Swiss National Science Foundation.

4 Primary Prevention

The members of the expert panel share the opinion that the primary prevention implemented by the SFOPH and the AHS in the wake of the NHAP 2004-2008 was partially successful. To meet the challenges outlined in chapter 2, the expert panel however recommends that the SFOPH reconsiders the priorities for, and approaches to primary prevention. Priorities should clearly be assigned to prevention activities targeting the most affected population groups. Consequently, primary prevention should mainly target self-identified gay men and other men having sex with men (MSM), as well as migrants coming from high prevalence countries. Furthermore, HIV prevention should be systematically embedded in a more integrated approach to sexual health promotion. The expert panel welcomes the comprehensive approach proposed by the 'Vision on sexual and reproductive health 2010' (SFOPH 2006) that differentiates between the five core issues of psycho-sexual development ('Psychosexuelle Entwicklung'), reproduction, sexual well-being, STIs and sexual violence. This approach should be followed despite institutional and structural barriers of the Swiss federal system. The internet and other new media offer new opportunities for primary prevention and could be used more extensively.

4.1 Recommendations on Primary Prevention Targeting Gay Men and other MSM

In Switzerland, the number of newly diagnosed HIV infections among MSM increased from 174 in 2004 to 334 in 2008. This signifies not only an increase in absolute numbers, but also in relative terms compared to other transmission ways: In 2004, 23,5% of all newly diagnosed HIV infections occurred among MSM, in 2008 this proportion increased to 43%. Thus, this population group is most affected by HIV infections in Switzerland.

4.a Prevention targeting gay men and other MSM should be strengthened.

The Swiss HIV policy should give prevention activities targeting this population group top priority. The expert panel recognizes the various activities of the AHS and its member organisations in this field, but it is not convinced that enough innovative efforts are dedicated to this population group. This is not a question of the number of activities or of new websites established, but of a coherent approach which takes into account the patterns of risk taking behaviour both with respect to the subgroups of MSM and to the respective risk situations. The assessment criteria of this prevention work could be based on a number of factors such as be-

havioural surveillance indicators and the number of newly diagnosed HIV infections among MSM. Thus, the expert panel recommends that prevention work with MSM, particularly self-identified gay men, needs to be greatly strengthened.

4.b Development of a comprehensive and coherent national prevention strategy for gay men and other MSM.

The expert panel thought that an explicit, comprehensive and coherent national prevention strategy for gay men and other MSM was missing. The panel noted that in June 2009 the central agency of the AHS submitted a document called "MSM Strategy". However, this paper appears to be a planning document rather than a coherent strategy. The activities of the AHS and its member organisations are manifold, but impart rather an additive than a strategic impression. The needed strategy for MSM would show how the various preventive approaches relate to each other and take into account the challenges outlined in chapter 2.

(1) First of all, a national strategy for gay men and other MSM should clarify the term 'medical prevention' frequently used by Swiss actors invited to the meetings held in May 2009. The low-threshold voluntary, community based counselling and testing facilities (the so called 'Checkpoints' in Geneva and Zurich) seem to be an important driving and innovative force behind the concept of 'medical prevention'. Checkpoint Zurich provides the most comprehensive services including post-exposure prophylaxis (PEP), HIV and STI testing and treatment, psychological support and counselling. Further, in 2007 Checkpoint Zurich started additional 'Checkpoint mobile' with on-site testing at sex parties, in dark rooms or saunas etc. The expert panel welcomes these developments but emphasizes the need to clarify the role of these checkpoints in the overall national strategy and to further develop the so called concept of 'medical prevention'. This concept should reveal how behavioural prevention, community-based approaches and prevention provided by the 'medical' system can be combined. Since this approach combines the instruments of prevention in a new way, accompanying research and evaluation is necessary.

(2) Second, the consequences of the "EKAF statement" (Vernazza et al. 2008), the availability of PEP as well as knowledge about primary infection should be considered within a comprehensive MSM prevention strategy. The EKAF, the Swiss National AIDS Commission, is an extra-parliamentary commission appointed by the Swiss Federal Council which provides strategic and specialist support for the SFOPH. The EKAF statement postulates that HIV-positive individuals without additional STIs and on effective ART are sexually non-infectious (Vernazza et al. 2008).

(3) Third, with respect to behavioural prevention, the strategy should take into account the effectiveness or otherwise of the different risk-reduction strategies such as serosorting, strategic positioning, withdrawal before ejaculation etc. that are, apparently, current practice among men having sex with men in Switzerland.

(4) Fourth, a comprehensive MSM prevention strategy should consider differentiating clearly and comprehensively between different groups of MSM, such as self-identified gay men, bisexual men and male sex workers (MSW), but also between different age groups, sexual preferences, etc.

(5) Finally, a comprehensive MSM prevention strategy should also include structural prevention measures such as political efforts to prevent discrimination and stigmatization as well as the provision of prevention material at places where sexual contacts take place. The expert panel welcomes the introduction and implementation of the charter of the 'Minimal Standards for Gay Venues' by the association of gay establishments (Verein Gaybetriebe Schweiz VEGAS), and acknowledges the efforts of preventing social and judicial discrimination. The expert panel recommends that these initiatives are strengthened and new approaches are developed. The expert panel also noted with interest the evolvement of a differentiation in prevention work targeting men in Geneva, where Dialogai might target self-identified gay men, and Group SIDA Genève might include messages targeting MSM in their general prevention campaigns in the future. This differentiation of preventive activities, and division of labour should be actively pursued. The effect of this division of labour should be assessed.

Such a comprehensive and coherent MSM prevention strategy should be informed by surveillance data and research, and encourage the involvement of the gay community and possibly other reachable MSM groups such as MSW. The MSM prevention strategy would provide coherent prevention messages and also define structural efforts to finally animate and support protective behaviour at the individual level.

4.c Participatory approaches should be strengthened.

The members of the expert panel share the opinion that participatory approaches should be strengthened not only to deliver but also to develop prevention activities that meet the needs of MSM. However, participatory and/or community-based approaches should be adapted to the changing structures and characteristics of the different subgroups of the gay community. The expert panel recognizes the problematic that the progressive professionalization of the HIV work might counter such initiatives. Nevertheless, the expert panel recommends considering the involvement of the community as obligation that should further be supported by social science research (especially participatory community-based research). The website www.loge70.ch developed by the association Loge 70, the AHS and the Aids Help Zurich is considered as a good example of such an initiative.

4.d Messages and measures should be more tailored to different subgroups of the gay community and the different contexts of risk behaviour.

This recommendation emphasizes that primary prevention for gay men has to reflect the diversity of this target group and takes into account contextual factors such as regional, local,

and age-specific differences with respect to lifestyle, meeting places, ethnicity, drug use, mental health or other factors (e.g. serosorting) that influence sexual risk behaviour. Specific preventive messages should be informed by research and should also acknowledge the different risk reduction strategies practiced within subgroups. For instance, one should consider the eventual effect of differentiating prevention messages and tailor them more according to different age groups.

4.e The potential of the internet and other new media should be recognized more and better used.

The members of the expert panel acknowledge that the SFOPH and the AHS have used the internet successfully for prevention (e.g. www.drgray.ch). The internet and other new media should be recognised as being a new space for HIV prevention that could be used even more extensively. The internet has become a central means of finding sex partners among gay men. Research shows that there is also big demand for using the internet to support prevention.

4.2 Recommendations on Primary Prevention Targeting Migrants Coming from Sub-Saharan Africa

Issues related to migration and HIV are manifold and complex. Migrants are particularly affected by HIV: First they might come from countries with a high prevalence of HIV. Second, migrants bear heightened risk of HIV infection, which results from the migration process itself. Access to prevention, testing and treatment for these population groups might be hampered due to socio-cultural or linguistic factors, or as a result of their residence status. Stigma and discrimination further exacerbates their vulnerability. Additionally, important questions concerning the family are often neglected; for instance, the question of how to care for HIV-affected children or the question of family members living in different countries and having different access to treatment. The expert panel first of all would like to emphasize the importance of the inclusive approach adopted by the Swiss government in not applying HIV-related restrictions to migrants.

4.f AFRIMEDIA: Prevention for Sub-Saharan Africans should be strengthened.

In Switzerland HIV is concentrated particularly in migrants coming from Sub-Saharan African countries with a generalized HIV epidemic. Since 2002, the prevention project AFRIMEDIA financed by the SFOPH has targeted Sub-Saharan African migrants. AFRIMEDIA was implemented by a cooperation of the Swiss Red Cross and the Swiss Tropical Institute till 2006, and afterwards transferred to the AHS. AFRIMEDIA operates a peer-education approach which includes the involvement of key persons of the migrant communities such as leaders of their religious communities. Currently, the programme is implemented by local

AHS units in seven cantons (Fribourg, Berne, Geneva, Neuchâtel, Vaud and Zürich) (Tshibangu 2007).

Based on the project documentation, the evaluation of AFRIMEDIA (Hammer et al. 2006) as well as the meeting with the coordinator of AFRIMEDIA, the expert panel considers the approach of AFRIMEDIA to be appropriate and promising for delivering primary prevention within these migrant communities. If the number of HIV diagnoses rises in migrants coming from other regions (e.g. Eastern Europe, Southeast Asia and Caribbean) similar prevention projects should also be established for these communities.

However, the expert panel had the impression that AFRIMEDIA is a small and fragile programme that should be sustained and extended. More concretely, the expert panel has formulated three recommendations aiming to improve AFRIMEDIA.

4.g AFRIMEDIA should concentrate on reducing the stigma surrounding HIV within the migrant communities as an absolute priority.

The expert panel is aware that AFRIMEDIA aims to reduce the stigma surrounding HIV and within this target population by initiating and supporting self-help networks for HIV-positive persons. Stigmatization might not only lead to isolation of the affected persons but also hamper effective prevention, early testing and treatment. Therefore, the expert panel strongly emphasizes the need to strengthen the focus on reducing stigma by, amongst other means, community discussions, involvement of religious and other community leaders, support to HIV-positive migrants being open about their HIV status, linkages to Swiss HIV-positive organisation and use of venues where migrants gather.

4.h AFRIMEDIA should strengthen its participatory approach.

The expert panel has the impression that the potential for mobilizing social institutions in the migrant communities (religious and cultural institutions, sport clubs, shops etc.) was not explored enough by AFRIMEDIA due to a lack of resources. Such institutions can reach the target communities in a more effective way than mediators alone and can especially help to reduce the stigma surrounding HIV. The expert panel recommends that this approach is strengthened and a first step could thereby be an inventory of social institutions.

4.i AFRIMEDIA should consider widening its focus.

On the one hand, HIV might not be the most important problem for migrants coming from Sub-Saharan Africa, and, they might get the feeling that they are only approached by Swiss institutions related to HIV. This situation might limit the effectiveness of prevention activities. AFRIMEDIA should consider widening its approach for instance by including other health topics, especially sexual and reproductive health, or by providing support for social

problems such as housing or social integration. However, such an approach should not be implemented at the expense of efforts for reducing the stigma surrounding HIV.

4.j Adequate prevention, counselling and testing for asylum seekers should be sustained.

In the last four years, the SFOPH and the Federal Office for Migration (former Federal Office for Refugees) have intensified prevention activities including voluntary counselling and HIV testing for asylum seekers. New prevention material has been produced, low threshold facilities have been established and regular information events regarding HIV were organised by local AHS units in asylum seeker accommodation centres. The expert panel supports these activities but had difficulties in assessing the quality and coverage of these activities. Therefore, the expert panel recommends that these activities are evaluated and, depending on the outcome of such research, they should be sustained and if necessary extended.

4.3 Recommendation on Primary Prevention Targeting IDUs

Since the mid-1980s, harm reduction measures have been introduced by Swiss towns and cantons to counter the acute problems associated with the increase in the intravenous use of heroin and the spread of HIV. Harm reduction measures comprise both health measures (e.g. distribution and exchange of syringes, supervised drug consumption facilities, methadone and heroin programmes) and social measures (e.g. contact and counselling, assistance in finding employment and accommodation). Since the beginning of the 1990s, the number of new HIV diagnoses among IDUs has decreased considerably as have their risk behaviours (SFOPH 2009: 92). At the national level, harm reduction activities are embedded in the national programme of measures to reduce drug-related problems supported and coordinated by the Section on Drugs of the SFOPH.

4.k Prevention activities targeting intravenous drug users should be continued.

Based on epidemiological and surveillance data (Zobel et al. 2003, Dubois-Arber et al. 2008), the evaluation by Zobel and Dubois-Arber (2004, 2006) and the meetings held in May 2009, the expert panel considers primary prevention targeting IDUs in Switzerland to be a success story – as regards HIV infection but far less regarding hepatitis C. The expert panel is convinced that these achievements can only be maintained by a continuation of the harm reduction programme. Surveillance of the IDU population continues to be crucial and should be maintained.

4.4 Recommendations on Primary Prevention Targeting the General Population

The SFOPH spent approximately 28% (CHF 2.4 million) of its yearly budget for HIV prevention for the campaign targeting the general population. The expert panel discussed whether the LOVE LIFE STOP AIDS campaign should be developed taking into account current challenges. The members of the expert panel agreed that the campaign should be continued and fulfil its three central functions as mentioned in the NHAP 2004-2008 (SFOPH 2003: 20): "1) It keeps the general public informed and motivates to adopt protective behaviour. 2) It makes a visible political statement that AIDS is a problem of national significance that has to be taken seriously. 3) It creates a common brand for AIDS prevention activities, motivates the SFOPH's partners in their prevention activities and supports them in their effort on the local level." However, the expert panel made the following recommendations.

4.l The general population campaign should be oriented more towards sexual health promotion.

In 2005, the new brand of the campaign 'LOVE LIFE STOP AIDS' was introduced to reflect a positive sexual experience and to support the new focus on sexual health being a part of an overall public health effort. The expert panel recognizes these efforts as well as the 'Vision on sexual and reproductive health 2010' (SFOPH 2006), and recommends that the SFOPH develops and implements a comprehensive approach towards sexual health. Such an approach would include not only specific HIV prevention activities but also target other STIs. The expert panel was well aware that in Switzerland, sexual health as a public health activity is a cantonal matter which is not regarded as a public health priority. The expert panel noted that the Foundation for Sexual and Reproductive Health (PLANeS) with its regional counselling centres for family planning, pregnancy, sexuality and sexual health education is the organisation which is able to develop and implement a comprehensive approach for the sexual health of the population. Therefore, the expert panel suggests the SFOPH involves PLANeS in the further development of the 'LOVE LIFE STOP AIDS' campaign.

4.m The general campaign should be tailored towards different population groups.

To deal with the heterogeneity of the general population, the expert panel recommends that the campaign should be tailored more towards different population groups taking into account sexual, cultural, social and local diversity. The expert panel particularly noted the lack of visible strategies related to migrant population groups.

4.n Activities aiming to improve sexual health education in schools should be continued.

Swiss schools cover the topic of sexual health (Spencer et al. 2001). However, the coverage and the models of how sexual health education is organised vary between the cantons. No

data are available about the quality of sexual health education and therefore, the expert panel had difficulties in assessing the current situation of sexual health education in schools.

Taking into account the federal organisation of the Swiss education systems, the expert panel recommends that the SFOPH continues to support the national "Centre of Competence for Sex Education in Schools", based at the Teacher Training University of Central Switzerland (Pädagogische Hochschule Zentralschweiz). Furthermore, the expert panel suggests an evaluation of school based sexual health education in the cantons.

4.o Primary prevention targeting female sex workers should be continued and more tailored towards the diversity of sex work contexts.

Female sex workers are a vulnerable group from legal, socio-economic and health point of view and thereby bear a higher risk of infection. The expert panel recommends the continuation of primary prevention activities targeting female sex workers and their clients. The projects targeting FSW 'APiS' and their clients 'Don Juan' are considered to be appropriate approaches by the expert panel and could be intensified. Additionally, geographic coverage should be expanded and innovative approaches should be developed in order to better respond to the needs of this increasingly diverse and mobile population which is hard to reach for prevention.

5 Treatment and Care

The recommendations relating to treatment and care primarily focus on access to HIV testing, diagnosis, treatment, adherence to therapy and comprehensive care.

5.1 Recommendations on Access to HIV Testing, Diagnosis and Access to Treatment

5.a Open access to treatment – irrespective of legal status – has to be maintained.

In Switzerland, health insurance is compulsory for all residents. Highly active antiretroviral therapy (HAART) is part of the catalogue of universal medical services that are covered by this compulsory health insurance. So in principle, every HIV-positive person in Switzerland has a right to therapy. This applies also to migrants without a residence permit. The insurance companies are not allowed to set any conditions relating to age, gender or state of health for coverage – as far as the compulsory health insurance is concerned. And they are bound to secrecy. Concerning migration, Switzerland has no restrictions on entry, stay or residence of people living with HIV. There are no regulatory restrictions on access to health care, no mandatory testing and no deportation as a consequence of an HIV diagnosis. As a matter of prin-

ciple, the legal status of the migrant is separated from treatment access. The panel emphasizes the importance of the inclusive approach adopted by the Swiss government in not applying HIV-related restrictions to migrants and it considers that these regulations are essential preconditions for responding to the epidemic.

5.b Access to HIV testing and diagnosis for migrants should be sustained and expanded.

Access to treatment in Switzerland is not influenced by risk group or geographic origin (Keiser et al. 2004; Staehelin et al. 2003). However, the crucial point is access to HIV testing and diagnosis. The fact that migrants present with comparably more advanced HIV disease than other groups shows that barriers to access to testing and diagnosis still exist. However, this situation also results from the fact that some migrants already had advanced HIV disease when they arrived in Switzerland. Staehelin et al. (2004) point out that 70% of the Sub-Saharan African migrants and 50% of the Southeast Asians living with HIV appear to have been infected before entry to Switzerland.

In recent years, several low threshold institutions for migrants have been established. In around one third of Swiss cantons, specific medical drop-in centres for asylum seekers and migrants have been set up. In these centres, a residence permit is not required in order to receive medical care. Furthermore, regular events regarding HIV take place in the cantonal and communal accommodation centres for asylum seekers. So, barriers to access to testing and diagnosis are slowly being removed for migrants. The expert panel recommends that this development is sustained, expanded and financed.

5.2 Recommendations on the Swiss HIV Testing Policy

5.c The expert panel recommends the formulation of a coherent HIV testing policy.

In 2007, the SFOPH introduced a new Voluntary Counselling and Testing strategy (VCT) aimed at preventing infections as well as detecting HIV infections at an early stage. This strategy addressed the general population. In the larger Swiss cities, VCT centres for the target groups of MSM and migrants have been established. Additionally, HIV tests can be carried out in every general practitioner's practice. More recently, in 2008, the SFOPH introduced a new counselling and data transfer tool (BerDa Beratungsleitfaden und Datenverwaltungssystem) for centres offering voluntary HIV counselling and testing (SFOPH 2008a). This tool is designed to help specialists working in the centres provide consistently high-quality VCT consultations and to implement the recommendations of the SFOPH correctly. Based on a questionnaire on sexual and risk behaviour completed by the patient seeking an HIV test, BerDa produces a risk profile that provides the counsellor at the VCT centre with

rapid and standardised information about the client's risk profile and coordinates the consultation through the stages of pre-test and post-test counselling. The expert panel considered that this approach to improving and assuring the quality of counselling was innovative and promising. If a future evaluation affirms the higher quality of counselling, this tool should be extended and sustained.

Besides self-initiated voluntary testing as described above, there are recommendations for physicians concerning HIV tests in special cases. For instance, HIV testing is systematically offered and suggested to pregnant women and tuberculosis patients. Additionally, there are several other situations (for instance STIs, mononucleosis, mucocutanous lesions, exanthema, recent blood transfusions, needle-sharing in IDUs and current sexual risk taking) where the SFOPH advises physicians to strongly propose an HIV test. This advice is given in accordance with the newly implemented Provider Initiated Counselling and Testing concept (PICT) (SFOPH 2007). The PICT concept also provides a checklist for the processing of a sexual history comprising sexual orientation, sexual risk taking, type of partnership, number of partners, drug consumption and sexual violence. The panel recommends extending provider initiated counselling and testing in order to reduce the number of late HIV diagnoses among those at highest risk. Early diagnoses offer opportunities for treatment and prevention.

However, Dubois-Arber et al. (2003a) show that doctors' attitudes to investigating the risk of exposure to HIV tend to vary according to the type of patient or the patient's situation. Physicians are most likely to pay attention to patients whose situations involve an "obvious" risk of contact with HIV (e.g. drug users). Although not neglected, patients in more "neutral" situations (young adults or patients coming for a check-up) are less likely to experience this kind of history-taking. Finally, migrants are rarely investigated for their risk of exposure to HIV. Unfortunately, there is no recent data that could show that the findings of Dubois-Arber et al. (2003) are not valid anymore and that the implementation of the PICT has profoundly changed doctors' attitudes.

So, the SFOPH provides basic guidelines for physicians to systematically investigate possible exposure to HIV. The problem is presumably the implementation of these guidelines. Therefore, the expert panel suggests adapting the existing guidelines, developing a coherent testing policy and ensuring its implementation by the physicians. Some crucial elements of such a policy are outlined below.

5.d The principle of informed consent for HIV and STI testing has to be maintained.

Before the launch of the VCT project in 2007, the SFOPH organised a broad consultation among Swiss experts. In this process, the experts consolidated the existing consensus that informed consent is a necessary precondition for HIV testing; particularly because for the persons concerned a positive result represents a life event that typically has serious and far-reaching implications – not only in medical but also in social and psychosocial terms

The expert panel therefore emphasises that HIV tests are always carried out on a voluntary basis. Routine tests without asking for consent or compulsory tests for specific target groups should not be considered.

5.e HIV testing should be free of charge or at lowest possible cost.

Today, HIV tests are only free of charge if embedded in a wider diagnostic procedure in a clinical setting. In this case, the costs are covered by the health insurance. In all other cases, the costs for testing have to be paid by the client. This undermines the public health imperative and the priorities of prevention. Moreover, it differs substantially from well established practices in other countries. The panel recommends that HIV testing should be free of charge or at lowest possible cost. This claim has to be negotiated between the SFOPH and the Swiss health insurance companies. In any case, the current practices of testing institutions of omitting the charge in certain cases should be supported and financially facilitated. Access to testing should not be hampered for economically disadvantaged persons.

5.f Concrete guidelines for physicians on taking patients sexual histories have to be formulated and implemented.

In order not to miss further opportunities for testing, precise guidelines for physicians are necessary. These guidelines should not only cover the crucial symptoms and diseases for conducting an HIV test or a checklist of sexual risk behaviour. They should give detailed instructions how to talk about the patient's sexual history and how to appropriately investigate the risk of exposure to HIV. According to a study of Dubois-Arber et al. (2003a), in a hypothetical situation with a young adult presenting with a non-urgent health problem, only half the doctors investigated the patient's sexual history.

Even with seemingly harmless health problems and with persons with a seemingly low risk of exposure to HIV, physicians should be encouraged to take their patients' sexual histories. Thus, they need helpful and precise guidelines. The newly implemented Provider Initiated Counselling and Testing concept (PICT) (SFOPH 2007) could be such a guideline. Or else, the new counselling and data transfer tool (BerDa Beratungsleitfaden und Datenverwaltungssystem) implemented in VCT centres might be adapted and also be applied by doctors in private practices. Both tools have to be evaluated in comparison to each other to develop concrete and helpful guidelines for taking patients sexual histories – tailored to different testing institutions if necessary.

5.3 Recommendations on Comprehensive Care and Adherence to Therapy

5.g Tailored case management is necessary to enhance individual well-being and to raise adherence to therapy.

Generally, experiences with HAART suggest that adherence is arguably the most important issue in successfully managing HIV (WHO 2003). To achieve high adherence rates it is crucial that medical care is comprehensive and provides individually tailored case management. Treating HIV-positive individuals is not only about medical services, but also about having conversations about their social and emotional life as well as their sexual history and sexual behaviour. Therefore, increasing the rate of adherence to treatment and protective behaviour is not only an individual issue, but a wider responsibility of the health care system, too.

Physicians in private practice are usually interested in the adherence of their patients, but, unfortunately, they do not show much concern about underlying factors like the emotional life of the patients (Dubois-Arber et al. 2003a: 53). Only two thirds of physicians take an interest in the impact of the treatment on the patient's family life and work (61% and 66% respectively). A third of doctors only enquired into the sex lives of their patients at the first appointment. Similarly, one quarter of physicians only took an interest in their patients' emotional lives and their protective behaviour when they first met. Consequently, doctors fail to gather information regarding the development of a health problem which is long term.

As an HIV infection is a lifelong threatening chronic condition which impairs many aspects of an individual's life, a comprehensive approach of care is needed to support individuals to cope with the disease, including the issue of transmission of the virus to sexual partners.

5.h It is important to change the incentives for doctors and patients to enhance continuous follow-ups and to prevent individuals from dropping out of care.

It is a known weakness of the Swiss health care system that chronically ill persons are not optimally supported due to adverse incentives in the federal health insurance act. As the continuity of care is not only an individual but also a public health concern, the establishment of financial and non-financial incentives for doctors and patients should be considered.

The health care system should provide strong incentives for physicians to avoid patients of dropping out of their contact with their HIV care provider. The expert panel recommends the SFOPH to assess the drop out phenomenon in collaboration with concerned organisations, the health care system and health insurances.

5.i It is necessary to put more effort into surveying sexual behaviour and investigating the sexual history of people living with HIV – as secondary prevention.

Within the SHCS, a brief questionnaire on sexual behaviour was introduced in April 2000. Patients were asked questions on protected or unprotected sexual intercourse (without distinguishing between vaginal, oral, or anal penetration), type of partnership (stable partnership or occasional partners), and known or unknown serostatus of a stable partner. Besides this survey, there is no systematic investigation of sexual behaviour or sexual history among people living with HIV in Switzerland. Instead of adopting a standardised approach, surveying sexual behaviour and talking about sexual histories with people living with HIV varies according to each individual physician.

In order to advance secondary prevention, it is necessary to put much more effort into discussing prevention issues with HIV-positive patients and therefore to consider the patients' emotional state, their current type of partnership as well as their social and sexual behaviour. Therefore, a systematic approach has to be developed.

5.j It is essential to include the primary partner in treatment and care.

According to the expert panel, an additional contribution to successful treatment and care and a high rate of adherence would be the inclusion of the patient's primary partner into the clinical setting. Working with couples would also be of great value regarding the importance of secondary prevention. Particularly serodiscordant couples could receive helpful support from their physician in managing their HIV risk and in dealing with difficult situations.

6 Positive Prevention

Since the availability of ART, survival times have increased dramatically and HIV has become a chronic disease. With HIV-positive people living longer, secondary prevention is becoming more important. Likewise, meeting the special needs of HIV-positive persons as well as addressing stigma and discrimination are crucial tasks within today's HIV policy system. Medicalisation of HIV infection is accompanied by a growing number of patients who want to speak on their own behalf instead of always being told what to do. Therefore, positive prevention aims at increasing the self-esteem, confidence and ability of HIV-positive people to protect their own health and to avoid passing on the infection to others (International HIV/AIDS Alliance 2007: 4). Regarding people living with HIV, the Swiss HIV/AIDS Programme 2004-2008 focuses so far on "solidarity with individuals at risk of infection and those with HIV and AIDS" (core field 3) and on "individual prevention and counselling" (level of intervention 3) (SFOPH 2003). With the extension of the programme until 2010, the three levels of interven-

tion were renamed as axes and the third axis now reads as follows: "preventing HIV transmission in serodiscordant couples" (www.bag.admin.ch, August 2009). As the concept of positive prevention has a wider scope and attaches importance to the needs and abilities of people living with HIV as well as to their self-determination, the expert panel employs this concept and regards it as essential. Positive prevention needs to be implemented within an ethical framework that respects the rights and needs of people living with HIV to enjoy sexual relationships, have reproductive choices and live a full and healthy life.

6.a HIV-positive people should be encouraged to speak on their own behalf.

According to the SFOPH, the inclusion of HIV-positive people is important for successful prevention and treatment of HIV infection. The collaboration with persons living with HIV has a dual purpose: optimising the health of infected people and preventing transmission to their non-infected partners (www.bag.admin.ch, June 2009). To let HIV-positive individuals raise their voice, it is necessary to strengthen institutions supporting people living with HIV. The only Swiss NGO working solely in this policy field is LHIVE – an association founded in 2007. It campaigns against prejudice, discrimination and stigmatisation of people living with HIV, organises regular meetings and activities for HIV-positive individuals and helps in reintegrating them in the labour market. The central agency of the Swiss Aids Federation (Aids-Hilfe Schweiz, AHS) also provides advocacy and campaigns against discrimination of people living with HIV.

6.b Primary prevention and medical prevention should be combined.

The changing patterns of HIV infection caused a shift from community based structural and behavioural prevention (with a focus on primary prevention) to health care based medical prevention (with a focus on "test and treat" that has an impact both on secondary and on primary prevention). To eliminate competition between these two approaches and to minimise the number of new HIV infections, behavioural and medical prevention have to be combined. Thereby, it will be possible to benefit from their different advantages. Representatives from the prevention and the clinical sectors should therefore cultivate a constant exchange of information and knowledge.

Positive prevention represents new activities for HIV clinics and health care workers which require additional education and resources.

6.c The expert panel recommends the creation of a comprehensive prevention strategy that comprises HIV and the broad field of all other STIs.

HIV and other STIs mutually increase their infectivity. This fact becomes even more important since HIV is no longer a fatal condition. A comprehensive prevention strategy therefore also includes all other relevant STIs besides HIV. This new orientation towards the broad

field of sexual health corresponds to the changing conditions and demands of people living with HIV.

In 2005, the Swiss STOP AIDS campaign was redirected and focused on the sexual health of the population as part of an overall public health effort. However, concrete prevention activities in the domain of STIs other than HIV are not yet part of the campaign.

6.d Counselling after a positive test should also include the primary partner of the person concerned.

If HIV infection is detected, the medical and psychological counselling should also include the primary partner of the person concerned. According to the Swiss AIDS Transmission (CHAT) study, in Switzerland in 2006 about 30% of infected men and 60% of infected women became infected in a stable partnership (www.bag.admin.ch, June 2009). So, the inclusion of partners in the counselling is of utmost importance. At present, this is not common practice in Switzerland. Furthermore, serodiscordant couples should get support from their doctor to manage their HIV risk successfully.

7 Governance

The chapter on governance assesses: (i) whether the different tasks in the HIV policy field are appropriately assigned to competent actors; (ii) if the allocation of the resources and prevention activities are adequately linked to the prevalence of HIV in the different risk groups and (iii) if the incentives can motivate the actors to fulfil their tasks properly. After assessing the current situation, the expert panel recommended some changes in the assignment of tasks and the allocation of resources. The corresponding recommendations are outlined below, subdivided into general recommendations and suggestions relating to the different target groups.

7.1 General Recommendations

7.a The assignment of tasks and the allocation of resources in the HIV policy field have to be reconsidered and adapted to the changing pattern of the disease.

The HIV policy sector is steered by the SFOPH by means of performance mandates and the funding of projects and institutions. To implement HIV prevention activities, close collaborations have been established between the SFOPH and the Swiss Aids Federation (Aids-Hilfe Schweiz, AHS) (Bütschi/Cattacin 1994). Being the oldest (founded in 1985) and the most experienced HIV-related NGO, the AHS has achieved a very strong, and in some respects, a monopolistic position in this policy field. These basic characteristics of the governance struc-

ture have not changed significantly over the years. According to Neuenschwander (2007), the Swiss HIV policy system is characterised by structural inertia.

Based on an analysis of the allocation of funds, the expert panel considers that the prevention activities of the AHS adequately reflect the prevalence of HIV in the different risk groups. However, there has not been an adequate reaction – besides the "Mission Possible" project which failed to reach its objectives – to the rapidly rising number of HIV diagnoses in MSM. This massive increase was not counteracted by appropriate prevention measures and financial resources. The central agency of the AHS has introduced several new prevention tools in the last years and drafted a general prevention strategy for MSM in June 2009, but these measures rather impart an additive than a strategic impression. So, the question still remains as to how far the funding strategy of the SFOPH and the prevention activities of the AHS really reflect the true epidemic *dynamics*.

The AHS acts as a large national umbrella organisation for its local and regional groups and provides structural and behavioural prevention in all relevant target groups. It offers a wide range of information material (e.g. websites and brochures) and advanced training for experts. In sum, the central agency of the AHS manages the day-to-day business very well, but has failed to come up with innovative ideas. Additionally, it seems that the AHS is losing contact with the gay community and is reacting very slowly to the international tendency to increasingly integrate HIV prevention into the broader field of sexual health. The SFOPH was not able to anticipate this development, nor to clearly take the lead in this matter.

Therefore, the expert panel is under a strong impression that there is a necessity for change. There are several possibilities for rearranging the assignment of tasks and the governance structures in the HIV policy field. The expert panel discussed various alternatives and considered some options as very promising. In the following sections, these options are presented in the form of suggestions.

7.b The EKAF is a valuable expert body that should be strengthened.

The Swiss National AIDS Commission (EKAF) is an extra-parliamentary commission appointed by the Swiss Federal Council. The EKAF was founded in 1988. The commission acts as an independent expert body providing strategic and specialist support for the SFOPH and reviewing the planning of the actors in the HIV policy system (SFOPH 2003: 43-44).

The expert panel appreciates the early establishment of such an expert commission that incorporates specialists from different professional guilds and differing fields. Furthermore, the EKAF connects state actors, NGOs, physicians, social scientists and other important players in the field of HIV policy. Therefore, the expert panel recommends that the EKAF should be sustained. Furthermore, it is desirable that the EKAF expands its focus to include HIV within the wider framework of sexual health.

7.2 Recommendation on Governance regarding MSM

7.c The expert panel recommends the creation of a Swiss gay men's health organisation.

Based on the meetings, the expert panel had the impression that numerous local gay associations do not feel represented by the AHS as they do not see a strong prevention strategy regarding self-identified gay men and other MSM. This is problematic since the number of new HIV diagnoses in this group has steadily increased over the last few years – from 159 diagnoses in 2003 to 327 diagnoses in 2008.

The expert panel therefore recommends the creation of a Swiss gay men's health organisation. This new structure could either be administrated by the central agency of the AHS with a large degree of independence or it could be established as an autonomous organisation. This decision would have to be discussed with the concerned parties. It is of vital importance that this new organisation has a gay identity and provides sustainable prevention work in targeted groups of either self-identified gay men, or these groups and other MSM. The gay men's health organisation should not only focus on HIV, but on sexual health in general. Additionally, it should address contextual issues (e.g. drug use, mental health, male sex work) and include gay men living with HIV. In sum, the new gay organisation will be based on a comprehensive strategic concept with a wide and comprehensive sexual health focus.

The expert panel recommends a bottom-up creation for the new institution by grassroots organisations with a strong gay identity like Dialogai, VoGay, the checkpoints in Geneva and Zurich, Loge 70 as well as PINK CROSS. PINK CROSS – the umbrella association of gay organisations in Switzerland – should be included in the formulation of the strategy, even though it does not mainly focus on HIV. However, PINK CROSS represents approximately 8'000 gay men and lesbian women as well as transgendered persons from the four linguistic regions of the country. It represents their interests in relation to the political authorities and the wider public, and assumes the role of the national focal point for all matters relating to homosexuality.

Since the SFOPH plays the leading role in the HIV policy sector, the AIDS section should liaise closely with the grassroots organisations in designing a comprehensive strategy for a Swiss gay men's health organisation. These efforts and the future institution could be funded on the basis of a performance mandate.

7.3 Recommendation on Governance regarding the General Population

7.d The expert panel recommends the transformation of PLANeS into a Swiss sexual health organisation for the general population.

PLANeS is a foundation for sexual and reproductive health and the national umbrella association of the counselling centres for family planning, pregnancy, sexuality and sexual health education. PLANeS provides curricula for sexual health education and a national information service on pregnancy, abortion and family planning. Its activities concern high quality sexual health education, the autonomy of women in reproductive issues and the prevention of STIs (including HIV).

The expert panel sees PLANeS as an appropriate institution for incorporating HIV and STI prevention into the broader framework of sexual health. It therefore recommends the transformation of PLANeS into a Swiss sexual health organisation for the general population.

Since the topic of sexual health – being part of the policy field of public health – is a cantonal issue, the SFOPH does not assume leadership in this sector. Currently, PLANeS only receives some subsidies from the SFOPH which aim at supporting PLANeS in its responsibility as an umbrella organisation. These funds are not regarded as directly prevention-related. However, if PLANeS could broaden its scope and lay more stress on HIV prevention activities, additional federal support could be provided due to federal responsibilities with respect to infectious diseases.

By broadening its scope, PLANeS should carry on emphasising high quality sexual and reproductive health education, the behavioural and structural prevention of STIs and discussion of sexual rights. While addressing the general population PLANeS also needs to provide prevention messages and information services to MSM who do not identify as gay. Not all of these men can be reached by the Swiss gay men's health organisation. Therefore, they need to be addressed by a sexual health organisation for the general population. Thus, besides its activities concerning reproductive issues, family planning and pregnancy targeting mainly heterosexual individuals, PLANeS should also focus on psychosexual development and sexual health issues especially in female sex workers and in MSM who do not identify as gay. To reach these goals, PLANeS needs to cooperate closely with the newly established Swiss gay men's health organisation and the central agency of the AHS.

The expert panel generally highlights the importance of integrating HIV prevention into the broader framework of sexual and reproductive health and the need for sexual health education.

7.4 Recommendation on Governance regarding Migrants

7.e The expert panel recommends strengthening the peer-education programme AFRIMEDIA within the AHS.

The expert panel recognises the importance of the AFRIMEDIA programme. It recommends a financial strengthening of the project to generate a more profound impact on the target population. The expert panel additionally suggests that AFRIMEDIA widens its focus and also addresses other needs of migrant communities such as general health issues, housing, integration, support in job search etc. Therefore, it needs suitable partner institutions and a financial commitment by the respective state actors.

AFRIMEDIA is affiliated to the AHS which seems to be a good arrangement. The expert panel does not question the existing structure, but strongly recommends continuing, strengthening and expanding the AFRIMEDIA programme. AFRIMEDIA should be supported by the AHS, but autonomously develop and implement its prevention activities.

The panel recommends an assessment of needs with respect to analogous organisations for other regional or ethnic groups of migrants in Switzerland. The epidemiological situation in other migrant communities needs to be under constant surveillance. If required, increasing numbers of HIV diagnoses have to be counteracted by appropriate programmes that could draw on the experience of AFRIMEDIA.

7.5 Recommendation on Governance regarding Positive Prevention

7.f The expert panel recommends strengthening grassroots organisations that support people living with HIV.

Positive prevention includes amongst other things the right of people living with HIV to speak on their own behalf. To guarantee this individual right, it is necessary to strengthen grassroots organisations supporting HIV-positive persons.

There is one Swiss NGO at the national level that solely acts as a self-help organisation and supports people living with HIV. LHIVE was founded in 2007; its small budget is financed through donations and membership fees. LHIVE campaigns against prejudices, discrimination and stigmatisation of people living with HIV and organises regular meetings and activities for HIV-positive individuals and helps in re-integrating them in the labour market. The central agency of the AHS also provides advocacy for people living with HIV and campaigns against discrimination.

The expert panel strongly recommends that the SFOPH assists LHIVE and the branch of the AHS working in the field of positive prevention with appropriate measures or encourages the

development and growth of other self-help organisations to let people living with HIV raise their voice.

8 Summary and Perspectives

The expert panel acknowledges the success achieved by the Swiss HIV policy in the past, but emphasizes that the policy should now be adapted to meet the new challenges created by the changed conditions and possibilities of dealing with HIV as well as developments within the society (role of the internet, migration patterns, individualisation etc.). More precisely, the expert panel has formulated detailed recommendations about how the Swiss HIV policy could be improved to minimize the number of new HIV infections and to guarantee timely testing, referral for treatment and high adherence to therapy.

Based on the scientific background report provided by the Swiss research team (Plüss et al. 2009), its discussions and the meetings with different actors held in May 2009, the members of the expert panel consider that major changes in the governance are necessary to effectively fight the HIV epidemic in Switzerland. The core element of the current governance structure in the field of HIV in Switzerland is the partnership between governmental and non-governmental agencies. While this partnership has been productive and effective in the past, developments on both sides are necessary to face the challenges ahead.

Regarding the non-governmental organisations, the expert panel feels, first, the need to foster the creation of a Swiss gay men's health organisation. This organisation should be created using a bottom-up approach to guarantee that future prevention activities are designed according to the needs and knowledge of the gay communities. Second, PLANeS seems to be the appropriate institution for incorporating HIV and STI prevention into a broader framework of sexual health promotion for the general population and should therefore play a role as a national organisation. Third, the existing programme AFRIMEDIA targeting migrants coming from Sub-Saharan Africa should be strengthened. Finally, grassroots organisations by people living with HIV should be strengthened and the concept of positive prevention should be introduced.

On the governmental side, the expert panel recommends that the SFOPH should allocate its resources more precisely to the evolution of the HIV epidemic and the HIV prevalence. Therefore, the SFOPH should adjust its collaboration with partners. The expert panel is aware that the SFOPH depends on the cooperation of various governmental and non-governmental actors for the implementation of a policy especially in a federal state. However, the expert panel had the impression that SFOPH could make better use of its steering mandate and capacities to allocate the resources to reflect the prevalence of HIV in the different risk groups. Therefore, the expert panel emphasizes that the SFOPH should fulfil its leadership role by

using the full range of steering instruments (performance mandates, incentive structures, collaboration in working groups etc.).

To sum up, the expert panel would like to emphasize that the successful development and implementation of a Swiss HIV policy from 2011 onwards strongly depends on the leadership of the SFOPH. The SFOPH has the ability to promote and support the necessary changes in governance as well as providing incentives that motivate the actors to fulfil their tasks.

9 References

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10 Appendix: List of the Participants to the Hearings

Date: May 6-7, 2009

Location: Berne / Zurich

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