Evaluation of the AIDS prevention strategy in Switzerland

Sixth synthesis report 1996-1998

University Institute of Social and Preventive Medicine, Lausanne
Unit for the Evaluation of Prevention Programmes

6

University Institute of Social and Preventive Medicine, Lausanne
Unit for the Evaluation of Prevention Programmes

Evaluation of the AIDS prevention strategy in Switzerland

Sixth synthesis report 1996-1998

Françoise Dubois-Arber, André Jeannin, Brenda Spencer,
Giovanna Meystre-Agustoni, Mary Haour-Knipe,
Florence Moreau-Gruet, Fabienne Benninghoff, Fred Paccaud

Collaboration
Thanks to the researchers who cooperated in the evaluation :
Chollet-Bornand Anne, Ernst Marie-Louise, Geense Rachel,
Gervasoni Jean-Pierre, Häusermann Michael, Hausser Dominique,
Kessler Daniel, Landert Charles, Link Institut für Markt-
und Sozialforschung, Thomas Ralph

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

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

Our very warmest thanks to them all.

This evaluation was mandated by the Federal Office of Public Health and funded by the AIDS Research Control Commission, Contract nr 316.95.5755 A-B-C, Bern.

Suggested citation
Dubois-Arber F, Jeannin A, Spencer B, Meystre-Agustoni G, Haour-Knipe M, Moreau-Gruet F, Benninghoff F, Paccaud F. Evaluation of the AIDS prevention strategy in Switzerland mandated by the Federal Office of Public Health : sixth synthesis report 1996-1998. Lausanne : Institut universitaire de médecine sociale et préventive, 1999.

Translation
BMP Translations AG, Basle

Ordering address
Institut universitaire de médecine
sociale et préventive/UEPP
17, rue du Bugnon
CH-1005 Lausanne
tél.: 0041 21 314 72 92
fax: 0041 21 314 72 44
e-mail: uepp@inst.hospvd.ch

Design and photocomposition : atelier k, alain kissling

Table of contents

Evaluation of the results of the prevention strategy

Some aspects of the psycho-social context

Results and future prospects

Appendices

1

Introduction

HIV/AIDS prevention strategy in Switzerland

Switzerland's HIV/AIDS-prevention policy has three objectives :

- to prevent new cases of infection ;
- to counter the negative consequences for those affected by the epidemic ;
- to promote solidarity.

The primary prevention strategy introduced throughout the country in 1986 provides for three levels of intervention :

- general measures intended to inform and motivate the population as a whole ;
- measures aimed at specific target groups (adolescents, drug users, homosexuals, etc.), conveying appropriate messages via suitable channels ;
- in-depth measures over the longer term, based on personal interaction (counselling, imparting information). These measures depend on persons whose situation or role makes them potential mediators of prevention messages (doctors, parents, teachers, etc.).

The strategy[a] applies an integration model, based on the belief that individuals are able to learn preventive behaviour and can be persuaded to adopt it. This involves heightening individuals'awareness and passing on information, motivating and helping them to acquire skills, and encouraging them to continue with existing preventive activities. Since the model also requires the development of an environment favourable to the prevention and management of AIDS, the promotion of solidarity and efforts to combat discrimination are an integral part of the prevention strategy.

The strategy is also pragmatic : by highlighting the different means of prevention available, it encourages a freedom of choice whilst taking into account the existence of high-risk behaviour. The use of condoms is therefore advocated for sexual behaviour involving a potential risk of HIV infection, while injecting drug users are encouraged to use sterile injection equipment. "Safe" behaviour is also advocated. For example, faithful sexual partners are encouraged to remain so, while drug users are advised not to begin injecting.

Continuous evaluation, approach and method

Since 1986, the Lausanne University Institute of Social and Preventive Medicine has been monitoring Switzerland's AIDS prevention strategy at the request of the Federal Office of Public Health (FOPH). This document provides a synthesis of the evaluation activities for 1996-1998 (seventh phase of the evaluation programme)[b].

In carrying out this task, the Institute adopted a **global** approach to evaluation, taking into account both the **process** and **results** of prevention measures, as well as relevant factors in the **social environment.**

The aim is to provide timely information which can be used in improving HIV/AIDS prevention activities in Switzerland, and to help those engaged in implementing them to take appropriate decisions. The evaluation programme complements the strategy and evolves as new questions emerge[1].

[a] This strategy is set out in detail in the manual entitled "Prévention du VIH en Suisse : buts, stratégies, mesures" (HIV prevention in Switzerland : aims, strategies, measures). Berne : Federal Office of Public Health ; Federal Committee for AIDS-related Problems ; 1993.

[b] See appendix 1, page 93, for a list of the reports published previously.

The main questions of the global evaluation are as follows :

Regarding the prevention process :
- **What prevention activities have been established ? How are they developing ? With what difficulties and success ? Do they meet the real needs ?**
- **Are there any gaps in prevention coverage (regional gaps, specific groups inadequately catered for, etc.) ?**
- **Is prevention developing at all the intended levels ?**
- **Are the FOPH's partners in the prevention field (associations, cantons, professional groups, mediators, etc.) working actively and efficiently ?**
- **Are there elements in place that guarantee the long-term quality of the prevention activities ?**

Regarding the results of prevention :
- **Are people better informed and are behavioural changes taking place in the fields targeted by prevention efforts (in particular, sexual habits, forms of drug use, quality of counselling, etc.) ?**
- **Are attitudes of solidarity or fear emerging ?**
- **Is the epidemiological situation changing ?**
- **Is prevention having unexpected or unwanted side-effects ?**

Regarding the environment in which prevention activities are taking place :
- **Is the environment favourable to the prevention methods being implemented ?**
- **What is the relationship between the context (environment) and the progress of the prevention measures adopted ?**

The evaluation programme consists of a series of successive phases lasting one year during the first few years, and subsequently from two to three years. Each phase consists of between 10 and 20 complementary studies, which[c] – taking into account the objectives and the related evaluation questions – form the basis for a global evaluation of the development and results of the prevention strategies adopted. For each period, the fields of activity to be evaluated are jointly selected by the FOPH and the evaluators. As well as the general questions described above, the evaluation also attempts to answer questions which are more specific to each field. Thus for each phase there are studies which are repeated regularly (monitoring of measures or behaviour), studies which adopt a new approach to look at a field which has previously been reviewed, studies of new fields, etc. (see appendix 2 for the table summarising the studies carried out since 1987, page 94). It is, however, impossible to report on all the prevention activities included in each phase (those directly initiated by the FOPH and those undertaken by its partners). Priorities therefore have to be made. Likewise, given the quantity and diversity of the different measures, it is not always possible to separate out the effects of each activity or programme.

The FOPH, for its part, sometimes commissions other institutions to evaluate specific programmes or conduct complementary studies ; the results are included in this overall evaluation.

The evaluation results are regularly submitted to the prevention authorities to enable them to make any necessary adjustments to the prevention strategy – as has happened on several occasions.

[c] Which also includes relevant information from other national and international sources.

During the 1996-1998 phase of the evaluation programme, **the following areas received priority attention:**

Regarding the progress of prevention measures and the emergence of multipliers (process)

- the STOP AIDS campaign (existing data in this field is assessed in each phase);
- HIV-related risk-reduction measures among drug users (an assessment of the existing data for this target area is provided during each phase);
- a review of the data available in Switzerland regarding HIV/AIDS prevention in prison;
- three programmes/projects aimed at specific target populations:
  - the "Gesundheit von Frauen, Schwerpunkt HIV-Prävention" (Women's health, a priority of HIV prevention). Phases I (1996) and II (1997) of the evaluation of this programme are here taken into account;
  - the MSM (Men having Sex with Men) Project, phases I (1996) and II (1998-1999);
  - the PAMiR project (commissioned directly by the FOPH);
- a review of the concept of mediators and the way they are used in HIV/AIDS prevention.

Regarding the effectiveness of the measures adopted (results)

- changes in the knowledge, attitudes and behaviour of the general population ages 17 to 45; and monitoring of condom sales (regularly repeated surveys to monitor medium-term trends, and analysis of other existing data);
- behavioural changes among adolescents (secondary analysis of data from various surveys);
- behavioural changes among homosexuals (regularly repeated study to monitor medium-term trends, 5th phase);
- behavioural changes among drug users (3rd phase of the study conducted in low-threshold centres, and analysis of other existing data);
- variations in the number of people with HIV or AIDS (use of epidemiological data provided by the federal monitoring system).

Regarding the environment in which HIV/AIDS prevention activities are taking place

- institutional discrimination against people with HIV;
- the consequences of new treatments for AIDS prevention;
- the sexuality of people with HIV;
- co-operation between the political partners in HIV/AIDS prevention (commissioned directly by the FOPH);
- HIV/AIDS as reported in the press (commissioned directly by the FOPH).

The methods used in the various studies undertaken in this phase of the evaluation – whether as part of the global evaluation programme or in addition to it – are summarised in appendix 3, page 95. Each individual area is discussed separately in the following chapters. The main evaluation questions are followed by a summary of the data collected, the conclusions resulting from the investigation, and appropriate recommendations. Conclusions and recommendations concerning the overall strategy are included at the end. Readers requiring further information may refer to the scientific reports on individual studies, or to published articles, references for which are given at the end, page 109.

2

The STOP AIDS campaign

Activities of the STOP AIDS campaign

The STOP AIDS campaign, which has targeted the entire population since 1987, has continued at a regular but slightly less intensive rate than in earlier years, following reductions in the funding available.

The use of condoms has continued to be a central focus. As well as repeating the message that condoms mean safer sex, the campaign has also covered various "technical" aspects of condom use, such as the importance of opening the packaging correctly to avoid damaging the condom, and the need to use condoms of the right size to minimise the risks of tearing and slipping. Attention has also been drawn to the responsibility of both partners in a relationship for contraception and the correct use of condoms.

The issue of new AIDS treatments was addressed for the first time in Switzerland in a campaign targeting the whole population. It was intended as a reminder that, although the new treatments offer hope to people already living with HIV, they are not an alternative to prevention, which remains the only way of avoiding infection.

Having given careful thought to the notion of solidarity, the group in charge of the campaign (Creativteam) decided to enlarge its scope beyond the single issue of AIDS and make contact with other organisations active in the health and social fields. The result was a campaign (TV spot and advertisement) on the theme "United in solidarity", planned in collaboration with Pro Infirmis.

Visibility and acceptability of the STOP AIDS campaign

The RGS institute[1] conducted a telephone survey of a representative sample of 1007 people to gather information on the visibility and acceptability of the 1997 STOP AIDS campaign.

On the whole, the STOP AIDS campaign continues to retain public attention : 93 % of the population were able to recall one or another of the items concerned. The television commercial and the "United in solidarity" advertisements had both been noticed by almost half the population. **On the whole, the messages retained by the respondents matched the campaign objectives.** For instance, the message "Sexual relations only with a condom" was spontaneously recalled by 50 % of the respondents ; the "Protection against AIDS" message by 30 %. On the other hand, only 4 % of the respondents spontaneously mentioned "Solidarity with persons living with HIV/AIDS". **91 % of the respondents were in favour of the AIDS prevention campaigns being continued.**

Conclusions

- **The STOP AIDS campaign fulfils a useful function in reminding the general population of the main prevention issues.**
- **The campaign continues to be highly accepted.**

Recommandation

- **The STOP AIDS campaign is still necessary and should be continued, though perhaps less intensively.**

3

Reducing the risks associated with HIV/AIDS in the field of drug use

The aim of harm-reduction strategies is to help drug users come through this period of their lives with a minimum of physical, mental and social harm[1], and to maintain and improve their chances of emerging from drug dependency[2]. A variety of services are provided : exchange of syringes, injection rooms, drop-in service, accommodation, work, substitution treatments, etc.

This chapter is concerned with one specific aspect of risk reduction : **reducing the risks of contracting HIV/AIDS and hepatitis.** In particular, it seeks to answer two questions :

- Are drug users' needs for injection equipment adequately covered ?
- What are the advantages and disadvantages of injection rooms ?

Risk-reduction activities were initiated in Switzerland at the end of the 1980s, when sterile equipment was first provided free of charge in low-threshold facilities (LTF)[a] and injection rooms[b] were opened in a number of German-speaking cities. During the same period, the unrestricted sale of syringes through pharmacies spread to the whole of Switzerland.

[a] These facilities are very accessible. Their aim is to maintain the state of health of drug users who are not yet ready to undertake a course of treatment or who have suffered a relapse.

[b] These rooms provide clean, safe conditions for users to inject substances previously obtained on the black market.

[c] Aargau, Berne, Basle City, Geneva, Lucerne, St. Gallen, Schaffhausen, Solothurn, Vaud, Zurich.

[d] Berne 1, Basle City 3, Zurich 6, Solothurn 2, Schaffhausen 1.

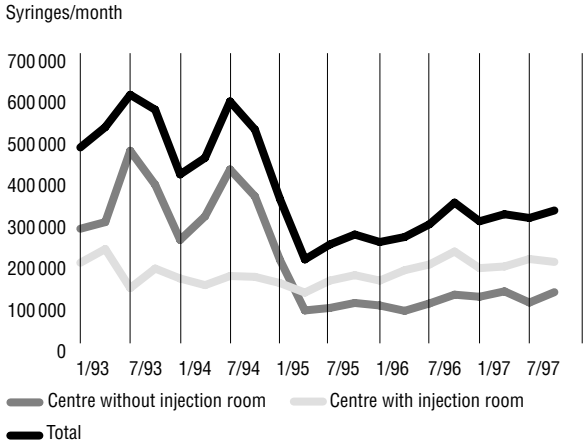
Provision of syringes in low-threshold facilities

The activities of low-threshold facilities specifically concerned with the prevention of HIV/AIDS in Switzerland have been monitored since 1993[3]. All 25 of Switzerland's low-threshold facilities take part in this exercise, recording, among other things, the number of syringes they provide each month. The facilities are spread over 10 cantons[c], mostly in the German-speaking areas. Thirteen of them have an injection room[d].

Between 1993 and 1997, the number of syringes provided by these facilities decreased. In 1993 and 1994, the annual number of syringes distributed remained stable, though there were seasonal fluctuations, with fewer syringes handed out during the winter months (figure 3a). The figures fell significantly at the end of 1994, reaching a low point in April 1995, with 200 000 syringes distributed that month. This drop is explained mainly by the closure of the Letten open drugs scene, in Zurich, in February 1995. During the second quarter of 1996, the figure began to rise again, the number of syringes distributed gradually increasing to 320 000 per month at the end of 1997.

Figure 3a

Trends in the number of syringes distributed in low-threshold facilities in Switzerland, 1993-1997*



* Number of facilities : 1993 : N = 28, 1994 : N = 23, 1995 : N = 23, 1996 : N = 24, 1997 : N = 25.

In total, some 6,5 million syringes were distributed in 1993 (maximum), 3 million in 1995 (minimum) and 3,8 million in 1997.

The number of contacts made in low-threshold facilities – i.e. the number of times people dropped in to request a service – **was more stable than the number of syringes distributed** (cf. figure in appendix 1, page 96). When the facilities were most heavily attended – i.e. during the summers of 1993 and 1994 – the ratio of syringes to contacts was over 10 (which means that an average of more than 10 syringes were handed out for each contact). Since 1995, the ratio has been under 10.

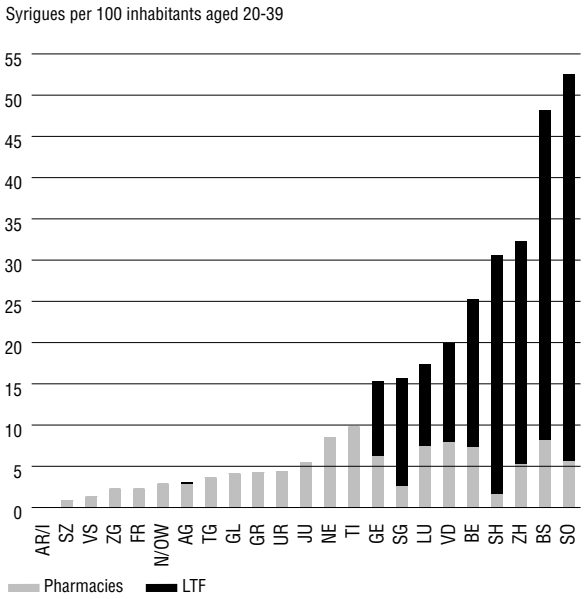
Sale of syringes in pharmacies

Pharmacies play a significant role in risk reduction. A survey of all Swiss pharmacies was conducted in 1995[4] and repeated in 1997[5]. At the beginning of each year, pharmacists were asked to estimate the average number of syringes sold to drug users for the months of October to December of the previous year. This method yielded monthly estimates for the years 1994 and 1996.

The estimated monthly figure for syringes sold in Swiss pharmacies was 117 000 (syringes + Flashboxes + Safety boxes[e]) in 1994 ; 122 000 in 1996. In some cantons sales had increased[f]. in others they had decreased[g].

Figure 3b

Average monthly number of syringes provided/sold by pharmacies and low-threshold facilities per 100 inhabitants aged 20 to 39, for different Swiss cantons, in 1996



In 15 cantons, pharmacies are the main source of supply for syringes. The volume of syringes made available to drug users is relatively small in these cantons compared with those having low-threshold facilities.

If we compare the number of syringes to the number of inhabitants aged 20 to 39 (figure 3b), we find that the source of supply of the syringes (pharmacy or LTF) is a significant factor in the extent to which the need for injection equipment is covered in each canton.

[e] Flashboxes and Safety boxes are injection kits. The former contain 2 syringes, 2 needles, 2 pre-injection swabs, 2 dry swabs, 1 gr. of ascorbic acid, together with a condom and instructions on prevention. The latter come in various forms (syringes and needles, and sometimes equipment for preparing for an injection).

[f] Aargau, Jura, Neuchâtel, Solothurn, Thurgovia, Valais and especially Berne and Zurich.

[g] Geneva, Graubünden, Lucerne, St. Gallen, Ticino, Vaud.

Other syringe supply sources

Some cantons have installed **vending machines** for syringes and Flashboxes. The first machines were installed in 1991 in the cantons of Basle City, Berne and Zurich. By 1996, Switzerland had 76 machines spread over 10 cantons[h]. In that year, between 15 000 and 25 000 syringes were sold each month by this method (approximately 250 000 syringes for the whole year)[6]. Another source of supply is the injection equipment provided to people taking part in **PROVE**[i]: a programme prescribing narcotic drugs under medical supervision. In 1996, 765 people were able to inject their particular substance under the auspices of this programme[j]. At an average rate of 3 injections per person per day, approximately 70 000 syringes were used each month in 1996.

In some cantons, there are also accommodation and/or treatment centres – not primarily concerned with risk reduction – which make syringes available to drug users (e.g. Jura, Fribourg). A list of such centres is currently being compiled. The volume of syringes distributed through these channels is, however, small compared with the sources of supply already mentioned.

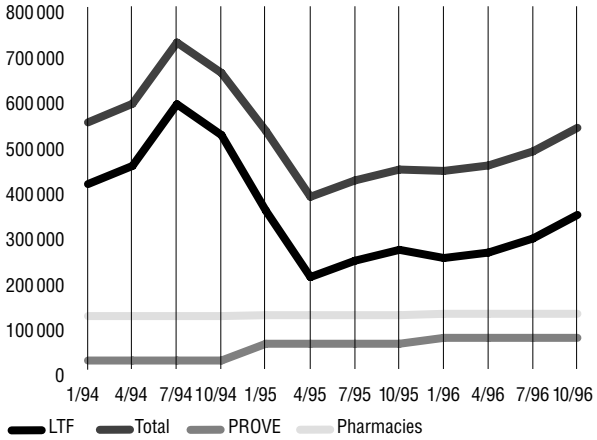
Estimate of the total volume of injection equipment made available to drug users in Switzerland

If we add the number of syringes distributed in low-threshold facilities (320 000 per month), sold through pharmacies (1220 000 per month) and vending machines (20 000 per month), and used in the PROVE programme (70 000 per month) during 1996, we obtain an average of 532 000 per month. This represents an annual volume of 6,4 million syringes nationally.

Using these different sources of information, we can draw a graph showing the trend in the number of syringes for the years 1994 to 1996, during which common data were collected[k] (figure 3c).

Figure 3c

Estimate of the total number of syringes sold or distributed to drug users in Switzerland, 1994-1996



The large drop in the number of syringes distributed in low-threshold facilities at the beginning of 1995 was compensated for in part by people entering the PROVE programme. By the end of 1996, the estimated total number of syringes had returned to the early 1994 level, i.e. 500 000 syringes per month.

The decrease in the number of syringes distributed or sold to drug users has not been due solely to the closure of open drugs scenes (where low-threshold facilities operated). During the same period, **a massive number of users embarked on substitution treatments using oral methadone.**

---

h Zurich 45, St. Gallen 8, Berne 7, Basle City 4, Solothurn 3, Lucerne 2, Ticino 2, Zug 2, Graubünden 2, Glarus 1.

i **PRO**jekt zur ärztlichen **VE**rschreibung von Betäubungsmitteln (Project concerned with the prescription of narcotics)

j This figure was calculated on the basis of people entering and leaving the PROVE programme. We would like to thank M. Ryser, of Mathias Markert, providing us with this information.

k A few adjustments have had to be made: as data for vending machines was available only for 1996, and the number of syringes distributed in this way was very marginal, we have simply ignored them; as we had only very approximate estimates for the syringes sold in pharmacies in 1994 and 1996, we adopted a hypothesis of steady growth in estimating the figure for 1995.

These substitution treatments help to reduce risks among heroin users by eliminating, or at least reducing, the intravenous use of the drug. Since the early 1990s, there have been changes in the way methadone treatment is organised : easier access to treatment, relaxation of the rule that the patient must abstain absolutely from other opiates during treatment, methadone given in larger doses, etc. Over the 10 years from 1987 to 1997, the number of courses of methadone treatment dispensed increased from 1800 to 15 400 per annum.

Syringes Distribution : international comparisons

There are no statistics at the international level that take into account all the supply sources of syringes. However, we do have some data on syringe-exchange programmes (LTF).

Table 3a

Annual number of syringes distributed in the low-threshold facilities of different countries

	Switzerland 1997	United States 1997	Quebec 4.1996 - 3.1997
Number of syringes	3772000[7]	17447000[8]	443000[9]
Estimate of the number of drug users	30000[10]	1640000[11]	23000[12]

Clearly the number of syringes distributed in Swiss low-threshold facilities in Switzerland is particularly high (table 3a). The total number of syringes per drug user in Switzerland is 6 times that of Quebec and 12 times that of the United States.

The merits of having an injection room in low-threshold facilities

A qualitative study[13] of 4 low-threshold facilities (2 in a fixed location with injection room in Basle and Zurich, 2 mobile without an injection room in Lucerne and Geneva) was conducted in 1996 to find out how teams of workers and drug-user clients perceived the merits of having an injection room. The study raised many questions and has produced some positive results (cf. appendix 2, page 97).

The **teams of workers** emphasised the better conditions for injecting (hygiene, sterile equipment, no fear of being disturbed, less stress). The injection room enabled them to provide “medical” supervision (safety, possibility of resuscitation). Preventive/educational messages could be given directly to the client while she/he was injecting. These messages could be geared to the observed risks. Users could keep a lower profile in town. However, there was also a less positive side. For example, the respondents were concerned about users injecting outside the premises at times when the centre was closed. They thought it was difficult to change the behaviour and injecting habits of long term drugs users. They also noted that the attention and requests of drug users tended to be focused on the injection room, rather than on the other services they offered. This led to a large influx of people and a lot of unrest at the centre.

The **drug users** also mentioned the sense of security when they were injecting (hygiene, no fear of being disturbed by the police, medical supervision, the possibility of resuscitation). Some users claimed that, when a low-threshold facility had an injection room, it helped them to control their consumption, or even reduce it. Others, however, said that it encouraged them to increase their use of drugs. The drug users also said that, by coming to the centre, they were certain to find the drug they needed in the vicinity (less stress, fewer problems with the police).

Conclusions

- **Compared with other countries, a significant quantity of syringes are being made available to drug users in Switzerland. Overall, access to sterile injection equipment is good. However, coverage still varies considerably from one canton to another.**

- **The courses of methadone treatment now being given – an eightfold increase in 10 years – and the PROVE programme of prescribing narcotics under medical supervision, are also helpful in reducing risks. Users giving up or reducing their intravenous intake of drugs, and coupled with the fact that they can inject in safe conditions, is helping to reduce the risk of their contracting HIV and hepatitis.**

- **Injection rooms certainly provide a safer environment for injecting, but they raise controversial issues relating to the frequency of drug use and minor drug trafficking in the immediate vicinity.**

Recommandations

- **Wider distribution of injection equipment might still be advantageous, especially in cantons which do not yet have low-threshold facilities or syringe vending machines. The distribution of syringes in Switzerland should continue to be monitored.**

- **In cantons which are less active in the area of risk reduction, efforts should be made to increase pharmacists' awareness of their role as partners in the prevention of HIV/AIDS and hepatitis among drug users. This would involve training, the development of networks of pharmacists willing to act as resource persons, etc.**

- **Efforts should be continued to diversify low-threshold facilities and treatment centres and make them more accessible.**

4

HIV/AIDS prevention in prisons[1]

The prevention of HIV/AIDS in prisons poses particular problems. How can one promote prevention activities (use of sterile injection equipment, protected sex) in a closed, supervised environment where, in theory, the activities necessitating such preventive measures are not supposed to take place?

Several studies on HIV transmission in Swiss prisons have been conducted, particularly in relation to psychoactive substances. An analysis of Swiss and foreign literature[a] (both published and unpublished) was undertaken in order to ascertain current knowledge, and to try to answer a number of questions.

- What is the situation as regards HIV/AIDS in Swiss prisons (prevalence of highly exposed populations, prevalence of behaviour involving risk, prevalence of HIV)?
- What efforts are being made to prevent the spread of HIV/AIDS in Swiss prisons? What facilities are available to persons at risk and to those who have contracted the disease?

The HIV/AIDS situation in prisons

Charges in relation to breaches of the Law on Narcotic Drugs have increased considerably between 1970 and 1997, from 7000 to 45 000.

The number of convictions has also increased[b], as has the number of convictions resulting in prison sentences. In 1993, over 10 % of all recorded sentences were for drug-related offences, twice as many as in 1976.

Drug users in prisons

Almost two thirds of the drug users in contact with low-threshold facilities have spent a period in prison ranging from a few days to several years (cf. appended tables, page 98). In European countries, the proportion of drug users among prison detainees ranges from 15 % to 65 %; Swiss statistics yield a figure of between 20 % and 50 %, depending on the penal establishment concerned. **However, it is difficult to form a precise picture of the situation.** It is necessary to bear in mind the great diversity of the prisons concerned (small district prisons, remand centres, large establishments for the serving of (long) sentences, etc.) and the fact that drug users spend varying periods in prison, depending on the seriousness of their offences. For instance, we have no accurate data on the proportion of drug users who spend very short spells in detention, nor where they are detained, and this makes it difficult to assess their needs with regard to prevention and treatment.

Drug use in prisons

It has been established that narcotic drugs are used in prison. Various European studies indicate that between 15 % and 70 % of detainees have used drugs one or more times during their stay in prison. In Switzerland, estimates vary between 20 % and 30 % (heroin and/or cocaine, means of administration unknown).

Approximately 60 % of drug users who have spent time in prison report having used drugs while in detention. **We do not have detailed information regarding the type of drugs concerned or the frequency of their use.**

[a] Exhaustive review for Switzerland.

[b] 40 % of convictions for drug-related offences were simply for the use of narcotic drugs, except in Geneva, where convictions for drug use accounted for less than 10 % of convictions.

Mode of drug use and exposure to the risk of HIV transmission by injection and by sexual contact

Approximately a quarter of injecting drug users report having injected narcotic drugs while in prison. However, we do not know the frequency of drug injection. From the very few data available, **it is believed that prison users both use and/or inject drugs less frequently, than they do on the outside.** It should be remembered that a proportion of them go through withdrawal (voluntarily or otherwise, with or without help) upon arrival in prison.

One person in five who injected while detained in prison shared his equipment at least once. If we consider persons who injected drugs before their imprisonment, the figure is one in twelve[c]. **We do not know the frequency with which equipment was shared, nor the times when the risk of sharing was greatest** (during the first few days, later, etc.).

Sexual relations are apparently a rare occurrence in Swiss prisons, given the way most prisons are organised, with detainees often kept alone in their cells. However, it is difficult to obtain information on this issue. It is not possible to estimate the extent to which condoms are used, either in prison or when prisoners are allowed out on parole.

The prevalence of HIV and hepatitis in prison

The prevalence of HIV infection among detainees varies between 2 % and 12 % ; that of hepatitis between 1 % and 18 %, but **statistics available are very imprecise.** HIV seroconversion in prison has been reported for other European countries, but the results of a Swiss study – conducted in just one prison and over a short period of time – showed no such conversion.

Efforts being made to prevent the spread of HIV/AIDS prevention, facilities available to persons at risk and those with HIV/AIDS in Swiss prisons

All detainees have the opportunity to undergo a medical examination when they are admitted to prison or during the first few days of their detention. In all penal establishments, medical care is given for drug-related problems and for problems relating to HIV/AIDS. However, **the treatment available varies considerably from prison to prison and, with regard to the treatment of dependency problems, this does not necessarily correspond with what is available on the outside.**

It would also seem that follow-up after a prisoner has been released is inadequate. This is partly due to the fact that prison medical services are not always informed of a detainee's release.

Although information regarding the risks of HIV transmission is widely distributed, it does not always cover all the possible risks. Only in 40 % of establishments did the information cover the risks associated with sharing injection equipment. Condoms were only made available in one third of the establishments (representing 75 % of all detainees). Only a few establishments had taken preventive measures in relation to drug injection, either by making sterile injection equipment available (8 establishments), or by distributing disinfectant with instructions on how to disinfect injection equipment (10 establishments). These establishments account for approximately one third of all detainees.

[c] Survey conducted in 1996 of drug users frequenting low-threshold facilities which provide injection equipment. The reference period for sharing was the previous two years.

Conclusions

- Given the large number of drug users in detention and the prevalence of HIV among this group, there is potentially a serious problem of infection with HIV and hepatitis in Swiss prisons.

- There is a risk of HIV and other infections being transmitted in prisons. However, in the light of present knowledge, the risk is not extreme.

- All establishments provide medical care, and most of the larger prisons offer preventive measures. The extent of the efforts being made varies from prison to prison. The services available in penal establishments are therefore often inadequate and are not generally on a par with those available in the outside world.

- The data currently available on the problem of HIV and the use of drugs and other psychotropic substances gives only a limited picture of the situation and needs to be supplemented. Despite these deficiencies, it can be stated that efforts to prevent the transmission of HIV by injecting drugs and by sexual contact are still inadequate.

Recommandations

- The Federal Office of Public Health – following the recommendations of the World Health Organisation, which stipulate that persons detained in prison should have access to preventive measures and to treatments equivalent to those available in the outside world – has set out a number of objectives and recommendations[2], particularly the need to ensure total cover in providing the means to prevent HIV transmission (information and equipment, condoms and syringes/disinfectants). These recommendations remain valid, but are far from being systematically applied.

- Similarly, in order to ensure effectiveness of these measures, more support should be given to quantitative and qualitative research in prisons. Efforts being made to prevent infection and provide treatment should be monitored.

5

The "women's health – HIV/AIDS prevention" action programme 1994-1998

Switzerland is one of the few countries to have set up a national AIDS-prevention programme for women. In 1994, the FOPH commissioned the Basle and Zurich Institutes of Social and Preventive Medicine to draw up and implement an HIV/AIDS action programme intended specifically for women. This was an external mandate, with a time limit of three years, to design and implement an action programme (AP) for the benefit of a "new" target population, thereby putting into effect measures corresponding to the objectives contained in the national HIV/AIDS-prevention strategy[1,2].

The strategy defined the target population in very broad terms : all women, in an individual capacity and as multipliers of prevention messages (e.g. in their role as mothers or in the course of their professional activity). HIV/AIDS prevention was to be promoted in the general context of women's health, in particular their sexual health. The evaluation was carried out in two phases.

First phase of the evaluation

Conducted in 1996, **the first phase** consisted of a rapid evaluation focusing on aspects of the programme's implementation. The following questions were asked :

- What activities were envisaged as part of the programme (what ? how ? for whom ?), and what has actually been done ?
- What were the reasons for any changes to the programme ?
- What factors have facilitated or hindered the progress of the programme ? Where necessary, how have problems been solved ?

The information analysed during this phase was obtained from the programme documentation (minutes, contracts, reports, etc.) and from interviews with the programme managers and their contacts at the FOPH.

The evaluation showed that the programme was progressing according to plan. However, it also revealed that the centre of interest had shifted, temporarily at least, from women in general – the original focus of the programme – to subgroups which were regarded as more vulnerable (this refocusing had been advocated by the FOPH in the course of the programme, but was eventually abandoned). The evaluation also identified a number of obstacles which were hindering the programme's development. The main ones were the relatively modest budget allocated for so ambitious and innovative a programme, the absence of clearly defined priorities, and confusion as to who was responsible for taking decisions within a highly complex organisation.

Following this initial evaluation, it was specifically recommended that the contract should be extended until 1998. General recommendations regarding the management of similar programmes were also formulated (see below). A report on this phase of the evaluation was produced for internal use[3].

Second phase of the evaluation

The second phase of the evaluation (February 1997 – March 1998) consisted of a description and analysis of what the AP had achieved between 1994 and 1997 (the various achievements are subsequently referred to as outputs)[4]. The following questions were taken into account :

- What has the programme produced in terms of outputs ?
- As regards the sustainability of the pilot programmes funded by the FOPH :
  - What is still in place after three years of the HIV/AIDS-prevention programme for women ?
  - What are the processes which tend to promote or hinder sustainability ?

- What lessons can be learned from the AP :
  - for other programmes concerned with women's health ?
  - for other public health initiatives ?

After a detailed reading of data and reports on the AP outputs (46 in all), a classification system was drawn up based on five types of output. A grid was developed to analyse and describe each type of output systematically. Six transverse analyses of all the outputs were then conducted (see below). This documentary analysis was then supplemented by sixteen interviews with AP co-ordinators and some of the external partners with reference to eleven of the outputs. We also interviewed four decision-makers to ascertain from different points of view what further initiatives might need to be launched in the wake of the AP.

Programme outputs

The assessment showed that the AP covered a **vast programme of activities** which was relatively well balanced as regards the mix of different types of output (see appendix, page 99).
Table 5a shows the different categories of output, with some key examples.

Transverse analyses were used in making a general assessment of the outputs of the AP, taking into account the 6 following variables :

- **Geographical distribution**
  Just under a half of the outputs (22) were national in scope. The German- and Italian-speaking areas of the country were better covered than the French-speaking part.

Table 5a

Categories of output

Categories	Description – Examples
Materials 10 outputs	**Physical items (e.g. brochures) designed to inform different population groups**
	A brochure "The six main questions asked by women on HIV/Aids", distribued on a large scale.
	A "kit" for young women : containing a condom and toiletries, together with an information leaflet on contraception and AIDS prevention. This kit is distributed in pharmacies, doctors'surgeries and health centres, and serves as an introduction to the subject of contraception and AIDS prevention.
Projets 11 outputs	**Fieldwork, targeting a specific population (but excluding the training of professionals). This category includes evaluations of the results of individual projects**
	In three youth centres in Basle : a series of discussions with girls aged 12 to 20 on issues of sexual health, with the opportunity to consult a nurse.
	The "Health course for Turkish women" project at Winterthur.
Training 8 outputs	**Training courses intended to impart new skills to professionals and voluntary workers acting as multipliers of prevention messages**
	A training course for women working in various professional fields (student nurses, "La Leche" Ligue counsellors, care assistants, volunteers working in women's centres and associations) in Ticino canton.
	In collaboration with the ASPFES[a], a survey of the resources available and the information and training needs of family planning advice centres and branches of AIDS support organisations in the three language regions.
Research 6 outputs	**Research projects investigating women's needs in relation to HIV/AIDS**
	A study entitled "Differences in the spread of HIV according to sex : analysis of the Swiss cohort survey with reference to HIV[5]".
Public relations (PR) 11 outputs	**Measures to advertise the programme. This category includes scientific dissemination (e.g. reports on conferences and reviews of recent publications).**
	The "Women's Health – HIV Prevention" brochure, which provides exhaustive information about the AP.

[a] Association Suisse de Planning Familial et d'Education Sexuelle = Swiss Family Planning and Sex Education Association.

- **Chronological distribution**
  The different categories of output did not necessarily have the same weight throughout the programme : research was more important in the initial phase and, following a FOPH decision, became less important subsequently ; training only became important in the second half of the programme.

- **Issues covered**
  All the outputs were concerned with HIV/AIDS, but a broad approach was adopted : one third (15) were devoted exclusively to HIV/AIDS, while approximately half (22) were concerned with wider issues of sexual health, and one fifth (9) with women's health generally.

- **Distribution according to target population**
  A large number of outputs (19) – mainly in the projects and materials categories – targeted specific groups (e.g. young women). Approximately one third (15) – mainly in the training category – were intended for professionals and mediators, and one quarter (12) – mainly in the public relations category – were addressed to the general population.

- **Distribution according to type of funding**
  Almost one third of the outputs (16) were co-funded. Expenditure on the different projects varied enormously, ranging from 100 Swiss francs (information stand) to 282 000 Swiss francs (young women's "Kit"). The bulk of the projects cost between 5000 and 40 000 Swiss francs. Leaving aside salaries, the most expensive type of output was materials, followed in descending order by materials, training, projects, research, and public relations (PR).

- **Distribution channels and approximate number of people reached**
  A large number of communications channels were used (brochures, films, drama, seminars, training sessions, the media, public debates), and in each case were geared to the particular target group. The number of people reached naturally depended on the type of output. A brochure, for instance, will tend to reach a large audience, while a training course will affect only a limited number of people, but in greater depth.

Sustainability of the activities

Below, we give some examples of outputs that have continued after the AP ended, using a series of sustainability criteria defined by the evaluation team.

Outputs continuing beyond the pilot and initial funding phase
A project targeting girls attending youth centres, and another for Portuguese women, were subsequently granted cantonal funding. The materials used in a number of projects were designed with financial support from the AP, then produced and distributed with funding from other sources. An AIDS-prevention film was funded partly by the AP and partly by the FOPH "Schools and Health" project, and later produced by the Swiss Health Promotion Foundation.

Outputs generating lasting or renewable products which can be used by others
Launched as part of the AP, the project to develop a consensus on contraception and AIDS prevention among girls has continued since the programme ended. This output was initiated by a series of AP activities (secondary analysis and assessment of the literature regarding adolescents, contraception and condoms ; meetings of experts to discuss this issue). Other AP products, such as the information brochures, continue to have an effect independently of the programme. Other outputs have the potential to be taken up by others, though this may not have happened yet. For example, though the inventory of sexual health resources could be used for purposes other than the AP, to date it has been used only by persons directly associated with the AP.

Outputs which have been incorporated into an existing structure, organisation or network
Several of the AP training projects derived from, or have been integrated into, pre-existing structures or networks, for example those targeting Portuguese or Turkish women. Some of the AP courses have been adopted by other institutions and included in professional curricula. The "OK Ragazze/Ho les filles" brochures have been taken up by several cantonal departments (health, youth), and by voluntary organisations set up to combat AIDS.

Outputs creating a new network or generating new activities (snowball effect)
An output can also be regarded as sustainable if it generates something new, for example a new network aiming to integrate AIDS prevention and contraception. Other typical "snowball" activities are those which involve mediators who have been trained to pass the baton on to others.

Generally speaking, various factors were identified as **promoting or hindering the sustainability of the programme**, for instance : the moment at which the objective of sustainability was taken into account (better earlier than later), the level of delegation (better to delegate, because it is difficult to co-ordinate and at same time be active in the field), the use of existing channels (better to rely on well-established structures).

The AP succeeded in working on two fronts. On the one hand, it sought to take into account the specific needs of women in relation to AIDS prevention ; on the other, it managed to introduce the issues associated with HIV/AIDS into women's networks not primarily concerned with such matters. According to the experts we interviewed, **the AP has helped to promote ideas and ways of thinking in these desirable directions, but without firmly anchoring the process ; this would have require more promotion, support and time.**

Planned to be of limited duration, then extended for a further year, **the AP ended without a satisfactory answer to the question of how to sustain the momentum.** Two short-tem "follow-up" contracts, of only a few months'duration, have been subsequently agreed with the programme co-ordinators : one to promote the sustainability of a number of outputs, the other to develop a proposal for activities to be undertaken in the field of women's health in general.

How the AP served to highlight issues in the field of prevention

The AP has highlighted the difficulties which arise when **defining the target of prevention activity and determining the criteria** for deciding which groups should be targeted. Problems arose when the AP had to decide whether or not to fund prevention activities targeting groups characterised by a "twin issue"[b] ("women + drug users"; "women + migrants", etc.). Whilst the original intention was to focus on "women in general", changes in FOPH personnel finally tipped the balance to favouring "those with greater vulnerability to the risk of HIV".

Thinking on HIV/AIDS prevention tends to change over time. This explains how the priority originally accorded to innovation and awareness of the need for prevention activities geared specifically to women's needs, was superseded, towards the end of the programme, by the imperative of sustainability. Whatever the programme concerned, such changes are normal, but can give rise to disagreements between the different partners.

The establishment of activities specific to women inevitably raises the question of men's needs. At the international level, the call for prevention activities specific to women is gradually being replaced by appeals for **gender-specific prevention.** The fact that women have specific needs has now been acknowledged in Switzerland. Specifically male needs have been very fully defined in the case of homosexuals and bisexuals, but not of heterosexuals.

[b] Which element should prevail when a twin issue is involved ? For example, given the limited means and energies available, should a prevention programme for female drug users be funded by the "Women and AIDS" programme or from sources concerned more specifically with drug dependency ? In a situation of this kind, should the AP limit itself to urging on the programme managers the need for an approach specific to women ?

Conclusions

- On the whole, the action programme progressed as planned. A large number of very varied activities (production of materials, field projects on the ground, training, research, public relations) were started, carried through and/or sustained. The programme was successful in making a number of institutions aware of the specific needs of women.

- Ambitious and innovative, the action programme nevertheless came up against various internal obstacles, in particular management difficulties arising from a lack of clear priorities and confusion as to the how responsibility was to be shared between mandator (FOPH) and mandatories.

Recommandations

In order to prolong the positive effects of the programme

- The FOPH should ensure that the issue of HIV/AIDS prevention continues to be included in "general health" and "sexual health" programmes for women. This could be done directly or indirectly by commissioning a programme more limited in scope than the AP.

- Similarly, it is important to continue to include "women's issues" in HIV/AIDS prevention activities, and more generally to take into account the specific needs of both sexes.

Lessons learned from the programme which can be applied to other prevention activities

- Allow enough time for the development and implementation of an innovative programme.

- Establish priorities, but make sure there is scope for adapting to unforeseen circumstances.

- Simplify the "administrative architecture" as much as possible ; do not add to the decision-making levels.

- Arrive at a clear definition of :
  - realistic objectives and criteria by which to measure success/failure ;
  - financial means and the skills required,
  - the roles of the different partners (FOPH, programme managers) ;
  - the degree of autonomy to be exercised by the programme managers ;
  - the ways in which the programme is to be sustained when FOPH funding ends ;
  - the institutional partners (cantons, NGOs) likely to ensure the sustainability of the programme ; include them in talks on possible future developments at an early stage.

6

The MSM programme

"Men who have Sex with Men"

Since its creation in 1985, the Aide Suisse contre le Sida (ASS – the Swiss Aids Federation), and its regional branches, together with the support of the gay organisations of the major cities, have undertaken the majority of prevention activities targeting homosexual and bisexual men. ASS works under mandate from the FOPH, which provides most of its funding. Its targeted prevention activities have taken many forms, "crystallising" in 1995 into the nationwide "MSM" programme : ("Men having Sex with Men")[a].

This programme targets men with a range of preferences and identities, the common denominator of which is that they engage, at least occasionally, in sexual relations with other men.

It has **two main components : a national campaign** to disseminate prevention messages through various channels, and the establishment of a **network of paid regional "outreach workers"** (ORWs), (committed for between 20-40 % of their time), whose task is to make contact with the target group at local level.

ASS began by concluding agreements with its local branches or with gay groups, to recruit and provide initial training for the ORWs, and provide them with infrastructural support.

The managers of the MSM programme at ASS were responsible for the content and professional orientation of the work, and for giving further training to all ORWs.

Phase I evaluation : 1996-1997[1]

The phase I evaluation was concerned with the development of the programme and its capacity to reach the various subgroups that had been targeted. It was based on interviews with the programme director and ORWs, and an analysis of the documentation and materials that had been produced.

The national campaign was based on three main themes : solidarity with people with HIV or AIDS ; young homosexuals (coming out and safer sex) ; and "X Moments" (times when it would be wise to use a condom). These themes were developed from many different angles.

At the beginning of 1997, 11 ORWs – the equivalent of 2,9 full-time appointments – were active in 10 different regions[b]. In seven of these regions, the partner organisation was a local branch of ASS ; in the other three (Geneva, Ticino, Vaud), it was a gay group.

The evaluation at the end of this first phase pointed to both strengths and weaknesses in the programme. For instance, it was considered appropriate to combine a national campaign – disseminating general messages – with regional activities, often at the initiative of the ORWs, to convey these messages in greater depth. Some ORWs had formed themselves into a local network, with the result that they were getting professional support or voluntary help in their daily activities. However, the issue of finding the programme's "ideal" local partner (cantonal branch, gay organisation) had not yet been resolved.

The level of activity in the various places where MSMs tended to congregate was uneven : it was good as far as clubs and commercial venues were concerned, less good in traditional pick-up spots (toilets, parks, motorway rest areas, swimming pools, places of prostitution, etc.)[c].

[a] There is also a programme addressed specifically to men engaged in prostitution.

[b] Zurich, Basle City, Berne, Lucerne, Vaud,Winterthur/Thurgau/ Schaffhausen, Ticino, St. Gallen, Geneva, Liechtenstein

[c] However, it is uncommon for MSMs to frequent pick-up spots to the exclusion of other meeting places. In the IUMSP/UEPP survey entitled "Vous, les hommes ayant des relations avec d'autres hommes, et votre santé" (Men who have sex with men, and their health), conducted in 1997, only 2 % of MSMs exclusively frequented pick-up spots (parks, toilets, motorway rest areas, places of prostitution), and never went to bars, saunas, parties/discos or gay events.

75 % of the respondents in the survey conducted in 1997[d] had seen a preventive action performed in a place frequented by homosexuals (this figure was fairly constant, whatever the social class, education, age or language region of the respondent, or the size of the place where he was living).

Because of management problems at ASS, there were long periods when the programme director's post was vacant. The consequent lack of supervision and support for ORWs resulted in deficiencies in regions where the partnership structures were weak.

The recommendations of the evaluation stressed to the need to develop collaboration with partner organisations ; improve training, follow-up and the ability of ORWs to evaluate their own work ; and give them greater autonomy by allowing them a small budget to manage. It was also proposed that coverage be improved by looking at ways of extending the programme to other regions, such as Solothurn/Aargau, Neuchâtel/Fribourg/Jura or the Valais, and by intensifying efforts in less open areas.

Phase II evaluation : 1998-1999[2]

Between the first and second phases of evaluation, there were various changes affecting the programme (management, organisation, partnerships). The current evaluation, still ongoing, concentrates on two aspects :

- assistance in developing an on-going process of self-evaluation ;
- assistance in clarifying the conceptual framework of working with ORWs in the MSM programme.

This "assistance-in-decision-making" type of evaluation is based on repeated interviews with the programme managers, interviews with ORWs and partner organisations, and case studies in certain regions.

A new programme director was appointed in 1997. At the beginning of 1999, there were 12 ORWs, committed for between 20 and 40 % of their time, depending on the region (table 6a).

Table 6a

Distribution of ORWs and their activity rates, by region (April 1999)

Major towns		Affiliation
Basle	**30 %**	Aids-Hilfe beider Basel
Berne	**30 %**	Aids-Hilfe Bern
	+ 20 %	*Funded by AHBe*
Geneva	**30 %**	Dialogai **
	+ 20 %	*Funded by Dialogai*
Lausanne	**40 %**	Directly dependent on the ASS programme director, using Vogay* premises
Zurich	**2 x 20 %**	Zürcher Aids-Hilfe

Small towns/rural areas		Affiliation
Lucerne	**20 %**	Aids-Hilfe Luzern
	+ 10 %	*Funded by AHL*
St. Gallen	**20 %**	Aids-Hilfe St. Gallen/ Appenzell
Ticino	**30 %**	Aiuto AIDS Ticino
Winterthur/Thurgau Schaffhausen	**30 %**	AHThurgau
Valais	**20 %**	Groupe Sida Valais
Zoug + Schwyz	**20 %**	Fachstelle für Aidsfragen Zug

* Local gay group
** Gay group and ASS branch of the MSM prevention programme (working alongside Groupe Sida, Geneva)

One point to note is that almost all the ORWs now report to a regional branch of ASS. In the case of Vaud canton, the local gay organisation is making its premises available but does not have any responsibility for the work of the ORW, who depends directly on ASS headquarters. In some regions (Berne, Geneva, Lucerne), the local ASS branch is co-funding the appointment of the ORW.

[d] See chapter entitled "Men who have Sex with Men".

A new job specification has been drawn up for ORWs. They must at least submit a quarterly report, structured according to a standard format. They now have quarterly meetings with the programme director, and report to him each month by telephone. Group meetings are held several times a year.

The evaluation shows that, given the great diversity of situations (size of town/region covered, existing local organisations, open/covert scenes), each ORW's priorities may be very different. In fact, the use of the term ORW to describe the workers engaged in this programme can lead to confusion[e]. In the context of the MSM programme, the fact of being present and distributing information in pick-up places and in commercial venues and clubs fits quite well with this description. However, the term covers only some of the activities involved and the role of an ORW goes far beyond it. The ASS is now arriving at a more precise idea of prevention work targeting homosexuals, and of the role of ORWs.

In regions outside the major urban centres, the ORW, working in conjunction with the regional branch of the ASS, is concerned mainly with building up a network of contacts – with gay[f] organisations, businesses, the media, partners in AIDS-prevention work – handing out MSM prevention material, and ensuring that national activities are echoed locally. The ORW is supervised by the national programme director, who assists – together with the ASS regional branch manager – him in assessing needs and preparing local activities. He gradually develops his own activities, and his approach becomes more like that of an ORW working in an urban area, where there is a long history of preventive activity among homosexuals, well-established gay groups, and a regional branch of ASS.

In urban areas, the ORW is basically a local project manager, virtually a specialist in the problems specific to MSMs. He is responsible for organising and co-ordinating all the AIDS-prevention activities addressed to MSMs. In evaluating needs and planning strategy and specific activities, he can draw on a network of resources in the homosexual setting. The local branch is responsible for some of his training and supervision. He organises contacts with the gay commercial scene (regularly supplying printed information for distribution in these settings), and is active in pick-up spots frequented by MSMs and at events organised by gay organisations (generally helped by a group of volunteers). Finally, he proposes specific regional activities, for funding by the MSM programme

This shows a definite change in the concept of MSM work. This is evident in :

- a **professionalisation** of local MSM work (the ORWs posts often recruited through advertisements) ;
- a **regionalisation** of MSM work : local workers take responsibility for all aspects of the work with the MSM target group (apart from producing materials and planning "campaigns") ;
- a **generalist approach** to MSMs : all the various sub-groups making up the target population have to be approached according to locally defined needs ;
- **partnership** – and greater integration – **with the regional structures of ASS,** while maintaining close contact with gay groups which are reckoned to be able to contribute expertise in gay matters. The advantage of this model is that it places responsibility for prevention activities with the local branches of ASS, which were set up for this purpose (and for supporting people suffering from AIDS).

---

[e] It is generally used to describe a person – who may or may not belong to the target population but who has access to that population – whose task is to make direct personal contact with members of the target population, in their own setting, often on a one-to-one basis, to make them aware of the problems and transmit information.

[f] In these regions there tends not to be an organised "scene", and pick-up spots are very important for making contact with MSMs. In addition, these pick-up spots are often scattered.

Conclusions

- **Most of the prevention work targeting MSMs is now co-ordinated, if not directly managed, by the MSM programme.**
- **The MSM programme is settling down and becoming rooted in the prevention activities of the ASS branches.**
- **The ORWs (with the help of ASS branches and local gay groups) are now more frequently expected to function as the primary contact in matters relating to MSM at regional and cantonal level ; they are covering all groups who fit into the MSM category.**
- **The roles of the various partners have been more clearly defined.**

Recommandations

- **While ASS should continue to support the MSM programme from central funds, there needs to be discussion of how the regional branches can gradually take back part of the responsibility for funding the work of the ORWs.**
- **Efforts need to be made to cover pick-up spots, particularly in regions which do not have a network of gay meeting places. The local ASS branches need to be made aware of this issue.**

7

The PAMiR AIDS-prevention project in the travel industry

The PAMiR project (Prävention von AIDS durch MediatorInnen im Reisebereich/Use of mediators for AIDS prevention in the travel industry) began in 1995. It consisted in organising[a] training programmes for professionals working in the travel industry. The aim of these courses was to train people as mediators, able to interact with clients and so influence their personal prevention behaviour.

The FOPH asked the Zurich University Institute of Social and Preventive Medicine[1] to evaluate this project[b]. The evaluation was to serve as a basis for deciding whether the project should continue, and was intended to answer the following questions:

- In the case of those responsible for running training courses for the travel industry:
  - What were their reasons for deciding whether or not to run training courses?
  - What were their intentions where continuing this type of training was concerned?

- In the case of the course participants:
  - What was the relevance of the courses to their daily work, and what opportunities were there for putting their training into practice?
  - What influence had the courses had on their personal behaviour?

The evaluation combined a qualitative approach (interviews with persons running the courses and with participants) and a quantitative approach (questionnaire addressed to course participants). The following points emerged.

With a few reservations, the persons running the courses thought the training had been useful. They saw it mainly as an opportunity to increase the professional competence in answering clients'questions. An active approach on the part of the professionals – particularly guides and escorts – is not desired, lest they upset their clients. Those running the courses also saw it as an opportunity to urge the professionals to take better protective measures themselves. They did not think that courses of this kind should be made obligatory.

The course participants pointed out that they had very few opportunities to discuss the topic of AIDS prevention, because their clients did not ask them questions about it. However, the courses would help them to talk about it, should the occasion arise. One in five reported that the course had influenced their own behaviour in relation to AIDS prevention.

[a] The project was run by the Berne Institute of Social and Preventive Medicine.

[b] Commissioned directly by the FOPH, in addition to the overall evaluation.

Conclusion

- **Travel professionals are not willing to take on an active role as AIDS/HIV-prevention multipliers. Moreover, the managers of travel industry businesses do not encourage them to do so, on the grounds that this might upset clients.**

Recommandation

- **It would be wise to explore in greater depth the feasibility of ground-breaking interventions before launching new projects, even pilot ones.**

N.B.
The project has been terminated in its present form. The idea of training professionals to take on a mediating role has been abandoned, but courses providing information about HIV/AIDS will be continued.

8

Working with "mediators" in AIDS prevention[1]

Peer education is a prevention method of British/American origin, used mainly among young people, and dating from the 1960s. The World Health Organisation has for many years recognised it as a valid response to its objective of improving the effectiveness of the contribution of non-professionals to primary health care. The concept has been widely taken up in AIDS prevention work.

In Switzerland, the term "mediators" is most often used, and many prevention programmes are designed around this concept[a]. Such programmes are particularly concerned with target populations that are difficult to reach through normal channels on account of their marginalised status, or because of cultural differences or language barriers.

Mediators are used principally because of:
- the need to adapt the form and content of prevention activities to different target populations;
- the influence that peers can exercise on one another;
- the possibility of involving target populations in prevention activities.

Working with mediators may make it possible to establish a feed-back mechanism (feeding back information to the programme managers and adapting the prevention measures accordingly).

Interventions involving mediators are regularly reported on. However, such reports provide an incomplete picture of a wide diversity of experiences. Few describe with any precision the roles and activities of mediators working in the field. Because of the prevailing confusion as to the reality of the work done by mediators, and the current interest in the concept of mediation, the aim of the study was to examine the experience gained in Switzerland. The following questions were asked:
- What have been the theoretical and practical results of interventions involving mediators?
- What is the relevance of the concept and its various practical applications in the field of AIDS prevention?
- In what circumstances is this concept used?

This study is based on a review of the international literature (both published and "grey") and an analysis of Swiss projects using "mediators" for AIDS/HIV prevention. The review of the literature permitted identification of a number of intervention models, and construction of an interpretative framework for analysing the basic principles, organisation and operation of Swiss prevention projects using mediators. This chapter of the report concerns only the Swiss projects.

Approximately forty projects using mediators were identified[b]. Those using young people in school settings were not included for the purpose of the analysis, as the focus was on the transposition of this "classic" model to other population groups. Training projects in which professionals (in the health, social work and education fields), or "lay people", were invited to act as transmitters of AIDS-prevention messages in the context of their daily work were taken into account only to the extent that such professionals were expected to actively reach out to a particular target population.

A list of the principal projects included in the analysis is given in appendix, page 104. The information was gathered from documents relating to the projects (protocols, reports, etc.), and from thirty interviews with managers of national projects, co-ordinators of local projects, and mediators.

[a] The term has no connection with the legal notion of mediation (intervention in the event of conflict), nor with that practised in the school setting (teachers acting as intermediaries in listening to pupils and relaying information, outside of their normal classroom teaching function).

[b] A list of projects using mediators was circulated among experts in the field for corrections, comments and additions.

The following topics were covered :

- general objectives of the project and reasons for using mediators ;
- how the mediators were recruited (ideal profile, job specification, difficulties) ;
- detailed description of the prevention activities undertaken by the mediators ;
- training and supervision/management, remuneration, problems encountered ;
- effects of the activities on the mediator, relationship between the mediator and the programme.

Mediator models

The term "mediator" covers a broad range of "human profiles" – people active in a wide variety of situations and using a number of intervention methods. Observation confirms that mediators may fulfil various functions within one and the same project (several profiles simultaneously or one after another). Table 8a sets out the main characteristics of mediators and their activities, together with the most significant aspects of the prevention projects in which they are involved.

Table 8a

Characteristics of activity of, and programmes using, mediators

Mediator	
Connection with the target population	Recruited/not recruited from the target population
Individual characteristics	Shares/does not share the same problems as the target population in respect of HIV/AIDS
	Professional/non-professional in the social work, health or educational fields
	Shares/does not share the language and/or culture of the target population
Role and activities within the project	Receives/does not receive specific training
	Repeated or one-off contact with the target population
	Needs/does not need supervision
	Autonomous/dependant
	Holds/does not hold a position of responsibility within the programme
	Salaried/volunteer
	Puts much/little effort into his/her work as mediator
	Involved/not involved in a feed-back mechanism
	Influences/does not influence definition of programme policy
Involvement in the development of the project over time	More or less flexible role (may/will not change with experience, e.g. by taking on supervision of other mediators)
Programme	
Target population	General population/specific group
	Located in one area/dispersed
	High or low probability of exposure to risk
	Marginalised/not marginalised
	Resident/transient
	Able/not able to communicate in a "local" language
Means	Distribute material
	Reach out with prevention advice
	Make self available to answer questions
	Build networks of contacts
Scope	National/regional or local
Programme development	Adapts/does not adapt to changes in the situation or in the target population (objectives, means, outreach, etc.)
	Long-term project/short-term project

It is obvious that the term "mediator" can mean many different things. There are wide differences in the way programme managers envisage mediators' characteristics and tasks. However, it is possible to identify three principal models, defined in terms of the populations targeted by the projects and the origins of the mediators (table 8b).

Table 8b

Models of intervention by mediators

Origin of mediators	Target populations	
	General populations	*Specific groups*
Mediators from same background	*Model A*	*Model B1*
Mediators not from same background	–	*Model B2*

Projects based on the intervention of mediators are intended to reach two types of target population :

- **"General populations":** the target population consists of people sharing a sense of community identity, but coming from different social classes, educational levels, etc. This population needs to be reached "by other means" on account of particular characteristics (e.g. cultural background or sexual identity) ;

- **"Specific groups":** the target population is smaller, consisting generally of marginalised people who are difficult to reach and/or characterised by behaviour involving a high probability of exposure to HIV (sex workers and their clients, injecting drug users, etc.).

In relation to the target population mediators may be :
- **from the same background ;**
- **not from the same background.**

In the case of model A, the target population is a "general population" and the mediators are always members of it (e.g. the "Migrants" or "Men who have sex with other men"/MSM programmes). These are nationwide projects requiring considerable effort in terms of management and co-ordination. The objectives are long term, and they depend on the participation of the communities concerned.

The mediators involved in these projects are recruited by the programme management. Their status and the work they do vary considerably. They chair prevention meetings, distribute information, help produce materials, facilitate contact between different groups, and interface with institutions. The mediators in the MSM programme are paid for their work ; their main role is as regional co-ordinators, and they are assisted by volunteers. The mediators in the "Migrants" programme perform various functions : training other mediators, contact with consultants, co-ordination at local level, support tasks, distribution of materials, etc. Some are paid, while others only have their expenses reimbursed (travel) or work on a voluntary basis.

In the case of model B1, the target population is a specific group and the mediators are from the same background. This is the classic peer-education model. Examples : the Barfüsserfrauen projects for women (migrant sex workers) in German-speaking Switzerland and in Lausanne ; the male sex workers (MSW) project, in certain cases ; the MEDIA project (present and former drug users, prisoners) ; and the "Donne a confronto" project (female drug users).

These projects are set up by health or social work professionals, who undertake the task of recruiting and training mediators (some of whom may even work in tandem with them). The main tasks of the mediators – some of whom are paid, others not – are to approach their peers, provide them with prevention materials, answer their questions, and give them the addresses of centres providing assistance or counselling. The intensity of contacts with the target population is variable (from a few minutes to several hours). In some programmes, the mediators simply make themselves available (being on duty) or, after some ad hoc training, lead discussion groups.

Table 8c
Prevention work with specific groups : Advantages and disadvantages of using different types of mediator

	Advantages	Disadvantages
Mediators from the same background (B1)	Ability to establish contacts in a difficult-to-access setting	Difficulty in recruiting mediators
	"Legitimacy" of the mediator	Need for substantial training
	Relationship of trust	Danger of role confusion
	Empowerment of the mediator	Mediator may have personal problems
		Difficulty in maintaining a "critical distance" between mediator and target population
Mediators not from the same background (B2)	Often professionals in the fields of social work or health, who therefore possess appropriate skills	Less knowledge of the environment in which they work
	Need less training and supervision	Possible lack of "legitimacy"
		Temptation to go beyond the role of mediator and act as helper in very difficult situations

In the case of model B2, the target population is also a specific group, but the mediators are not from the same background. They may, however, have certain things in common with the population in question (language or culture). Examples : the Barfüsserfrauen project in the Ticino or in Geneva (language in common), MSW (sexual preference in common). This model is often a "fall-back" solution, adopted due to difficulties in recruiting mediators from the same background. The way these programmes operate and the tasks undertaken by the mediators are very similar to those described under model B1, but in these cases the mediators engage in outreach work. In some cases, the mediators in this category are professionals in the social work or education field.

The different types of project involving mediators are summed up in the table in appendix, page 105.

Table 8c sets out the advantages and disadvantages of using the different types of mediator in prevention projects targeting specific groups.

Keys to success ?

Whatever the type of mediator involved, the programmes which succeed in the long term (e.g. Migrants Project, HSH, Barfüsserfrauen) have the following points in common :

- They are based on a preliminary study of needs and feasibility.
- They have clear, long-term objectives. The final objective is more important than the means employed. The means are suited to the context, and these programmes are able to evolve over time.
- They are pro-active in their approach to prevention work, proposing solutions rather than waiting for requests for help.
- They are launched and managed at national and regional levels, but stress participation and feedback. The activities are prepared and supervised by stable organisations able to recruit and train their own mediators.
- These programmes have the capacity to mobilise volunteers willing to commit themselves to a cause. Empowerment (of the mediator and of the target population) is an important aspect of their work.

In contrast, the programmes which have found it difficult to continue or expand (MEDIA, PAMiR) are characterised by inadequate assessment of need and feasibility. They have tended to emphasise means rather than ends, which has prevented them from adapting to changing circumstances. There has also been a lack of appropriate follow-up. Empowerment was not emphasised.

Finally, though it is not possible to suggest solutions that apply in all circumstances, two problems – which have been handled very differently, sometimes within one and the same programme – need clarification :

- Should mediators be paid or work on a voluntary basis ? Paying mediators is certainly advantageous in terms of professionalism, stability, recognition of the value of the work, and the possibility of control. On the other hand, it adds significantly to the cost of a programme. Using people in a voluntary capacity makes for commitment and mobilises the community, but it is not possible to demand the same standards of quality and continuity.
- Power and autonomy : working with mediators (whether volunteers or remunerated) involves a degree of power-sharing and, above all, recognition of mediators' special skills. Such sharing is potentially enriching, but its advantages are often insufficiently exploited.

Conclusions

- **In AIDS prevention, using people closely associated with the target population as mediators is a good way of ensuring that an activity reaches its destination, but it is not a panacea.**
- **The concept of mediation is a very broad one. It is important to recognise the characteristics, strengths and weaknesses of different types of mediation if mediators are to be used effectively and appropriately.**
- **Programmes involving mediators – whichever model they conform to – require significant, on-going investment. Evaluation of the needs and feasibility of the project is therefore crucial. It is also essential to define the objectives and adopt flexible means, depending on the context and the stage of development of the programme.**

Recommandations

- **Decisions to launch projects using mediators need to be carefully thought through, and their implementation should be followed up with close supervision in the early stages, then, as far as possible, gradual increase in autonomy and self-evaluation.**
- **It is important to organise in-service training and opportunities for contact between mediators working on the same programme. Sharing of experience and feed-back to the programme should be encouraged.**

The chapters devoted to the results of the HIV/AIDS prevention strategy seek to answer the following evaluation questions :

- Are people better informed, and have there been behavioural changes in the fields targeted by the prevention activities (in particular sexual behaviour, modes of drug use, etc.) ?
- Is prevention having any unexpected or unwanted side effects ?
- Is the epidemiological situation changing ?

The presentation of the results focuses on long-term behavioural trends and any disparities between the subgroups of a particular population. When possible, comparisons are made with other countries. In tables, data is presented with confidence intervals of 95 %, calculated by the normal methods of approximation. The confidence intervals are not mentioned in the text, but only differences or trends significant at the threshold of 95 % are discussed.

9

The general population

Since 1987, the overall results of efforts to prevent AIDS in the general population have been monitored using a periodic telephone survey[a] of residents aged 17 to 45[b]. The survey was conducted annually until 1992, and has since been repeated in 1994 and 1997 (N = 2800). The information from the survey is supplemented with data from other sources to give a more complete and validated picture of the situation.

In this chapter, we first describe the present situation as regards people's awareness of ways of taking precautions against AIDS, sexual behaviour, and use of condoms as a means of protection. We then tackle some important topics relating to prevention : how strategies change during a relationship, sexual relations during holidays abroad, problems encountered when using condoms, responsibility for use of condoms on the part of men and women, and the HIV test. The final part of the chapter examines the question of social differences in preventive behaviour and how they are evolving.

[a] Enquête téléphonique périodique auprès de la population générale pour l'évaluation de la Prévention du Sida en Suisse (EPSS) = Periodic telephone survey of the general population to evaluate AIDS prevention in Switzerland.

[b] Until 1988, the samples included only persons aged 17 to 30 from the German and French-speaking regions of Switzerland ; since 1989, persons aged 31 to 45 from these regions have been included and, since 1991, persons from the canton of Ticino

Awareness of ways of taking precautions against AIDS

People's awareness of how HIV is transmitted and how to protect oneself against it was measured by analysing spontaneous responses to questions on this topic. **Condoms were mentioned by almost 90 % of the respondents as an effective means of AIDS prevention and, generally speaking, methods of protection were always mentioned more frequently than methods of avoidance** (for example, use of condoms rather than sexual abstinence or avoidance of contact with prostitutes ; use of sterile syringes rather than abstinence from drugs). There was a large degree of uniformity in this respect. In particular, condoms were mentioned with great frequency (over 90 %), irrespective of age, sex or level of educational attainment, in all three language regions, and by both Swiss and non-Swiss nationals.

Despite growing contact with the disease, evidenced by the fact that the percentage of people who knew someone affected by the virus had increased (from 13 % in 1987 to 28 % in 1997 among 17-30 year olds, and from 13 % in 1989 to 31 % in 1997 among 17-45 year olds), the level of fear of AIDS has remained

Table 9a

Frequency of situations in which AIDS prevention was an issue, general population aged 17 to 45, 1987-1997, %

Category	Jan. 87	Oct. 87	Oct. 88	Oct. 89	Oct. 90	Oct. 91	Oct. 92	Oct. 94	Oct. 97
17-30	**n=1182**	**n=1211**	**n=1213**	**n=1231**	**n=1227**	**n=1426**	**n=1427**	**n=1378**	**n=1405**
31-45				n=1177	n=1175	n=1371	n=1374	n=1425	n=1460
New steady partner in previous 12 months									
17-30			**20±2**	**15±2**	**17±2**	**14±2**	**15±2**	**14±2**	**13±2**
31-45				4±1	3±1	4±1	4±1	4±1	3±1
One or more casual partners in previous 6 months									
17-30	**18±2**	**14±2**	**15±2**	**15±2**	**12±2**	**15±2**	**14±2**	**13±2**	**10±2**
31-45				9±2	10±2	10±2	8±2	9±2	6±1
Experience of injecting drugs (lifetime)									
17-30	**1±1**	**<1±1**	**1±1**	**1±1**	**1±1**	**1±1**	**1±1**	**1±1**	**1±1**
31-45				<1±1	1±1	1±1	1±1	1±1	1±1
Contacts with prostitutes in previous 6 months (men)									
17-30	**2±1**	**1±1**	**1±1**	**2±1**	**2±1**	**3±1**	**2±1**	**2±1**	**2±1**
31-45				1±1	1±1	2±1	2±1	3±1	2±1

relatively stable : of the 31-45 years olds, in 1987 24 % said they were sometimes afraid of contracting AIDS, 26 % in 1997 ; for the 17-30 year olds, the figures were 18 % in 1989 and 16 % in 1997.

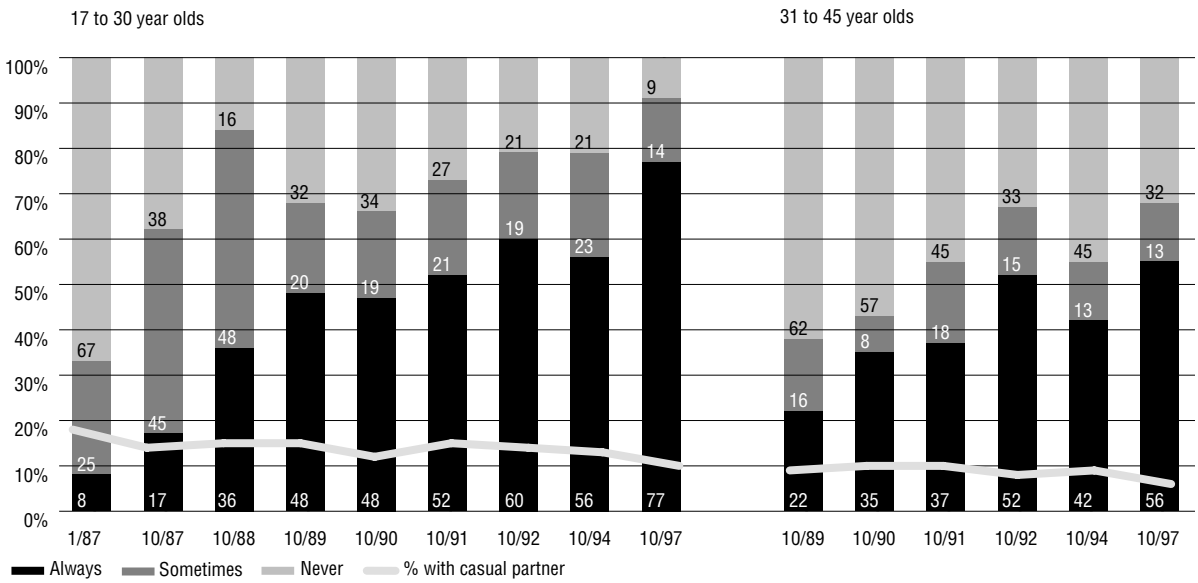
Sexual behaviour and use of condoms for protection

AIDS prevention does not seem to have had any major effect on sexual activity per se[1]. Between 1989 and 1994 (the last year for which this statistic is available) there was no change in the frequency of sexual relations during the previous seven days. In 1989, for instance, 40 % of the 17 to 30 year olds reported not having had sexual intercourse at all, 12 % had had sex once, and 38 % had had sex twice or more often. In 1994, the corresponding figures were 44 %, 15 %, and 42 %. **The median number of lifetime sexual partners has decreased in the case of men but remained constant in the case of women.** Among men aged 17 to 30, it has fallen from 4 in 1987 to 3 in 1997 ; among men aged 31 to 45, from 6 in 1989 to 5 in 1997. The median has remained at 2 for women aged 17 to 30 and at 3 for those aged 31 to 45.

At any given moment, a significant proportion of the population was in the position of having to confront the issue of AIDS prevention, because they had recently changed partner, were having sex with casual or concurrent partners, or were injecting drugs. In 1997, for instance, among the 17 to 30 year olds, 13 % had changed their steady partner in the previous twelve months, and 10 % had had sex with one or more casual partners in the 6 months prior to the survey (table 9a). Moreover, 15 % had another partner at the time when they first had intercourse with their new partner.

Figure 9a

Proportion of respondents reporting sexual relations with casual partners during the previous 6 months, and whether or not condoms were used[c]



[c] The STOP AIDS campaign began in February 1987.

Figure 9b

Proportion of respondents reporting a new steady partner in the previous 12 months, and whether or not condoms were used

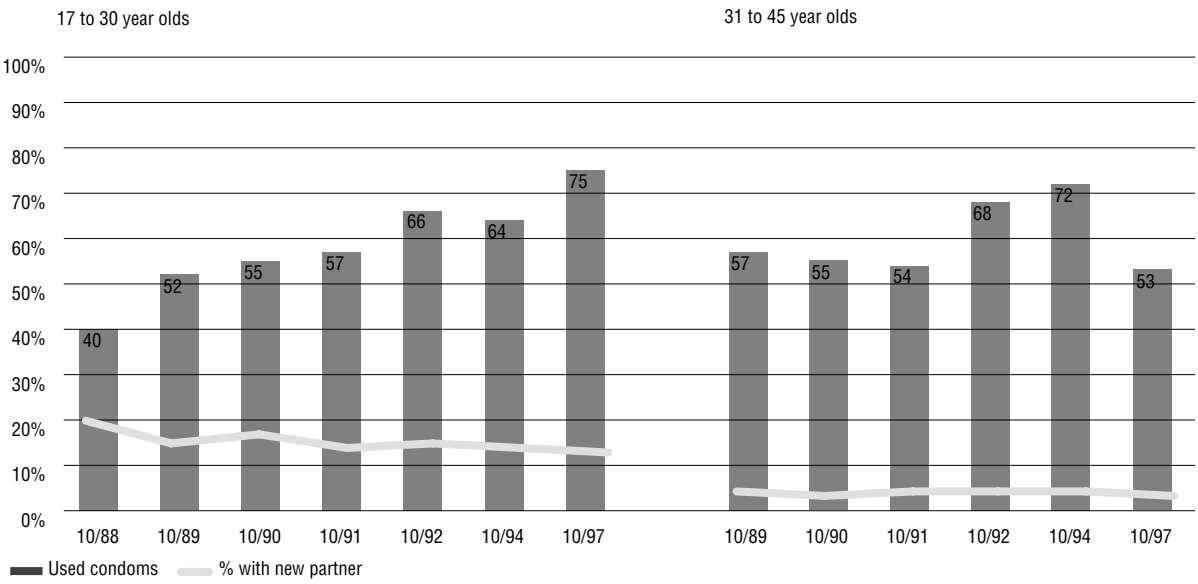
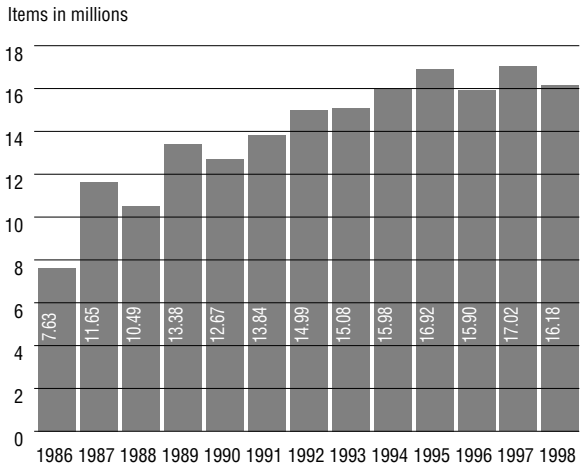


Figure 9c

Sales of condoms in Switzerland (these figures are estimated to account for over 80 % of the market)



The main change that has occurred since the introduction of the AIDS-prevention strategy is an increase in the use of condoms in situations of potential exposure to the risk of contracting HIV :

- among 17 to 30 year olds, systematic use of condoms in relations with casual partners had increased from 8 % in 1987 to 77 % in 1997 and, among 31 to 45 year olds, from 22 % in 1989 to 56 % ;
- the frequency with which condoms are used at the beginning of a relationship with a new steady partner has also increased, but only appreciably so among the younger age group : in 1997, the proportion had reached 76 % among the 17 to 30 year olds ; it is difficult to interpret the variations observed for the 31 to 45 year olds ;
- use of a condom when last having sex – the most telling indicator for the population as a whole – reflects the general trend : among the 17 to 30 year olds, 31 % reported use in 1991 and 37 % in 1997 ; among the 31 to 45 year olds, frequency of use has increased from 14 % to 19 %.

This increase in the use of condoms is confirmed by sales statistics. Sales increased from 7,6 million items in 1986 to 16,2 million in 1998 (figure 9c).

Changes in protective behaviour in the course of a relationship

For the first time, the 1997 survey provided a sequential picture of changes in protective behaviour against HIV in the course of relationships with new steady partners. The information obtained was in respect of 448 persons (53 % men, 74 % aged 17 to 30) who had begun a new relationship[d] in the 2 years prior to the survey. The questions covered the situation when the new couple first had sexual intercourse, the means of prevention they adopted following this first contact, and the means of protection they used when they last had sex (figure 9d).

In 75 % of cases, these couples used a condom (whether the partners had been tested or not) when first having intercourse in the context of the new relationship ; in 4 % of cases, both partners had been previously tested[e] and did not use a condom ; the remaining 21 % did not take any protective measures.

Of those who used a condom when first having intercourse, 57 % decided to continue using this form of protection, 15 % underwent an HIV antibody test then stopped using condoms, and 26 % stopped using condoms without having been tested (we lack information for the remaining 3 %).

Of the respondents who had been tested before they first had intercourse, 89 % continued not to use condoms. Of those who had neither used a condom nor been tested before they first had intercourse, 84 % continued not to use condoms, and 97 % of the latter reported not having used a condom when they last had sex.

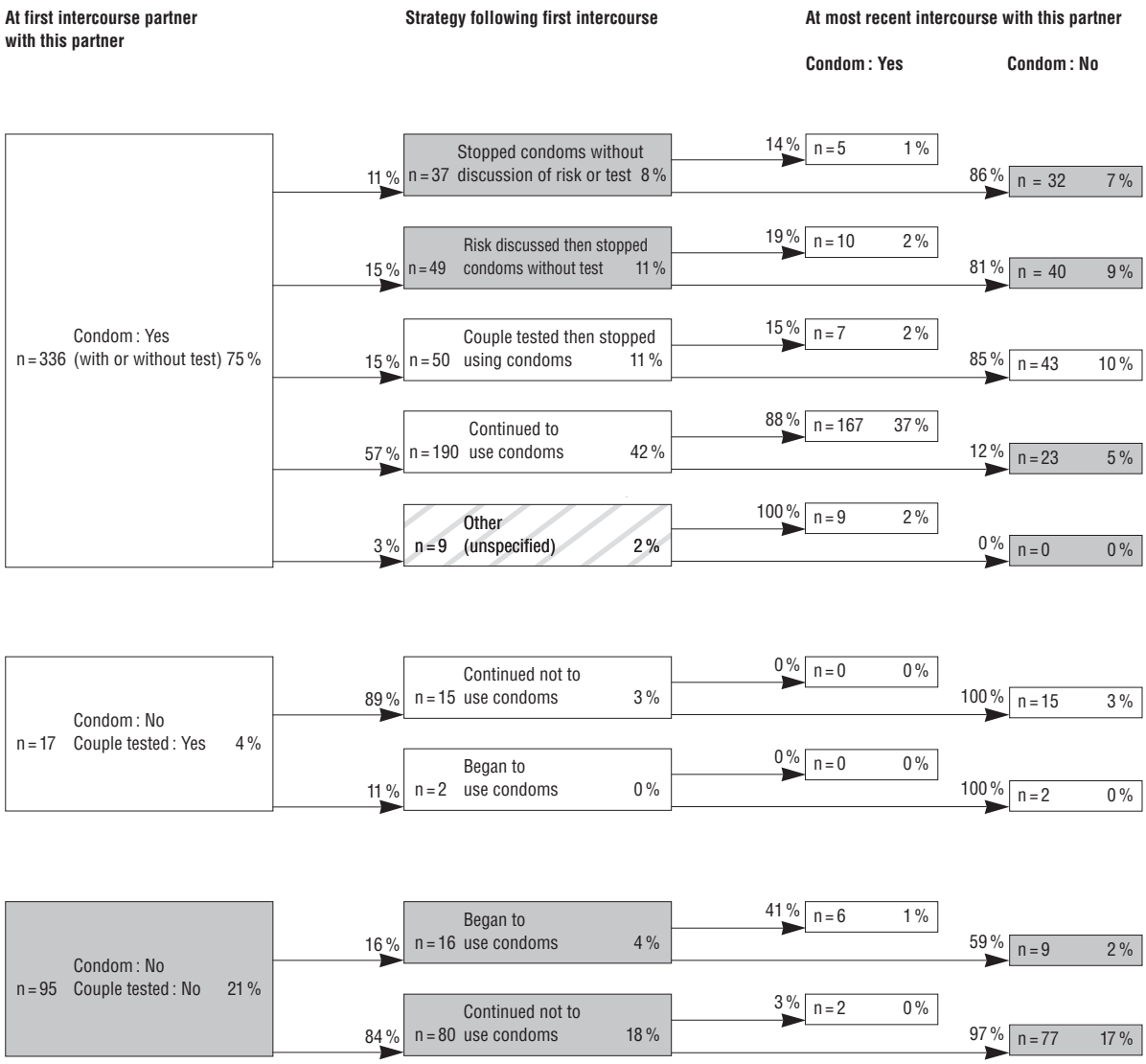
There are inconsistencies in these couples' reports of their most recent sexual contact. For instance, some of those who said they used condoms as their regular means of protection did not in fact use one when last having sex and, conversely, some of those who said they did not use condoms reported using one when they last had sex.

[d] Described at the time of the survey as a relationship with a steady partner.

[e] Both members of these couples had been tested for HIV and had obtained the results before they first had intercourse.

Figure 9d

Changes in protective behaviour in relationships with most recent new steady partner. General population aged 17 to 45 (n = 448)



The text in the boxes indicates the strategy chosen, the number of persons concerned and the percentage of the sample they represent (at the stage of the relationship being considered). The arrows indicate the subsequent developments (in %) of a given strategy. The white boxes indicate strategies involving no risk of transmission of the virus, the grey boxes those involving a potential risk of transmission, the hatched boxes those for which information is deficient.

Certain factors seemed to be linked to the likelihood of condom use at first sexual intercourse with a new steady partner (excepting couples who had previously been tested for HIV). Of those who considered the issue of AIDS when envisaging sexual relations with the new partner (n = 283), 81 % subsequently used a condom when first having sex with him/her. However, of those who had not considered the issue (n = 104), only 61 % subsequently used a condom. Of those who, before first having sex with the new partner, thought he/she would agree to using a condom (n = 367), 78 % in fact used one, as compared with only 43 % of those who thought that he/she would not agree to using one (n = 17).

This longitudinal analysis of protective behaviour in new relationships highlights some key points.

Firstly : the diversity of situations in which the couples found themselves if we consider their past history from the point of view of protective behaviour.

Secondly : the importance of the strategy they adopted when first having sex. The method of protection they adopted at this point is a good indicator of how they would continue to protect themselves.

Finally : the importance of the circumstances in which this initial decision was taken. They were far more likely to use condoms if social norms and behavioural models predisposed both partners to expect use of this method.

Sexual relationships while on holiday abroad

There are few data regarding sexual behaviour and the use of condoms as a means of protection when people travel abroad. People who go abroad, on holiday or on business, sometimes have sexual relations with inhabitants of the countries they visit. Unless they use some means of prevention, they are running the risk of contracting or transmitting HIV. In 1990, and again in 1997, the survey of the sexual behaviour of 17 to 45 year olds included a module of questions regarding holidays abroad. The situations involved may, of course, differ considerably : from unforeseen love affairs to sexual encounters planned as part of the trip (often for payment).

In 1997, 3,5 % of the respondents who had been on holiday abroad had engaged in sexual intercourse with somebody from the country they had visited[f]. Applying this percentage to the entire population of 17 to 45 year olds gives an estimated figure of between 30 000 and 80 000 people who may be in this situation.

More men than women reported sexual relations with local people during their trip abroad. And homosexuals seemed to engage in this type of relationship more frequently than heterosexuals. Compared with other holiday-makers, the persons manifesting this behaviour were more likely to be from the French-speaking region of Switzerland, young, single and travelling on their own. They had also had more casual partners, and more experience of drug use. They were also distinguished by having a greater fear of AIDS.

In both years, 18 % of the travellers who had had sex with local people reported having paid for the privilege, in cash or kind. The “payers” were distinguished from the “non-payers” by the fact that they were all male, single or divorced, and they most often travelled on their own or in the company of someone of the same sex.

[f] This is probably an underestimate because, in cases where the respondent had made several trips abroad, only the trip to the most distant country (presumed to have a higher incidence of HIV) was taken into account for this purpose. In most cases, the countries concerned were in Europe.

In 1997, 65 % of the women (60 % in 1990) and 79 % of the men (70 % in 1990)[g] had always used condoms in sexual relations with partners encountered abroad. In 1997, as in 1990, 17 % had never used a condom in this situation. Younger women with a single partner encountered abroad were over-represented in this group. The men who had never taken precautions tended to be older married men.

Problems with condoms

The Swiss AIDS-prevention strategy puts great emphasis on the use of condoms as an effective means of prevention. It is therefore essential to monitor any problems associated with their use. 88 % of the respondents who were sexually active had used a condom at least once in the course of their lives. Of these, 3 % reported breakage when they last used one, and 2 % said they had experienced a problem with slippage (similar rates are reported from France[2]). The women reported more breakages than men (but a similar proportion of slippages) : 1 % as against 6 % ; this discrepancy may stem from differences in perception of the problem or in readiness to report it. Age seemed to make no difference to the incidence of reported breakage, but slippage was more frequently reported by members of the older age group (17 to 30 year olds : 1 % ; 31 to 45 year olds : 4 %).

Overall, in 1997, the proportion of the population not reporting any problem in the previous 6 months stood at 82 %, a figure not significantly different from 1994 (cf. appended table, page 106). In 1997, 10.5 % of the respondents who had used condoms in the previous 6 months reported having experienced a breakage, representing an increase on 1994. As there had been changes in the sequence of questions used to elicit this information in the 1997 survey, it was not possible to decide whether the variation reflected a methodological artefact or an actual change. There was no change in the proportion of respondents reporting slippages.

Responsibility for using condoms on the part of men and women

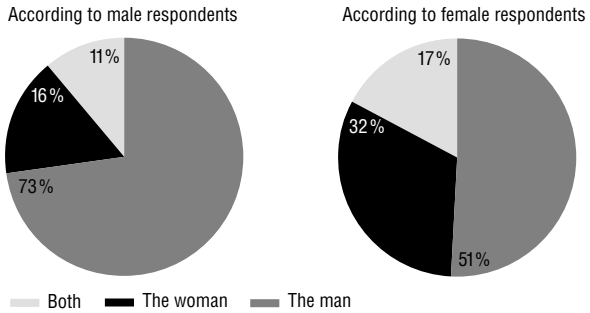
Concern has often been expressed about the difficulty women experience in protecting themselves because of the power constellation that exists between men and women. In particular, it is assumed to be difficult for the women to take the initiative in using a condom : the condom is worn by the man and is therefore thought to be a “masculine” method, making it difficult for the woman to take control. Questions relating to this problem were included in the 1997 survey of the general population ; they covered the purchase of condoms, the proposal that a condom be used, and who actually puts it on. The results give an insight into the situation as seen by both partners.

31 % of the respondents aged 17 to 45 said they had used a condom when they last had sex. One third of the women said that they themselves had purchased the condom used on that occasion[h] and approximately one fifth said that both partners had been responsible for its purchase (figure 9e). The men portrayed the women’s role as less significant, claiming that in three quarters of cases they purchased the condom.

Most of respondents (men 58 % ; women 66 %) reported that the proposal to use a condom had been a shared responsibility.

Figure 9e

Who purchased the condom ?



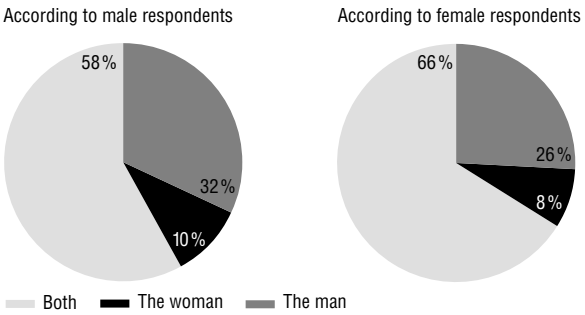
[g] These differences are not significant.

[h] Data corroborated by sales statistics.

Between a third and a quarter (men 32 % ; women 26 %) said they had been personally responsible (figure 9f). Very few attributed the initiative to their partner alone.

Figure 9f

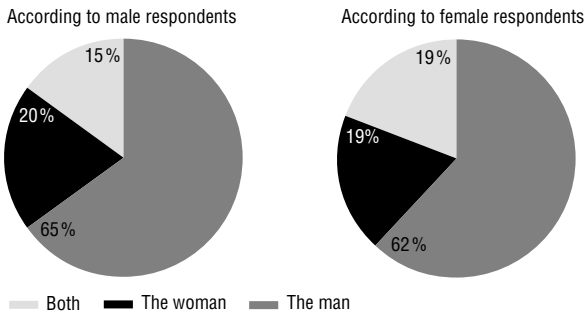
Who proposed use of the condom ?



Where putting on the condom was concerned, there was substantial agreement (figure 9g) : in two thirds of cases it was the man who was reported as putting on the condom, and in one fifth of cases the woman. In the remaining one fifth or sixth, they did it together.

Figure 9g

Who put on the condom ?



Some inconsistencies are found in the statements made – by men and women – particularly regarding the purchase of the condom. On the whole, however, the picture that emerges is one of – at least partially – shared responsibility for using a condom.

The HIV antibody test

A growing proportion of respondents have chosen to undergo an HIV antibody test. Among those aged 17 to 30, the proportion has increased from 23 % in 1992 to 34 % in 1997 ; among those aged 31 to 45, from 23 % to 40 %. However, the rate of increase has been slowing down. The respondents who had undergone their first test during the year of the survey accounted for 5 % of the 17 to 30 year olds in 1992, 3 % in 1994 and in 1997 ; among the 31 to 45 year olds, the corresponding figures were 3 %, 3 % and 1 % respectively.

Overall, also taking into account tests performed when people gave blood, 59 % of the resident population aged 17 to 45 had been tested at least once up to 1997.

Major long-term behavioural trends in relation to AIDS prevention

Two of the three main aims of the AIDS-prevention strategy are concerned with the population of the country as a whole : preventing the further spread of the disease and encouraging solidarity. Because of the requirements of fairness, equal access to information and social justice, it is important to examine the following questions :

- Do some sub-groups exhibit differences in attitudes and awareness, in risk-taking and in the way they protect themselves against infection ?
- Are these differences becoming more or less significant : have we seen a growing uniformity over time or more obvious divergences ?

We tackled these questions using the principal data from the periodic telephone surveys of the general population. Our analyses therefore reflect the limitations inherent in data of this kind, in particular the absence of information from social strata whose members are difficult to reach by telephone or who are not on the telephone at all. In all the analyses, we also made a distinction between the younger (17 to 30) and older (31 to 45) age groups.

Sex-related differences

In awareness and attitudes, there was little to choose between men and women. The condom was mentioned as a means of protection with almost equal frequency. There was no difference in the image of the condom as seen by men and women. A high proportion of members of both sexes consistently took the view that people with HIV were able to take precautions to protect others.

There were differences in the distribution of relational situations : at all ages, slightly more women reported that they were living in a "steady and faithful" relationship – a difference that had not changed over the whole period. At the beginning of the period, more men than women reported a change in steady partner, particularly in the younger age group ; this difference had narrowed and the percentages had become very similar. However, differences did persist, with a higher proportion of men of all ages tending to report relationships with casual partners in the previous 6 months.

There was an inconsistency where the use of condoms as a means of protection was concerned. As regards the use of condoms with a new steady partner and in relations with casual partners, the percentages and trends for men's and women's behaviour were similar. However, if we take the global indicator – use of a condom when last having sex – there was a persistent difference, with always more men than women reporting the use of a condom. The difference disappears if we consider only the most recent intercourse with a steady partner, suggesting that the distribution of types of partner at last intercourse differed between men and women.

Differences relating to language region

From 1987 to 1990, only the German and French-speaking regions of Switzerland were included in the surveys. The canton of Ticino was not included until 1991.

On the whole, differences in attitudes and knowledge between one region and another were slight. The frequency with which the condom was mentioned as a means of protection, and trends in this indicator, were extremely similar in the German-speaking and French-speaking regions of Switzerland. It was mentioned less frequently in Ticino in 1991 and 1992, in both age groups, but the figure for this indicator had caught up with the other regions by 1994. Some differences had persisted over time : condoms were more frequently viewed as "everyday objects" in the German-speaking region, slightly less frequently in the French-speaking region, and least frequently in Ticino. German-speakers were less likely than French-speakers or inhabitants of the Ticino to hold the opinion that condoms "reduce pleasure" or "are not natural". Though there had been a narrowing of the gap between French and German-speakers, the Ticino dwellers still held firmly to these opinions. There were no differences between French and German-speakers in their perception of the capacity of people with HIV to take precautions (consistently high levels reported). In Ticino, the level was lower and actually went down between 1994 and 1997.

There were no differences as regards changes of steady partner and relations with casual partners in the previous six months.

The percentages and trends for the use of condoms with a new steady partner were similar in the German and French-speaking regions, but the percentage was perhaps slightly lower in the Ticino (it was difficult to be sure with so small a sample). The same was true for the use of condoms in relations with casual partners, where the figure among younger Ticino-dwellers was perhaps slightly lower. However, the global indicator – use of a condom when last having sex – did not reflect these differences : the percentages and trends were similar for all three language regions.

There were some differences between language regions as regards awareness of and social attitudes towards methods of protection. Some of these differences had tended to disappear over time, in particular between the French and German-speaking regions. Ticino continued to be different in some respects, particularly as regards the image of people with HIV and, possibly, the use of condoms.

Differences relating to level of educational attainment

Level of educational attainment is an important indicator of a person's social position and cultural capital. This being the case, any differences relating to level of educational attainment are indicative of social inequalities where AIDS prevention is concerned. Information regarding the level of educational attainment of respondents has been available since 1987. For the purposes of this research, we defined three educational levels : primary education (approx. 10 %), secondary (approx. 80 %) and higher (universities and federal institutes of technology, approx. 10 %).

Attitudes and knowledge appeared to be very similar in all three categories. The differences that were apparent in the early years had gradually become less marked. At the beginning, for instance, condoms were less frequently mentioned as a means of protection by respondents educated to primary level, but this difference had become far less evident, especially among the younger age group. Level of educational attainment made no difference to the way condoms were regarded, whether we consider percentages or trends. Only one significant difference emerged : an increasing number of 17 to 30 year olds educated to primary level said they would buy more condoms if they were less expensive. There were no differences (percentages or trends) in the perception of the capacity of people with HIV to take suitable precautions.

There were no appreciable differences in the proportions of people who had changed their steady partner in the course of the year or who had had relations with casual partners in the previous six months.

Where the use of condoms with a new steady partner was concerned, the situation had tended to stagnate among members of the younger age group educated to primary level, whereas the percentages had increased among those educated to secondary or higher level. Percentages and trends for the use of condoms in relations with casual partners were similar. The same was true where the use of a condom when last having sex was concerned, though there had been a more marked increase in condom use among members of the older age group educated to higher level.

On the whole, the available data did not seem to indicate systematic differences related to levels of educational attainment. However, there were a few signs that a divergence could develop among members of the younger age group educated to primary level.

Differences relating to size of place of residence

Information relating to the size of a respondent's place of residence has been available since 1987. For the purposes of our analysis, we divided the places concerned into "small municipalities of less than 10 000 inhabitants" and "large municipalities of 10 000 inhabitants or more".

We found no significant differences for any of the relevant criteria. The percentages and trends for all the indicators were very similar.

This absence of differences in relation to all the indicators was certainly determined to a large extent by the growing cultural uniformity that now characterises urban and out-of-town areas and most rural regions. Where the rural areas were concerned, the threshold figure of 10 000 – which was chosen so as to obtain a sufficient number of places in this category – was perhaps too high to enable us to isolate the kind of habitat in which one might find a sufficient concentration of specific behavioural patterns to be detected in surveys of the general population.

Differences relating to nationality

Almost 20 % of the people living in Switzerland are non-Swiss nationals. When the national prevention campaign began, it could not be assumed that the entire resident population would be uniformly reached by the various activities[i]. Information about the nationality of survey respondents (Swiss or non-Swiss) has been available since 1989.

[i] It was for this reason that, as early as 1991, the FOPH set up a special programme (the "Migrants Project") for non-Swiss nationals.

The attitudes and awareness of non-Swiss nationals resident in Switzerland differed only slightly from those of the Swiss themselves. The gap that existed in 1989 among 31 to 45 year olds in the frequency with which condoms were spontaneously mentioned as a means of protection had narrowed. Some differences regarding the image of the condom had remained constant : non-Swiss nationals of all ages were less likely to regard condoms as “everyday items” and slightly more likely to think that they “reduce pleasure”. There was no difference (in percentages or trends) in the perception of the capacity of people with HIV to take precautions.

There were no differences (in percentages or trends) between Swiss and non-Swiss nationals as regards the proportion who had changed their stable partner in the course of the year, or who had had relations with casual partners during the previous 6 months.

At the beginning of the campaign, non-Swiss nationals of all ages used condoms with new steady partners and with casual partners less frequently than did Swiss nationals. This difference has practically disappeared. The frequency with which a condom was used when the respondents last had sexual intercourse was similar for both communities.

The available data did not show any systematic differences between Swiss and non-Swiss nationals, at least as far as the non-Swiss national communities reached by the telephone surveys are concerned. The differences that persisted concerned the social image of the condom. However, these differences do not seem to affect its use, and in this respect non-Swiss nationals seem to be catching up.

Conclusions

- **Three quarters of the population aged 17 to 30 in Switzerland (but only half of those aged 31 to 45) use condoms in relations with casual partners, and at the start of new steady relationships.**
- **Use of condoms at the start of a relationship is related to the integration of social norms regarding the need for protection. Protection strategies take different directions in the course of a relationship : the partners may continue to use condoms, or stop using them whether or not their partner has been previously tested. The decisions taken at the beginning of the relationship (effective protection or not) seem to determine subsequent developments.**
- **It is not uncommon for people to have sexual relations while on holiday abroad with someone from the country they are visiting. Most of these relationships are not with prostitutes. In most cases, condoms are used. Young single women and older married men seem more prone not to use condoms in these situations.**
- **Even though condom breakage rates are still very low, with increasing use of condoms more and more people experience a problem (condom breakage or slippage) at some time or another.**
- **Condoms are not just a man's business : women are partners in the purchase of condoms, in proposing that a condom be used, and in putting it on.**
- **There are no longer any notable behavioural differences between the major social groupings in Switzerland where protection against HIV is concerned. Preventive practices have been uniformly adopted over time.**

Recommandations[j]

- **Most of the conclusions confirm the efficacy of the prevention strategy, which has succeeded in building a shared norm of preventive behaviour. Subsequent prevention activities targeting the population as a whole, particularly the STOP AIDS campaigns and school-based activities, should seek to uphold this frame of reference.**
- **Though it is inevitable that problems associated with the use of condoms will arise, it is important to improve the available information and counselling to ensure that "accidents" do not discourage people from using condoms. Solutions need to be found to concrete problems in several areas : access to suitable condoms, advice on how to use them, emergency contraception, and post-exposure prophylaxis (PEP) in situations where there is a high risk of HIV being transmitted.**
- **Attention needs to be paid to certain aspects of the situation where information is lacking or circumstances are changing : the fact that a ceiling has been reached in the use of condoms by people in the 31 to 45 age group, the situation among older people, and changes in the behaviour of younger people of lower educational attainment.**

[j] The general recommendations set out in chapter 19 – not repeated here – also apply to the general population.

10

Adolescents and young adults

It is very important to monitor behavioural changes in adolescents and young adults in relation to AIDS : at each phase of the evaluation programme, they are the "newcomers" to active sexuality. In addition, the time when they are becoming sexually active is often characterised by a series of exclusive relationships ("serial monogamy"), before they establish a more lasting bond. Each time they form a relationship with a new partner, the issue of AIDS prevention arises.

This assessment of the situation is based on an analysis of two sources of information : the general population survey on sexual behaviour, conducted regularly since 1987 as part of the evaluation programme (1997 data for 17-20 year olds)[1] and another survey[a], conducted in 1995-1996, of Swiss adolescents aged 15 to 20[2]. We also refer to the results of a recent French survey[3] for the sake of comparison.

Sex education at school

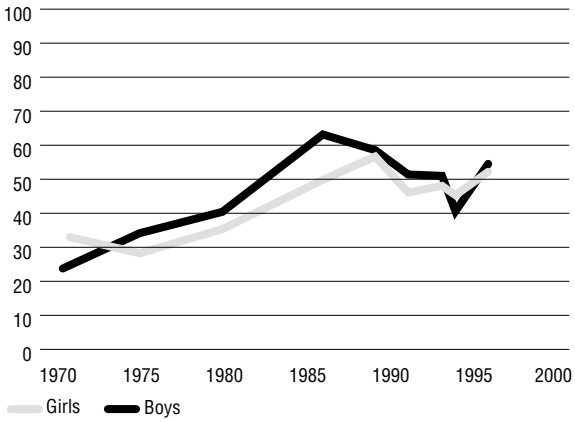
According to the 1995-1996 survey, almost all adolescents over 16 years of age had followed a course of sex education[b]. However, sex education was provided less systematically in the German-speaking region of Switzerland, where 14 % of adolescents had not received this kind of teaching (8 % in Ticino canton, 4 % in the French-speaking part of Switzerland)[2].

Becoming sexually active, and contraception

The late 1980s saw a halt – and even a reversal – of the gradual downward trend in the age at which young people become sexually active. However, in more recent years the percentage of young people who are sexually active at the age of 17 has begun to rise again, though it has not yet returned to the level reached in the late 1980s (figure 10a). In 1997, 52 % of girls and 54 % of boys aged 17 had already had sexual intercourse.

Figure 10a

Proportion of young people sexually active at the age of 17, Switzerland, 1972-1997



Data from various surveys : in 1972 concerned only with boys, in 1973 only with girls.

Very similar figures were reported from France (in 1997 49 % of girls and 53 % of boys aged 17 had had sexual intercourse. On the other hand, the general trend in the age at which young people become sexually active does not seem to have changed in recent years. As in Switzerland, there is now less of a difference between girls and boys in this respect[3].

In Switzerland[2], 87 % of girls and 86 % of boys used an effective method of contraception (condom or pill) the first time they had sex. A condom was used in 77 % of cases, usually as the sole method of contraception. In France, 87 % of young people aged 15-19 used a condom when they first had sex[3].

[a] Research project funded by the AIDS Research Monitoring Committee.

[b] We have no data regarding the duration, content or quality of these courses.

Sexual behaviour[1]

Between 1987 and 1997, there was a **reduction in the number of sexual partners** reported by 17-20 year olds (see table 1, appendix, page 107). In particular, the number of adolescents who reported having had 3 or more partners dropped from 33 % in 1987 to 24 % in 1997. The median continued to be 1, while the average had fallen from 2,4 in 1991 to 1,9 in 1997.

Less young people reported forming a new relationship. In 1988, 27 % of 17 to 20 year olds said they had acquired a new steady partner in the course of the year, as compared with 17 % in 1997. A similar trend was apparent in the percentage of adolescents who had had a casual partner (or partners) in the previous six months : 17 % in 1987, 9 % in 1997.

Protective measures adopted[1]

Use of condoms was still high : in 1997, they were used by 69 % of the 17 to 20 year olds involved in a new steady relationship ; 85 % [c] always used them in relations with a casual partner (or partners). 61 % of the adolescents reported having used a condom when they last had sex[d] (in France, 80 % of the boys and 53 % of the girls)[3].

Young people tended to manage the risk of contracting AIDS in a variety of ways, based mainly on the use of condoms, but also on the HIV antibody test and an assessment of risks run in the past. Questioned in 1997 about their prevention strategy when beginning their relationship with their most recent steady partner, 89 % of the 17-20 year old concerned said they had relied on a condom when first having sex with this partner ; 9 % had not used one, without first having undergone a test ; while 2 % had undergone a test (both partners).

Of those who had begun by using condoms, 68 % had continued to do so as the relationship progressed ; 10 % had undergone a test and stopped using condoms ; 10 % had assessed the risks run by both partners in the past and had stopped using condoms ; 7 % had stopped without taking any precautions ; and 5 % said they had followed some other, unspecified, procedure. 8 % of those who had not used condoms at the start of the relationship had begun to do so subsequently. Of all the young people in this category, 67 % said they had used a condom when they last had sex with the partner in question.

[c] The highest rate of protection since 1987.

[d] The data does not specify the reason (failure to use a condom, condom breakage or slippage, or forgetting to take the pill).

Accidents with condoms and use of the “morning-after pill”

The widespread use of condoms by young people makes it likely that some of them will have experienced the problem of a condom breaking or slipping. A situation of this kind raises the question of the need for post-coital contraception, if the girl concerned is not also on the pill.

It emerged that this situation was not at all uncommon : in 1994, 24 % of the 17-20 year olds concerned had already experienced the problem of condom breakage or slippage. In 1997, 6 % said the problem had occurred on the most recent occasion when they had used a condom[1].

A large majority of sexually active girls aged 15 to 20 were aware of the possibility of post-coital contraception (“morning after pill”, emergency contraception) : 82 % in the German-speaking part of Switzerland, 93 % in the French-speaking part, and 98 % in the Ticino. Many said they had already used this form of contraception[d] : 12 % in the German-speaking part of Switzerland, 25 % in the French-speaking part, 29 % in the Ticino[2].

HIV test

There had been an increase in the percentage of young people aged 17 to 20 who had undergone the HIV test (other than in relation to giving blood) : from 11 % in 1992 to 15 % in 1997[1].

In 1997, in France, 12 % of girls and 8 % of boys aged 15-19 had been tested for HIV[3].

Conclusions

- Young people are manifesting a degree of prudence in sexual matters. This is evident in the fact that they are waiting longer before becoming sexually active, that they are having relations with fewer partners, and that they are forming new relationships less frequently.

- Using a condom has become the norm among young people, particularly when they begin sexual activity. Even though many continue to use condoms as the relationship progresses, some subsequently adopt other protective strategies which do not involve the use of condoms. These strategies are not all totally safe, particularly if they are based on mutual trust or on an ad hoc assessment of the risks run by each of the partners in the past.

- A significant percentage of young people have experienced problems when using condoms (breakage, slippage). They seem fairly well aware of the possibility of seeking emergency contraception.

- Sex education in schools is not achieving the total coverage required, particularly in the German-speaking part of Switzerland. However, this does not seem to have led to blatant inequalities in the adoption of preventive behaviour, probably because the issue of AIDS prevention is still very much in the public eye.

Recommandations

- The STOP AIDS campaigns are still an important instrument in reminding young people of the need to take preventive measures. To ensure that the message continues to be communicated, sex education needs to be made available to all, and should include the issue of AIDS prevention. Regional inequalities in the form and quality of the sex education provided need to be investigated.

- Greater efforts should be made in promoting condoms as the most suitable method of contraception, at least until a stable relationship is established. Access to emergency contraception should be available everywhere. The reasons and circumstances resulting in recourse to emergency contraception need to be investigated.

11

Men who have sex with other men

From the five quantitative surveys so far conducted (1987[1], 1990[2,3], 1992[4,5], 1994[6], 1997), it is possible to assess the preventive behaviour of homosexuals[a] in Switzerland over a period of ten years. The same method was used in all five surveys : a questionnaire inserted into gay magazines in the French and German-speaking areas of Switzerland. The principal questions were retained from year to year and new topics added to reflect current needs and interests. Between 800 and 1200 questionnaires were returned, the number varying from year to year. The collectives obtained in this way are globally comparable, enabling us to analyse trends.[7]

This quantitative approach was supplemented in 1996 by a qualitative[8] study focusing on the problem of protection as faced by homosexual couples. This study included a projective test on the way the partnership functioned and interviews with both partners (N = 16 couples). They were questioned separately on their life as a couple and the way they managed the risk of contracting HIV.

Results of the quantitative surveys

Confronting the epidemic

In the early years of the epidemic, homosexuals were the group worst affected by the disease. At present, they occupy second place, after drug users. In 1987, 60 % of homosexuals knew a person with HIV or AIDS, or who had died from the disease. The proportion had risen to 78 % by 1997, more than double the figure for the general population (30 %).

Sexuality

Some aspects of sexual activity in homosexuals not changed since 1987 :

- **They tend to have a large number of partners :** since 1992, the reported number of partners has remained constant. Three quarters of the respondents had had more than one partner in the 12 months prior to the survey, and one third had had more than ten.
- **They tend to have sex frequently :** several times a week for one third of the respondents.
- **As in the past, a variety of sexual practices was reported :** the most widely practised was mutual masturbation. Many homosexuals practised fellatio and anal penetration, but sado-masochistic practices, fisting and oral-anal sex were less common.

There have been changes, however, in other areas :

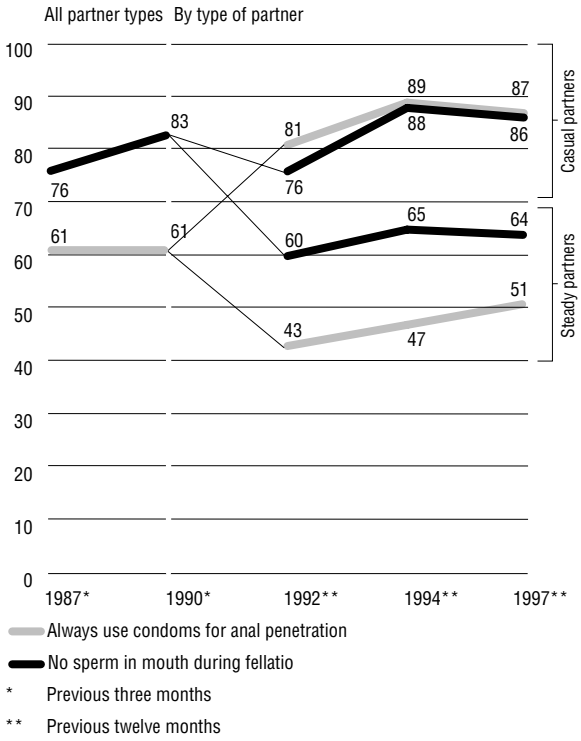
- **There has been an increase in the proportion of respondents with a steady partner :** from 54 % in 1992 to 74 % in 1997. In 1997, approximately one third of relationships had been going on for less than a year, but between 1994 and 1997 the median duration increased from 2 to 3 years. There had also been an increase in the proportion of steady relationships reported to be exclusive (approximately 50 %).
- **There has been an increase in the proportion of respondents practising anal penetration with casual partners during the twelve months prior to the 1997 survey[1]** (1992 and 1994 : 60 %, 1997 : 69 %), but no change in the proportion reporting this practice with steady partners (approximately 75 %).

[a] Each year, men who have sex with both male and female partners account for only a small proportion of the sample (6 % in 1997). This is why we have used the term “homosexuals” to designate all MSMs. Differences between homosexuals and bisexuals are mentioned when relevant.

[b] In the 1987 and 1990 surveys the reference period was the previous 3 months and no distinction was made between types of relationship (casual/steady). Since 1992, for the sake of international comparison, the reference period has been extended to 12 months and preventive behaviour has been evaluated according to type of partner (steady or casual).

Figure 11a

Preventive behaviour when practising fellatio and anal penetration, according to type of partner and year of survey (%)



- **There has been an increase in the frequenting of meeting places and pick-up spots :** in 1997, 86 % said they frequented gay bars (47 % in 1987) ; 53 % saunas (30 % in 1987) ; 41 % parks (24 %) ; 27 % public toilets (18 %).

Preventive behaviour

The incidence of preventive behaviour was measured using two indicators : use of condoms, and the risk of taking semen into the mouth when practising fellatio.

In 1987 and 1990, with reference to the previous three months – and taking account of both types of relationship (stable or casual) – approximately 80 % of the respondents said they had not taken semen into the mouth when practising fellatio, and 60 % said they had always used a condom for anal penetration.

Since 1992, a majority of respondents have reported preventive behaviour with casual partners, whether practising fellatio or anal penetration (approximately 80 % in 1992, rising to 90 % in 1994 and 1997). However, the reported level of preventive behaviour when practising these activities with a steady partner was considerably lower. In 1997, 64 % of the respondents had never taken semen into the mouth and 51 % had always used a condom with their steady partner. There has been an observable improvement in preventive behaviour with steady partners in recent years.

The HIV antibody test and seropositivity

In 1987, 57 % of homosexuals had been tested for HIV at least once. Survey by survey, the proportion of homosexuals having undergone the test has increased, reaching 80 % in 1997. In 1997, 69 % of those who had been tested had done so within the three years prior to the survey. **The proportion of homosexuals reporting themselves to be HIV positive[c] had decreased slightly, though not significantly, from 14 % in 1987 to 11 % in 1997.**

Changes in behaviour according to certain social characteristics

We tried to determine whether the level of protection adopted was related to certain social characteristics[d] and, if this was so, what changes there had been between 1992 and 1997.

We found minimal differences in protection according to a town-country gradient (better protection in town), which had become less evident between 1992 and 1997. The same was true for the level of education – the better educated respondents had protected themselves slightly more effectively in 1992, but the difference had disappeared by 1997. The difference between the number of persons tested (more in towns and with a higher level of education) and those with HIV

[c] Self-reported seropositivity.

[d] Each of these characteristics being expressed in two levels.

(more in towns and with a higher level of education), has also become less significant over time.

On the other hand, there were significant differences between French-speaking and German-speaking Swiss : the former were more likely to have been tested and to be HIV positive (constant difference over time). They tended to protect themselves less effectively, both in relationships with steady and casual partners (divergence over time).

Finally, we found differences in the level of protection adopted by homosexuals and bisexuals, particularly with casual partners. The latter tended to protect themselves less effectively, and the difference was growing.

Young homosexuals

In 1987, the proportion of young homosexuals (aged 18-29[e]) and of older homosexuals (aged 30 and over) who knew a person with HIV or AIDS, or who had died of AIDS, were very similar (approximately 60 %). In 1997, this proportion had remained constant among 18-29 year olds but had risen to 80 % among the 30-and-over age group. Fewer 18-29 year olds reported having a large number of partners (more than 10) during the previous year, this being the case for every survey conducted. Since 1992, anal penetration has been more common among the 18-29 age group.
The proportion of respondents using condoms, in relations with both steady and casual partners, is identical for both age groups. In 1987, the proportion of respondents with HIV in the 18-29 age group was almost identical to the proportion in the 30-and-over age group (18-29 age group : 15 %, 30-and-over age group : 13 %). Up to 1997, the proportion of respondents with HIV in the 30-and-over age group had remained constant at around 11 %, while the figure for the 18-29 year olds had decreased by a half (6 %). Those 30 years and above, were 10 % more likely to have been tested than those in the 18-29 age group.

Protection and HIV status

As in previous surveys, the respondents with HIV tended to have had more partners during the 12 months prior to the survey than those who had not been tested or were HIV negative. In fact, they had had even more partners than in 1994. Respondents with HIV were more likely to have practised anal penetration – both with their steady partner and with casual partners – than those who were HIV negative or had not undergone a test.

Respondents with HIV were less strict in taking protective measures. In 1997, 25 % of the respondents with HIV had had unprotected anal sex at least once with a partner of unknown or different HIV status. The figure was far lower among those who were HIV negative (9 %) and those who had not been tested (19 %).

However, the situation has improved compared with earlier years. In 1997, 82 % of the respondents with HIV (77 % in 1994) had always used a condom with their steady partner during the previous 12 months, and 89 % (81 % in 1994) had done so when they last had sex with their steady partner[f]. 79 % of the respondents with HIV (66 % en 1994) had always used a condom with casual partners, 94 % (78 %) when they last had sex with a casual partner.

National and international comparisons

National comparisons

A survey conducted on the gay scene in Zurich in 1998 (Zürcher Männer Studie/Züms) enables us to validate these results. The respondents were contacted in bars in Zurich and completed a computer-based questionnaire. Most of the questions were identical[g] to those contained in the surveys conducted throughout Switzerland using a self-administered questionnaire published in newspapers.

[e] This age range was chosen to allow comparisons to be made between the 5 surveys (precoding in 1987 and 1990).

[f] The respondents whose partners were also HIV positive were excluded from this analysis.

[g] We would like to thank Jen Wang (IUMSP Zürich) for sharing his preliminary results with us.

The Zurich sample was slightly younger and less closely linked with gay groups and other AIDS support groups. Comparisons between the two samples – stratified by age group – in terms of behavioural variables, prevalence of testing, and declared seropositivity produced similar results. The incidence of exposure to risk (by not using a condom) with casual partners was slightly higher in the Zurich group than in the all-Switzerland sample.

International comparisons

For several years now, France and Germany[h] have been conducting surveys using the same methods and the same questionnaires as used in Switzerland. These surveys have shown similar trends in levels of exposure to risk and protective behaviour. In 1997, in France[i] and Germany[9], the figures for homosexuals who have a steady partner, as well as the number of partners during the previous twelve months, and frequency of sexual relationships were comparable to those reported in Switzerland. The incidence of protective behaviour with casual partners was also similar (respondents not taking risks, Switzerland: 91 %, Germany: 88 %, France: 89 %).

There were differences in the proportion of those who had been tested (Switzerland: 80 %, Germany: 73 %, France: 87 %), whereas the rates of seropositivity were almost identical (Switzerland: 11 %, Germany: 11 %, France: 12 %).

[h] Only comparisons with the former West Germany have been taken into account.

[i] We would like to thank M.-A. Schiltz and P. Adam for sharing their results with us.

Homosexual couples and AIDS

Although the use of condoms was normal practice with casual partners, the prevention strategies adopted by couples tended to be more diverse and complex, and might change over time. If their prevention strategies are to be effective, and particularly if they wish to give up using condoms, couples need to share certain facts about themselves and arrive at explicit and repeated agreements (HIV status of either partner, the possibility of having other partners, what practices are "permitted" with third parties, etc.) The ability to communicate and negotiate is therefore a vital factor in risk management, and effective protection will depend on the personal characteristics of the partners, and on the couple as an entity.

Table 11a

Methods of HIV risk management within couples (%)

	Respondents with one steady partner ▼ n = 173	Respondents with steady and casual partners n = 598	Both categories combined n = 765	Significance
We do not practise anal penetration	14	13	14	n.s.
We have stopped practising anal penetration because of the risk of contracting HIV	0	2	2	n.s.
We always use a condom when practising anal penetration	27	49	43	**
We each decided to be tested and, being HIV negative, stopped using condoms	37	21	25	**
We have not been tested since we have been together, have assessed the risks we have run in the past and do not use condoms	5	7	6	n.s.
We have not been tested since we have been together, we are faithful and do not use condoms	12	2	4	**
We practise anal penetration, are both HIV positive and do not use condoms	1	1	1	n.s.
Other (unspecified)	4	5	5	n.s.

▼ during the previous 12 months. Of the 387 homosexuals who reported an exclusive relationship with their steady partner, 173 (i.e. 45 %) said they had not had any casual partners in the course of the year.

n.s. not significant

** $p < 0.001$

Results of the quantitative surveys : diversity of strategies and extent of exposure to risk

The most common method of HIV risk management adopted by couples is the consistent use of condoms (43 %), this method being almost twice as common when the members of a couple also have sexual relations with casual partners (table 11a). On the other hand, the second most common method of risk management (25 %) – giving up using condoms after both partners have had an HIV test – is far more widespread among couples who do not have sex with third parties. Some couples in this "faithful" category (12 %) had given up using condoms without having undergone a test together. This was the case for only 2 % of the couples who reported also having casual partners. One sixth of the couples did not practise anal penetration, whether or not they also had sex with casual partners.

In 1997[i], half the couples concerned consisted of partners who were both HIV negative, 3 % of partners who were both HIV positive, 10 % of partners who were of different HIV status ("discordant"), and the remaining 36 % were not aware of their respective HIV status. The HIV-negative and HIV-positive couples were far more likely to practise anal penetration than the "discordant" couples and those who were unaware of their respective HIV status.

Of the couples who practise anal penetration, "discordant" couples are the most likely to use condoms systematically (85 %), followed by HIV-positive couples (64 %). Only 60 % of the couples who were unaware of their respective HIV status used condoms, and 35 % of the couples in which both partners knew themselves to be HIV negative.

Three quarters of the couples had discussed HIV risk management with external partners, and most non-exclusive couples had promised not to take chances with a third party. More worrying was the fact that many couples who had not discussed the issue of possible relations with third parties said that they protected themselves and hoped their steady partner did likewise (table 11b).

Results of the qualitative study : the importance of negotiating skills

In the qualitative research based on data collected from both members of 16 homosexual couples, **our hypothesis was that couples possessing good negotiating skills would be better placed to manage the risk of exposure to HIV, within and outside their partnership, than those who were less skilled in this area. This proved to be the case.**

The relationships of couples who were good at negotiating tended to emerge as only relatively cohesive, while those of couples who experienced difficulties in this area emerged as very cohesive (close).

Most of the couples who had run the risk of contracting HIV were deficient in negotiating skills. On the other hand, most of the couples who had not run the risk were good negotiators.

Various **types of protective strategy against HIV** emerged from our research :

- **Consistent use of condoms, both within and outside the partnership.** These couples possessed good negotiating skills. They had agreed to continue to use condoms in their own relationship, and all protected themselves effectively when engaging in anal sex with third parties. One might think that consistent use of condoms (which "gets rid of" the need to reach an agreement about sex with third parties) would be the preferred option of couples with limited negotiating skills. This was not the case.
- **Faithfulness in the case of both partners, decision not to use condoms.** Most of these couples were deficient in negotiating skills and all had run a more or less serious risk of exposure when they implemented their decision to stop using condoms.

[i] Respondents gave information about the couple and about their partner.

Table 11b

"Have you and your partner discussed ways of managing the risk of contracting HIV if either of you have sex with third parties?" (%)

	Respondents with one steady partner ▼ n = 173	Respondents with steady and casual partners n = 598	Both categories combined n = 764	Significance
Responses of those who had discussed ways of managing the risk of contracting HIV from third parties:	73 n = 126	76 n = 454	76 n = 580	n.s.
We have only talked about it vaguely	5	12	10	*
We have discussed it, but without deciding anything as we do not have sex with third parties	14	5	7	**
We have discussed it and know that neither of us has other partners, but we have agreed to talk again if one of us were to have another partner in the future	34	7	13	**
We have discussed it and have decided not to have sex with third parties	27	4	9	**
We have discussed it and decided not to practise anal penetration, or always to use condoms with third parties	19	69	58	**
Other (unspecified)	2	4	3	n.s.
Responses of those who had not discussed way of managing the risk of contracting HIV from third parties:	27 n = 47	24 n = 144	24 n = 191	n.s.
It has not occurred to us to talk about it	10	15	14	n.s.
Talking about it would create too many problems between us	5	7	6	n.s.
I do not take risks with third parties and I think my partner follows the same rule	26	53	47	**
In any case, we do not have sex with third parties, so it is pointless to talk about it	46	10	18	**
Other (unspecified)	13	16	15	n.s.

▼ During the previous 12 months. Of the 387 homosexuals who reported an exclusive relationship with their steady partner, 173 (i.e. 45 %) said they had not had any casual partners in the course of the year.

n.s. Not significant

* $p < 0.05$

** $p < 0.001$

These couples would prove fragile if it came to one of them having sex with a third party, as most of them could not even talk about infidelity.

- **Condoms not used within the partnership, but some form of protection with third parties.** These couples were characterised by good negotiating skills. They had engaged in sex with third parties, had discussed the subject, and had both been tested for HIV. These couples had used condoms for a long period before giving them up, then had established clear rules for future conduct.

- **No strategy or frequent changes of strategy.** These couples were poor negotiators. They were unable to come to an agreement regarding relations with casual partners and had run the risk of infection.

The characteristics of the couple as an entity, rather than of the individual partners, were important factors in the way the couple coped with the risk of contracting HIV. The couple's negotiating skills were very important at three key stages in the relationship: when they first got together; the period when they took the test, abandoned protective measures and entered into a relationship of mutual faithfulness; and if either or both entered into sexual relations with a third party.

Conclusions

- In 1987, most homosexuals said that they already took protective measures. This trend has strengthened over the years, and there is no observable regression in protective behaviour ; there seems to be a homogenisation of prevention right across the diverse social groups. Differences nevertheless persist : French-speaking Swiss and bisexuals are slightly less careful about protection.

- Young homosexuals are as careful about AIDS prevention as their elders.

- More HIV-positive homosexuals had put themselves in a situation that might lead to HIV transmission than had their HIV-negative or untested counterparts (reference : at least once in the previous twelve months).

- A wide range of prevention strategies are adopted by homosexual couples. One of these strategies involves establishing one another's HIV status, then giving up the use of condoms.

- Not all couples establish the necessary rules regarding protection within their own relationship and in the event of their having sexual relations with third parties. Negotiating skills are vital in agreeing on a safe prevention strategy. Lack of clarity in these matters exposes them to the risk of contracting HIV.

Recommandations

- Prevention activities targeting young homosexuals (before and after their coming out) and homosexuals living with HIV/AIDS need to be intensified.

- Homosexuals need to be made more aware of post-exposure prophylaxis (PEP), while ensuring that this is not seen as an alternative to condoms, but rather as an emergency measure in exceptional cases. PEP should be made readily accessible.

- It would be useful for homosexuals to be made aware of :
  - the fact that prevention raises special problems for established couples ;
  - the advantage of a clear agreement between couples on AIDS-prevention strategy within their own partnership and in the event of relations with third parties ;
  - the fact that they run greater risks at certain stages of their relationship : when they first form a relationship, and if they begin to have sexual relations with third parties ;
  - the safety rules they need to observe when a couple wish to stop using condoms : testing of both partners, waiting period, explicit agreements that must be respected.

12

Drug users

Drug users run the risk of contracting HIV/AIDS and hepatitis by using a syringe/needle already used by someone else, by sharing equipment used for preparing an injection (spoon, filter, cotton wool, water, etc), or by not always using a condom on every occasion when having sexual intercourse. This chapter is concerned with trends in some of the indicators used to evaluate preventive behaviour among this population.

This information has been gathered mainly from the surveys[1,2] conducted in 1993, 1994 and 1996 of users of low-threshold facilities (LTF[a]) specifically geared to HIV/AIDS prevention in Switzerland. For various reasons[2], not all the facilities were able to take part in all three surveys. Only the LTFs of towns which took part in all three surveys have been included in the trend analyses, i.e. 9 centres covering 7 towns[b]. The total numbers of respondents for the three survey years were 1019 individuals in 1993, 764 in 1994 and 661 in 1996.

Other sources of information – national and international – have been used to shed further light on the subject.

Changes in the characteristics of users of low-threshold facilities in Switzerland

Social and demographic characteristics

The population of drug users frequenting LTFs was ageing ; it consisted principally of long-term users, who were increasingly dependent on social security. The average age of LTF attenders had risen over time, from 26.6 years in 1993 to 28.6 years in 1996, and the proportion of attenders who had began injecting drugs recently (in the previous two years) showed a sharp decrease from 31 % to 14 % between 1993 and 1996. There were fewer drug users of no fixed address : 14 % in 1994, 8 % in 1996. There had been increases in those benefiting from social insurance (invalidity, unemployment ; 8 % in 1993, 25 % in 1996) and from social security : 24 % in 1993, 34 % in 1996. The unemployment rate had remained steady over the period of the surveys (approximately 50 %).

Modes of drug use

There had been an increase in multiple drug use (heroin and cocaine). Most LTF attenders injected themselves : 85 % to 86 % had injected drugs in the 6 months preceding the survey, with slight variations from year to year. Three quarters had used heroin and cocaine separately or simultaneously (in “cocktail” form) during the previous 30 days. However, heroin was the most regularly used substance : more than two thirds of the attenders used it several times a week (64 % in 1993 and 69 % in 1996). There had been an increase in the regular use of cocaine : in 1993, 24 % of drug users used cocaine several times a week, 32 % in 1996. Regular use of “cocktails” had more than doubled : from 17 % in 1993 to 36 % in 1996.

The LTFs were also attended by drug users undergoing treatment. Of those who used LTFs – mainly drug-injecting users – 34 % were following a course of methadone treatment in 1993. In 1994 and 1996, the figure was 45 %. In 1994, 7 % [c] were involved in programmes prescribing drugs under medical supervision (PROVE) ; the figure in 1996 was 12 %.

Relations with the police authorities

There had been a steady increase in police checks on drug users : in 1993, during the month preceding the survey, 35 % had been subject to a check relating to their use of drugs. This figure increased to 43 % in 1994, and 53 % in 1996. In 1996, a third of the LTF attenders said they had spent time in prison during the two previous years.

[a] See chapter 3 for a definition of low-threshold facilities (LTF).

[b] Berne, Solothurn, Olten, Basle, St. Gallen, Geneva, Lucerne.

[c] This question was not asked in Basle in 1994 (n = 391).

Table 12a

Risk-taking and protective behaviour, LTF attenders in Switzerland: 1993 to 1996 (%)

		1993 n = 1019	1994 n = 764	1996 n = 661
Sharing of syringe/needle*	Lifetime	38 ± 3	37 ± 4	41 ± 4
	During previous 6 months	**15 ± 2**	**9 ± 2**	**10 ± 2**
Use of condom **				
With steady partner(s)		60 ± 3	56 ± 4	56 ± 4
Of these:	Condom always used	**26 ± 4**	**24 ± 4**	**24 ± 4**
	Condom never used	56 ± 4	62 ± 5	63 ± 5
With casual partner(s)		34 ± 3	29 ± 3	29 ± 4
Of these:	Condom always used	**61 ± 5**	**71 ± 6**	**66 ± 7**
	Condom never used	16 ± 4	14 ± 5	16 ± 5
Female prostitution		–	30 ± 9	25 ± 6
Of these:	Condom always used***	–	**93 ± 9**	**93 ± 8**
HIV: test and result	Persons tested	**88 ± 2**	**91 ± 2**	**93 ± 2**
	HIV positive****	**10 ± 2**	**8 ± 2**	**8 ± 2**

* Rate for injecting drug users.
** In the previous 6 months. Used: always, sometimes, never (total = 100 %).
*** Use of condom with clients.
**** Percentage of persons proving to be HIV positive at most recent test.

Changes in exposure to risk, protective behaviour and HIV antibody testing among LTF attenders

The use on at least one occasion of a syringe/needle already used by someone else[d] had remained stable over the period of the three surveys (38 % in 1993 and 41 % in 1996) (table 12a). In contrast, **recent use – in the six months preceding the survey – of a syringe/needle already used by someone else had diminished: from 15 % in 1993 to 9 % and 10 % respectively in 1994 and 1996.**

In 1996, almost all those who had shared injection equipment had washed it before injecting (91 %). However, the method of the method of disinfection used was generally inadequate: 87 % had used water, 28 % alcohol and 2 % bleach.

The rate for sharing in the previous 6 months had tended to be higher among younger drug users, but this difference was disappearing (22 % among the under-25s and 11 % among the over-25s in 1993, as compared with 12 % and 10 % respectively in 1996).

Persons of no fixed address tended to share equipment more frequently than those with their own accommodation (20 % and 14 % respectively in 1993, 20 % and 10 % in 1996). **The HIV status of an individual had no bearing on the probability of his or her sharing used injection equipment.**

Protection within sexual relationships shows no significant change over the recent years and is still inadequate, especially with steady partners.

In 1996, two thirds of the drug users had always taken protective measures when having casual sexual relations during the six months preceding the survey, but 16 % never used a condom. In steady relationships, the reverse was the case: a quarter of the respondents always took protective measures, two thirds never. The protection rate was higher when the steady partner was not a drug user: in 1996, 31 % always used a condom when their steady partner was not a drug user, 16 % when he or she was.

[d] Sometimes referred to as **sharing of injection equipment** in this chapter.

The proportion of people engaging in prostitution was distinctly higher among the women : 25 % of them had prostituted themselves during the previous 6 months, as compared with 2 % of men (1996). **There was also a sex-related difference in the use of condoms in the context of sexual relations engaged in for money :** almost all the women always used a condom with clients (93 % in 1996), whereas less than half the men used one on every occasion (44 % in 1996).

HIV status was a powerful factor in determining whether or not an individual used condoms. **Persons with HIV were more likely to use condoms systematically, in both steady and casual relationships.** However, this difference has tended to diminish slightly over time. In 1993, 68 % of the respondents with HIV systematically used a condom with their steady partner, as against 22 % of those who did not have HIV ; the corresponding figures for 1996 were 57 % and 20 % respectively. In the case of casual relationships, 89 % of the respondents with HIV and 59 % of those who did not have the disease protected themselves on a systematic basis ; the corresponding figures for 1996 were 83 % and 65 % respectively[e].

The women tended to be less careful than the men in taking protective measures in steady relationships. The differences in behaviour were not statistically significant, but they had persisted over time : in 1993, 23 % of the women and 27 % of the men were protecting themselves systematically ; in 1996 the figures were 19 % and 25 % respectively. **On the other hand, a higher proportion of the women took protective measures in the context of casual sexual relations** (in 1993, 71 % of the women and 58 % of the men protected themselves systematically, as against 76 % and 63 % in 1996).

There has been an increase in the proportion of people who said they have undergone an HIV antibody test : from 88 % in 1993 to 93 % in 1996. The rate of reported HIV infection had decreased from 10 % in 1993 to 8 % in 1996. The proportion of those having undergone the test was higher among older drug users, but this distinction had become less pronounced over time : 93 % of the over-25s and 80 % of the under-25s in 1993, as against 94 % and 88 % respectively in 1996. The rate of HIV infection was also higher among the older age group, though here too the difference has tended to become less pronounced : 14 % of the over-25s and 2 % of the under-25s in 1993, 10 % and 3 % respectively in 1996.

Exposure to risk : other national data

Recent trends in exposure to risk and protective behaviour among LTF attenders can be compared with older data and with data relating to drug users frequenting other types of centre, in particular centres offering treatment[f] (cf. table in appendix, page 108).

The rate of sharing among LTF attenders had decreased over time, particularly in the French-speaking part of Switzerland. For example, in Geneva the rate of sharing was 44 % in 1992[3], falling to 14 % in 1996[4] ; in Zurich the figure was 13 % in 1989[5] and 10 % in 1996[4]. There is too little data on the sharing of equipment in treatment centres to allow us to analyse trends. However, in the few cases for which data is available, the rate of sharing was low.

Where **the reported rate of HIV infection** was concerned – and here we have more data – **there had been a gradual decrease in centres of all kinds : this was a general trend.** In LTFs, the rate of HIV infection had fallen, in Geneva, from 17 % in 1992[3] to 8 % in 1996[4], and in Zurich from 24 % in 1989[6] to 21 % in 1996[4]. In outpatient treatment centres, in 1989[6] 15 % of drug users had been HIV positive when they started treatment, 13 % in 1996[7], 10 % in 1997[7]. In the residential treatment centres in Zurich, the rate of HIV infection fell from 21 % in 1990[8] to under 10 % en 1993[9]. In 1997, the average rate of infection for persons embarking on residential treatment was 5 %[10].

[e] The difference was not statistically significant in 1996, because only a small number of the persons with HIV reported having had casual sexual relations (n = 12).

[f] Representing different sub-populations of drug users.

In the trials on the prescription of drugs under medical supervision (PROVE)[11], the rate of HIV infection at the start of treatment was slightly higher (16 % for the 1993 - 1996 evaluation period), but the subjects in this case were especially vulnerable long-term drug users.

Exposure to risk : international comparisons

Sharing among LTF attenders in Switzerland is uncommon compared with other countries, not all of which, however, have experienced a high prevalence of HIV. In Switzerland[g] in 1996, 11 % of LTF attenders had shared a syringe in the course of the previous 6 months. In London[12] in 1993, the corresponding figure for a group of drug users, some undergoing treatment and others not, was 39 %[h]. In Australia[13] in 1995, in the context of syringe-exchange programmes, the rate of sharing during the previous month was 31 %[i]. In programmes conducted in Vancouver[14] in 1996[j], the figure for the previous 6 months was 40 %.

g Prevalence of HIV 11 %.

h Prevalence of HIV 7 %.

i Prevalence of HIV 2 %.

j Prevalence of HIV 23 %.

Conclusions

- Syringe sharing has been on the decrease in recent years in Switzerland. Young drug users have adopted the same non-sharing habits as their elders. On the other hand, drug users in precarious circumstances run greater risks, and a person's HIV status does not seem to influence his or her behaviour where the sharing of equipment is concerned.

- The use of condoms continues to be inadequate, given the prevalence of HIV in this population. In addition, some drug users have partners who do not use drugs. The rate of protection in relations with casual partners is, however, comparable with that of the general population. Protection is less systematic in relations between steady partners.

- The rates of HIV infection confirm that the progress of the epidemic among this population – which is tested on a large scale – has been halted.

- These generally satisfactory results can be ascribed to the considerable effort made to increase and diversify the sources of supply of injection equipment, and to the growth in substitution treatments.

- The growing proportion of LTF attenders undergoing substitution treatments raises questions as to the quality of such treatments (inadequate dosage of methadone ? parallel use of cocaine ?)

- There has been a worrying increase in the use of cocaine. The resulting increase in the number of injections, stress and compulsive behaviour could lead to increased exposure to the risks of contracting HIV/AIDS and hepatitis in the future.

Recommendations

- Risk-reduction measures need to be further developed, particularly measures targeting drug users living in precarious circumstances and those undergoing treatment who continue to inject from time to time. Emphasis needs to be put on the dangers of sharing the equipment used for preparing an injection (spoon, filter, cotton wool, water, etc), and on ways of disinfecting syringes properly in the absence of new sterile items.

- Special efforts are needed to promote protective behaviour among drug users when they engage in sexual relations. They need to be made aware that there is also a significant risk of HIV being transmitted by sexual contact.

- Attention needs to be paid to trends in the use of cocaine and other stimulants, which might threaten the progress made in risk reduction. Surveys of drug users need to be repeated at regular intervals in order to monitor behavioural trends in drug use, risk taking and the related circumstances, and the prevalence of HIV and hepatitis.

13

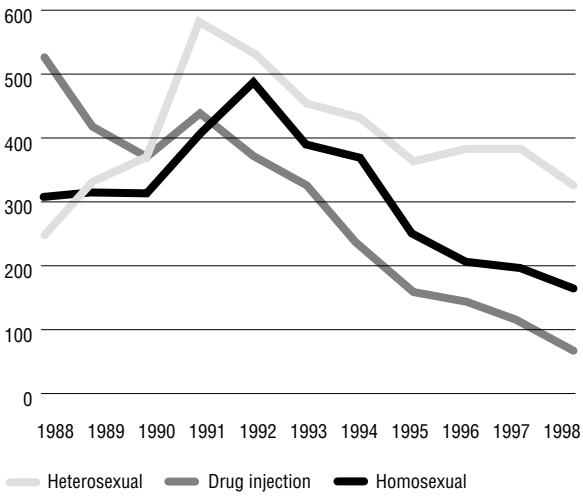
The epidemiology of HIV/AIDS in Switzerland

Since 1987, there has been a profound change in the epidemiological situation of HIV/AIDS. The number of **reported new cases of AIDS** reached its peak in 1995 (737 reported new cases). Since then, there has been a significant decline in new cases, with 428 reported in 1998[1]. There has also been a reduction in the number of deaths from AIDS : for example, in 1994 AIDS was the second most common cause of death among men aged 25 to 44 (second only to accidents). In 1996 it had fallen to third place (after suicides and accidents). This significant reduction is due mainly to the advent of powerful antiretroviral combination treatments, now available to patients affected by HIV, including those who do not yet show any outward symptoms of illness.

Where the transmission of HIV is concerned, there has been a steady decrease in the number of **newly reported cases of seropositivity,** from 2144 cases in 1991 to 656 in 1998. In total, 23 820 positive HIV test results had been reported up to the end of 1998.

Figure 13a

Estimate of the number of new diagnoses of HIV infection, taking into account the principal modes of transmission[2]



OFSP, 1998

The reduction in the incidence of new cases can be attributed mainly to prevention activities.

There has also been a **qualitative change**[2] in the situation :

- The proportion of women among the newly reported cases of seropositivity increased from 30 % in 1987 to 37 % in 1997

There has been a change in the relative percentages for the different modes of transmission. We have witnessed :

- A reduction in the proportion of cases due to drug injection 55 % in 1987 to 15 % in 1997.
- A stabilisation of the proportion of cases resulting from homosexual contact 25 % in 1987 to 26 % in 1997.
- An increase in the proportion of cases resulting from heterosexual contact 18 % in 1987 to 51 % in 1997.

In the “heterosexual” transmission category, there has been an increase in the proportion of situations in which one or both partners were from a country where heterosexual transmission is predominant[a].

However, it should be noted that, in absolute terms, the number of new cases of seropositivity has declined in all three transmission categories (figure 13a). Finally, there has been a decrease in the proportion of new cases of infection diagnosed among 20 to 29 year olds, and a corresponding increase among 30 to 39 year olds, in all transmission categories.

[a] Mainly African countries

Conclusions

- **Prevention activities have been successful in bringing about a significant reduction in the number of newly diagnosed cases of infection (three times fewer in 1998 than in 1991). However, there are still two new cases of infection each day in Switzerland.**

- **Despite a decrease in new cases of sero-positivity, there may be an overall increase in the number of people living with HIV/AIDS, given that their life expectancy has been prolonged.**

- **Infection is now more likely among the older age groups.**

- **There has not been a sharp rise in infections among Switzerland's heterosexual population. In absolute terms, there has been a decrease in cases of infection via the heterosexual route, but this has become the principal means of transmission.**

Recommandations

In addition to continuing prevention activities among the general population, which have proved their worth, it is necessary to ensure that

- **persons from countries where heterosexual transmission of the disease is predominant (and their partners) have access to suitable and sufficient information regarding the prevention and care of HIV/AIDS (migrants programme) ;**

- **adults over 30 – who tend to be less careful in protecting themselves than younger people – receive the necessary attention.**

14

Discrimination, stigmatisation

In society at large, AIDS is portrayed in various ways. This gives rise to different attitudes and types of behaviour – solidarity, discrimination or stigmatisation/ rejection – which have consequences for prevention. Promoting solidarity with people living with HIV, combined with efforts to discourage discrimination, is therefore one of the three pillars of Switzerland's AIDS-prevention strategy.

This chapter is an attempt to answer the following evaluation question :

- Does institutional discrimination against persons affected by HIV exist in Switzerland ? If so, in what areas is such discrimination to be found, and what form does it take ?

In answering this question, we have drawn on data deriving from

- a study conducted in 1997 on **institutional** discrimination related to HIV[1]. The study was based on a protocol drawn up by UNAIDS. This was the first time it had been tested in an industrialised country ;
- specific modules on discrimination and stigmatisation in relation to AIDS integrated into periodic surveys of the general population and of homosexuals.

Institutional discrimination against persons living with HIV in Switzerland

The study was conducted in the cantons of Vaud and Geneva. The two cantons, which have long experience of dealing with the epidemic, were regarded as a regional entity.

The definition of discrimination used here was a legal one : "any measure entailing any arbitrary distinction between people on the basis of their confirmed or suspected HIV serostatus or their state of health". A measure was regarded as discriminatory if it was **specific to HIV/AIDS** (not applied to other diseases) and **arbitrary** (lacking reasonable justification). In looking for **institutional** discrimination, the sources taken into account were **legislative texts, written internal regulations** (for example, a company's recruitment rules), and the **practices applied** or recommended within institutions.

Stigmatisation or discrimination exercised by individuals (for example the rejection of a person with the disease by his or her family) did not come within the remit of the study. **Only discrimination exercised by public or private institutions (the State, hospital services, schools, etc) were taken into account.**

We examined 35 situations in nine major fields of social life : health, employment, justice/legal process, administration (prisons ; civil, military and police service ; admission to and stay in Switzerland), social welfare, public housing, education, family life and insurance (table 14a).

Strict rules were adopted for the purposes of the study. A reference period of two years (1996-1997) was set for affirming the existence of current institutional discrimination. Only proven cases of discrimination were accepted. On the other hand, the discovery of just one instance of institutional discrimination was sufficient to classify a given situation as discriminatory. The anonymity of informants and the confidentiality of the information provided was guaranteed.

The various government services of the cantons concerned formally agreed to co-operate in the study, which subsequently facilitated contacts with administrative departments and institutions.

The study was conducted by a multi-disciplinary team of 16 persons (lawyers, members of AIDS groups, those responsible for AIDS prevention programmes at government level, professionals in the fields of social work, health and education[a]). Responsibility for data

[a] We would like to extend our warm thanks to all those who took part in this study : Marina Alberti, Sylvie Aubin, Christine Bally, Stefan Brauchli, Stéphanie Chatelain, Anne Chollet-Bornand, Claire Henny, Florian Hübner, Olivier Ischer, Kim Kellner Ali, Yvan Muller, Sylvie Ramel, Immanuel Weber, Monique Weber Jobé, Claude-François Robert, Miguel Sanchez and Delphine Spohn.

Table 14a

List of the 35 situations regarded as discriminatory covered by the study

I.	**Health**
1.	Restrictions on access to care : refusal to treat or different treatment on grounds of HIV-positive status
2.	Restrictions on access to care due to limitations imposed by provident associations or insurance
3.	Routine testing with results linked to names without consent in clinical situations, non-confidentiality of medical data
4.	Routine testing with results linked to names without consent in non-clinical situations, non-confidentiality of medical data
5.	Health controls, quarantine, compulsory internment, segregation in hospitals
6.	Compulsory notification of serological status to partner or family
7.	Testing without consent ; failure to inform patient of results
8.	Dismissal of health professionals or changes in their conditions of employment on the grounds of HIV status
II.	**Employment**
9.	Mandatory testing at recruitment and/or during employment
10.	Questions on recruitment form/during interview relating to HIV status and/or "lifestyle"
11.	Non-respect of confidentiality
12.	Dismissal or changes in conditions of employment on the grounds of HIV status
13.	Unjustified restrictions on promotion, job location or employment benefits on grounds of HIV status
III.	**Justice/legal process**
14.	Criminalisation of behaviour (such as prostitution or homosexuality) considered to be conducive to spreading the virus
15.	Inequality before the law of groups regarded as being at risk of HIV
16.	Impediments to legal recourse resulting from discrimination on account of HIV (fear of publicity, loss of privacy, long delays)
17.	Difference in conviction and/or sentence on grounds of real or perceived HIV status
IV.	**Administration**
	Prisons
18.	Mandatory HIV testing on admission, during term, upon release
19.	Special conditions of detention on grounds of HIV status (location, access to certain activities/benefits, home leave, parole, reductions of sentence, denial of visiting privileges)
20.	Restrictions on access to care
	Civil-defence, military or police service
21.	Mandatory testing at recruitment or during employment
22.	Dismissal on the grounds of serological status or unjustified changes in conditions of service
23.	Lack of confidentiality, restrictions on insurance
	Admission to Switzerland and/or residency permits
24.	Mandatory testing, declaration of status, HIV-free certificate as condition of admission, of residence or freedom of movement
25.	Expulsion on grounds of HIV status without appropriate procedures
V.	**Social welfare**
26.	Denial of, or restrictions on, access to benefits
VI.	**Public housing**
27.	Mandatory testing, declaration of status, HIV-free certificate as condition of access to housing or the right to remain
VII.	**Education**
28.	Denial of access to education or restrictions imposed in educational setting on grounds of HIV status
29.	Denial of employment or dismissal of teachers on grounds of HIV status
VIII.	**Family life**
30.	Mandatory premarital testing
31.	Mandatory prenatal testing
32.	Mandatory abortion/sterilisation of HIV-positive women
33.	Withdrawal or modification of conditions of exercise of parental custody, support, inheritance rights on grounds of HIV status
IX.	**Insurance**
34.	Restrictions on the granting of social security or national insurance on the grounds of HIV status, (e.g. sickness benefit, income support, state retirement and invalidity pensions, state accident insurance)
35.	Restrictions on acceptance for life insurance or other types of insurance on the basis of HIV status or belonging to a group regarded as being at risk of HIV

gathering was shared among the team members, and the work was co-ordinated by the two researchers leading the study.

In the initial phase, voluntary bodies working in the field of HIV made a brief survey of the cases of discrimination that had come to their attention. This procedure helped define the areas which called for investigation in greater depth. (The areas highlighted in this way were those of employment, health, the family and insurance).

More than 200 interviews were conducted with informants and experts, covering each of the areas. A great deal of documentation was also collected (e.g. job application forms and insurance proposal forms).

In parallel with this activity, an appeal was made, through voluntary bodies, treatment centres, professionals working in the field, a web site, etc., for people to testify as to experiences of discrimination. Other witnesses were recruited through the networks of members of the working party. Thirty-one testimonies were obtained by these means.

The data gathered was discussed and carefully evaluated during a final meeting of the multi-disciplinary work group, and the presence or absence of institutional discrimination in each field was decided by consensus.

Results

For legal texts and regulations, no discrimination was encountered concerning the questions posed in the UNAIDS protocol.

In practice, one situation of discrimination was found, in the field of health, in a hospital department (routine testing with results linked to names and without patient's consent, Question 3).

In **three other situations, it proved impossible to confirm or invalidate reports of discrimination in current practice** : in the health field as regards testing without consent ; in the employment field as regards dismissal on the grounds of HIV status ; and in the field of life insurance and similar forms of private insurance[b]. In these situations, respectively :

- cases – admittedly few – had existed in the past and it was not possible to be certain either that the practice had been completely eliminated or that the discrimination was truly institutional (dismissals, Question 12) ;
- or discriminatory practices persisted, but it was not possible to be sure that the discrimination was in fact institutional (testing without consent, Question 7) ;
- or there were restrictions, but it was not possible to be sure that stricter rules were applied to persons with HIV than to those with a comparable illness (taking out an insurance policy : similar restrictions are imposed in the case of other illnesses with reserved short-to-medium term prognoses, Question 35).

The work group found **two other situations in which discrimination was practised,** but which were not covered by the UNAIDS protocol : penalisation of transmission of the disease, and restrictions on obtaining a bank loan. In both of these situations persons with HIV/AIDS were subject to special, unfavourable, treatment.

On the other hand, there was evidence of **positive evolution** in actual practice compared with the early years of the epidemic (e.g. the ending of routine testing in prisons). Moreover, several witnesses reported instances of "positive discrimination" (e.g. one employer, having learned from an employee that he had HIV, avoided dismissing the employee in question even though the company was laying off a large number of workers).

However, the study also revealed the persistence of **individual discrimination and stigmatisation.** Situations were encountered in which discrimination was practised by individuals, despite existing recommendations (testing without consent, unfair dismissal, harassment). Informants reported having encountered stigmatising attitudes.

[b] Insurance against loss of earnings, for example.

The study also confirmed that AIDS tends to **bring to light existing problems which are not specific to HIV/AIDS :**

- poor practice relating to other illnesses (problems of confidentiality in several fields, problems of examinations carried out without informed consent or without adequate counselling, etc.) ;
- inadequate social protection in the event of illness (dismissals on the grounds of illness although within legally prescribed notice periods, difficulties with pension funds, restrictions imposed by private insurance companies which result in insurmountable financial problems for people who are ill) ;
- stigmatisation of, and discrimination against, certain groups regardless of problems related to HIV : migrants, drug users, homosexuals, among others.

Discrimination, stigmatisation : results of other studies

Data derived from regular surveys with homosexuals and bisexuals sheds further light on perceived risks of discrimination and on the existence of solidarity (table 14b).

Table 14b

Perceptions relating to discrimination, stigmatisation and solidarity, homosexuals and bisexuals, 1992-1997 (% of positive responses)

	1992 n = 934	1994 n = 1195	1997 n = 1097
Persons with HIV can rely on doctors to maintain medical confidentiality	73 ± 3	74 ± 2	72 ± 3
To avoid discrimination, a person with HIV would be wise to keep his diagnosis secret	72 ± 3	65 ± 3	67 ± 3
Employers or insurance companies have have the diagnostic test carried out without people knowing	39 ± 3	37 ± 3	*
Even among homosexuals, those with HIV are sometimes marginalised	72 ± 3	66 ± 3	67 ± 3
In recent years, there has been an increase in acts of violence against homosexuals	69 ± 3	60 ± 2	40 ± 3
On the pretext of combating AIDS, certain instances of police misconduct are increasing	31 ± 3	18 ± 2	*
The threat of AIDS has strengthened solidarity among homosexuals	58 ± 3	60 ± 2	57 ± 3

* Question not asked in 1997

Clearly, confidence is growing, but there is still a degree of uneasiness, particularly as regards the issue of solidarity/discrimination. The fear of violence appears to be diminishing.

A comparison between HIV positive and HIV negative respondents shows that the former are more likely to believe that doctors respect medical confidentiality. On the other hand, they are more likely to think it wise to keep their diagnosis to themselves and to believe that persons with HIV are sometimes marginalised among homosexuals.

Revealing to one's immediate circle that one has HIV seems to have become slightly easier : in 1997, 89 % of homosexuals and bisexuals had disclosed their situation to their partner (85 % in 1994), 75 % to their friends (75 %), 61 % to members of their family (55 %) and 42 % to their colleagues at work (32 %).

The data gathered in the behavioural surveys of the general population showed an increase in confidence that persons with HIV were able to protect other people from the risk of infection. The proportion of respondents aged 17 to 45 who agreed that "people with HIV who are well-informed take precautions not to infect others" had increased from 82 % in 1990 to 88 % in 1997.

Conclusions

- The study revealed discriminatory practice in one of the 35 situations investigated for evidence of institutional discrimination. With regard to three others, doubt persists. Two additional discriminatory situations – not covered by the protocol – were also identified. The rarity of institutional discrimination can undoubtedly be ascribed to national and cantonal policy, which is very much based on solidarity with people affected by the disease.

- Institutional discrimination or malpractice not specifically connected with HIV/AIDS (but with other illnesses) exists in the following fields:
  - social protection (insurance, protection against unfair dismissal);
  - confidentiality of information;
  - informed patient consent.

  These issues, concerning social protection in general and the medical field in particular, demand a broadly based social response.

- There continue to be cases of discrimination and stigmatisation at an individual level.

Recommandations

- Campaigns to promote solidarity/non-discrimination need to be continued on a regular basis, to maintain an attitude unfavourable to discrimination.

- Public and private bodies need to be encouraged to draw up specific anti-discrimination policies.

- The FOPH (Swiss Federal Office of Public Health), the cantons and organisations engaged in combating AIDS, in conjunction with other interested bodies (representing patients, health professionals, lawyers, etc.), should act to ensure that measures are taken to end institutional discrimination or poor practice in fields where it exists, whether or not it is specific to AIDS.

- Surveillance of problematic situations should be implemented.

- In fields where no evidence of discrimination or stigmatisation was detected, vigilance should still be the order of the day. Voluntary bodies and public authorities should encourage clients to report instances of discrimination they have observed or experienced, and should pursue a policy of actively supporting those who are most vulnerable to discrimination (specialised support and counselling structures).

- Evaluations of institutional discrimination should include questions relating to bank loans and the penalisation of transmission of HIV.

15

New treatments for AIDS : initial consequences for prevention

The advent in 1996 of new, more effective drugs for treating AIDS (protease inhibitors), which were given wide coverage in the media, created a new situation where AIDS prevention was concerned, arousing fears that individuals might be less careful in protecting themselves. To assess the risk of this happening, the October 1997 telephone survey of the general population and the questionnaire addressed to homosexuals in the Spring of 1997 both included a series of questions regarding awareness of the new treatments and their possible consequences for prevention behaviour[1,2]. The second point was tackled from two different angles : what changes in behaviour people envisaged in their own case, and what changes they anticipated among people in general (or among homosexuals in general, in the case of the questionnaire addressed to this group).

Awareness of the existence of new treatments

Thirty per cent of the Swiss population aged 17 to 45 had heard of the new treatments, 7 % were not sure and 63 % had not heard of them. These percentages were similar among men and women, young people (17-30 years old) and older people (31-45 years old). There were however significant differences between the various sub-groups taken into consideration : of people educated to primary level 22 % had heard of the new treatments ; of those educated to secondary level 29 % ; and of those educated to university level 47 %. In German-speaking Switzerland 24 % were aware of the new treatments, in the French-speaking regions 51 %, and in the canton of Ticino 17 %.

The proportion of homosexuals who had heard of the new treatments was higher than that of the general population : 70 % had heard of them, while 23 % had not (no information was available for the remaining 7 %).

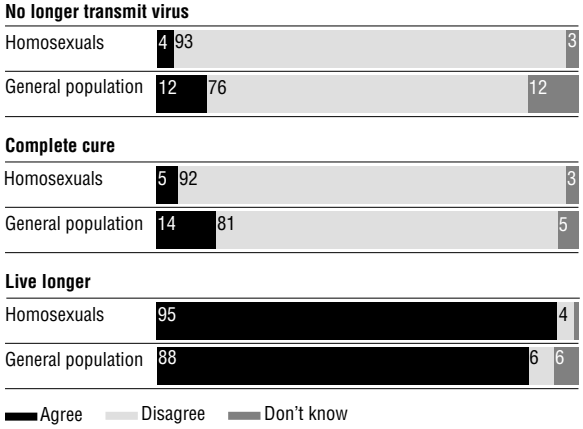
Awareness of the characteristics of the new treatments

Both amongst the general and homosexual population, a large majority of those who had heard of the new treatments were aware of their characteristics (figure 15a).

Where awareness of prolongation of life expectancy and the possibility of being cured were concerned, there were no major or significant differences relating to age, gender, level of educational achievement or language region. On the other hand, persons of low academic achievement knew significantly less about transmission : 21 % of those educated to primary level said they did not know (as against 11 % of those who had attended university) and 24 % thought that people with HIV/AIDS who had been treated no longer transmitted the AIDS virus (7 % among those who had attended university).

Figure 15a

Awareness of the characteristics of new treatments among those who had heard of them, in the general population (n = 1055) and among homosexuals (n = 735)

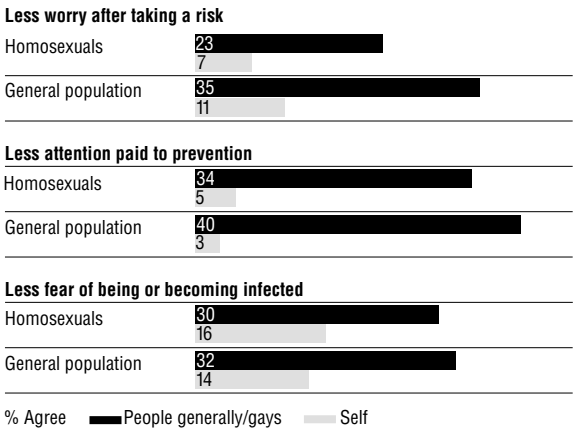


Supposed consequences of the new treatments for AIDS prevention

A series of questions was included to assess the possible consequences of the new treatments for AIDS prevention, in respect of "the person him- or herself" and "people generally" (figure 15b).

Figure 15b

Consequences for prevention attributed to the new AIDS treatments by people who had heard of them. Proportion (%) of persons who said they agreed for themselves and for other people generally in the general population (n = 1055) and among homosexuals (n = 745)



Only a small minority of people thought that the new treatments would influence their attitude and behaviour in relation to AIDS prevention and **hardly anybody said that they personally would think of being less careful about prevention. As far as perceptions about people's behaviour in general was concerned, a strong minority expected the population at large and homosexuals in particular, to become less attentive.**

There were differences between sub-groups of the general population in respect of some of the supposed consequences for prevention. In response to the questions about "people generally", there were appreciable differences between linguistic regions : the figures for anticipated reductions in the fear of being infected, in the attention paid to prevention and in worry after taking a risk were all significantly greater in German-speaking Switzerland. In particular, 49 % of the respondents resident in German-speaking regions thought that the attention paid to prevention by people generally would diminish, as against 32 % in Ticino and 27 % in French-speaking Switzerland. Also, a larger proportion of older people thought that people generally would pay less attention to prevention, or would be less fearful of being or becoming infected.

Where "the person him- or herself" was concerned, reduction in the fear of being infected seemed to be linked to the person's level of educational achievement (it was mentioned by 27 % of the least educated, 14 % of those who had been to secondary school and 9 % of those who had attended university). Those reporting less worry after having taken a risk, were slightly more numerous in German-speaking Switzerland.

International comparisons

At the end of 1997, awareness of the existence of new treatments among the general population of the countries under consideration[1,2] varied considerably : 22 % in Germany, 25 % in Norway and 67 % in France. Differences in media coverage of this subject were probably a contributing factor. As in Switzerland, the level of awareness in these countries was related to the level of educational achievement. Of those who were aware of the existence of new treatments, the level of knowledge was similar to that found in Switzerland.

In these countries, too, only a small minority of people thought that the new treatments would influence their behaviour in respect of AIDS prevention, but a larger minority believed that they would affect the behaviour of people generally. As in Switzerland, such opinions were more prevalent among social strata with lower levels of educational achievement.

Conclusions

- **On the whole, the new treatments for AIDS do not seem to have aroused exaggerated hopes or resulted in profound changes in personal attitudes towards prevention. However, people are anticipating a widespread relaxation of vigilance, and this could lead to a set-back in what has so far been achieved in AIDS prevention.**

- **For the time being, however, there are no indications of changes in the protective behaviour reported in the various evaluation studies.**

Recommandations

- **As part of the STOP AIDS campaign, it would be wise to repeat[a] that the new therapies do not lessen the need for prevention, and remind people of this in all communications relating to treatments.**

- **It is necessary to continue monitoring attitudes and behaviour in respect of prevention among the general population.**

[a] This message has already featured in one of the 1997 campaigns.

16

The sexuality of persons living with HIV/AIDS

A large number of people live with HIV/AIDS. Thanks to the progress being made in treating the disease, the prognosis is no longer one of death in the short or medium term. Rather, it means a long-term change in the patient's condition. Persons with HIV can now expect to enjoy a longer lease of life during which their state of health allows them to be sexually active, form a stable relationship, and even have a family.

In 1997, a study[1] was undertaken to find answers to the three following evaluation questions :

- What problems of a sexual nature are encountered by people living with HIV ?
- How do they cope with them ? What consequences do they have for preventing the transmission of HIV ?
- How is it possible to develop care facilities for people with HIV which take better account of their sexual problems ?

The study consisted of an analysis of the relevant literature and two series of interviews, one with professionals[a] involved in the field of HIV/AIDS (n = 19), the other with persons living with HIV (n = 25). The second group included men and women of all sexual preferences, of different ages, at different stages in the development of the disease, living alone or with a partner, with or without children. Conducted in the French- and German-speaking regions of Switzerland, the interviews covered various topics relating to the respondents' sexual and emotional lives : self-perception (self-image and image of one's body), sexual desire, the search for a partner (or partners), love, sexual activity (practices, protection, frequency), satisfaction, relationships with partners, and desires and plans to become a mother/father.

[a] Doctors (in domiciliary practice or in hospitals), nurses working in teaching hospitals or institutions caring for drug users with HIV, psychotherapists in domiciliary practice or working for voluntary bodies, pastors with a ministry to AIDS patients, permanent officials of voluntary bodies, managers of institutions offering residential care to people with AIDS.

Generally speaking, the literature we examined was concerned primarily with the protective behaviour adopted by people living with HIV/AIDS[2]. It provided little information as to the way people experienced living with HIV on a daily basis, the constraints it imposed upon them, and the reactions it occasioned from their partners. The information gathered from the professionals was useful mainly in giving guidelines for preparing the interviews with the respondents with HIV. The material gathered in the first two stages of the study has not been used for the purposes of this report. What follows is based solely on the information obtained during the interviews with people with HIV.

The nature and acuteness of the effects on sexuality of a person's being HIV-positive depend on several factors. These include the history of the epidemic (each individual trajectory corresponds to a particular stage in the development of the epidemic), the individual's experience of the disease (the stage to which any particular remark applies), and the relational situation of the person with HIV. Moreover, the fact of being HIV-positive has effects in several fields relating to sexuality : it has a psychological impact (becoming a dimension of the person's identity), a somatic impact (the bodily symptoms of the disease and its treatment), a social impact (it is part of a system of ideas and values which determine the attitudes and behaviour of the general population towards people with the disease, and is also an aspect of sexuality in general) and, finally, a behavioural impact (the person is obliged to take precautionary measures).

Contracting HIV engenders a **considerable deterioration in a person's self-image.** Most people with HIV experience a loss of self-esteem, the feeling of having become dirty and dangerous. They regard themselves as unworthy of being loved. For people infected during the early years of the epidemic, contracting HIV also meant their life expectancy was very limited.

This deterioration in self-image is generally accompanied by reactions of a depressive type, often associated with a temporary loss of interest in sex and any desire to form a new love relationship. Though strong during the period immediately after a person learns he or she has contracted the disease, these reactions tend

to fade during the phase when there are no outward symptoms. They return with force when the first visible signs of the disease make their appearance.

This deterioration in self-image was reported by almost everybody, and was independent of the type of relationship in which the person with HIV was involved (stable relationship or looking for a partner). It was based to a large extent on the social significance of HIV/AIDS : discovering that one has HIV leads a person to define himself or herself in accordance with society's view of the epidemic, which in turn disrupts the norms underlying the development of relationships of a sexual nature. The deterioration in self-image which accompanies the first visible symptoms is also to do with a new awareness of the reality of the disease.

The **physical effects of the disease** (and the secondary effects resulting from treatment) act as a damper on sexual activity. There is an obvious stigma attached to them, likely to reveal the fact that the person is HIV-positive to potential sexual partners. They increase the probability of being rejected and therefore make it more difficult to establish a relationship in which sex has a part.

For people involved in a stable relationship, the physical and functional effects often lead them to look for an alternative to sexual intercourse, for instance non-sexual demonstrations of tenderness. It is painful for people with HIV to accept a diminishing of their sexual capacities and, as a result of weakness, pain and discomfort, have to give up practices from which they derived pleasure. They are also aware of the frustrations they cause others. As a result, they feel guilty, and this may cause them to stifle their own wishes and concentrate on the satisfaction of their partner. People without a steady partner, fearful of being rejected if they are identified as being HIV-positive on account of the physical signs of the disease, may give up looking for a partner completely, or restrict themselves to relationships with other people with HIV.

Because they are effective in combating the symptoms and bring about a general improvement in the state of health of people with HIV, the new treatments have forced some people to re-evaluate their prospects, and in particular their expectations where sex is concerned. Several of our respondents mentioned their difficulty in "managing the reprieve" that had been offered them. Some also spoke of the gulf between their desire to enjoy sex as in the past and their now-limited physical capacities, which gave rise to a great deal of frustration.

The respondents who were looking to form a new relationship often mentioned the **rejection** they had suffered from potential partners who were HIV-negative. In many cases, this was based on bitter experience. But what they emphasised above all was the fear of being rejected. As this type of fear emerges very soon after a person learns they have contracted the disease, it cannot be attributed exclusively to unhappy experiences. It derives partly from the deterioration in one's self-image, i.e. from the feeling of having become dirty and a danger to others.

Fear of rejection leads to an impoverishment of sexual experience. Not wanting to face this kind of situation, people with HIV who do not have a steady partner may decide not to form any sort of relationship. Or they may form relationships while trying to conceal the fact that they are HIV-positive.

Whether or not to declare their HIV status is the dilemma faced by all those who have contracted the disease when they are seeking a new partner. Declaring their HIV status is painful on several counts : it reminds the person with HIV of a situation which is already difficult for him or her to accept, and exposes them to the critical appraisal of the potential partner. If the person with HIV has decided to declare their position, there is then the problem of when to do so : should they do it immediately, or should they wait for the relationship to become established and run the risk of their partner reacting badly because they feel they have been deceived ?

In the early days, most of our respondents had tried to inform the people with whom they were thinking of having sexual relations as soon as possible. This

was when many of them suffered the experience of rejection. When this experience was repeated, many of them adopted a less clear-cut attitude. The tendency was to declare their HIV status fairly quickly if the relationship looked like lasting, or if the partner gave the impression of being understanding and inspired confidence. However, not declaring one's HIV status (while nevertheless protecting one's partner) was the more common solution if the relationship was likely to be short term.

Many of the respondents engaged in a stable relationship had declared their HIV status immediately. However, some said that they had not explained the position – or only at a later stage. The announcement itself had not led to the break-up of the relationship. When this did occur, it tended to be later and generally because it had proved impossible to rebuild a satisfactory relationship in which the partners'demands were met. The break-up was then not "unilateral", but resulted from an awareness of failure on the part of both partners.**Fear of infecting one's partner** is a constant factor in the life of people with HIV, and most of them have a strong sense of **responsibility for protecting the other person.** The practices arising from these two factors determine the nature and quality of their sexual experience. In particular, the person with HIV feels the need to remain vigilant and not lose control during sexual relations. He or she feels they must ensure that the necessary precautions have been taken and that they remain effective for the duration of their sexual relations. They must try to avoid behaviour that might result in infection, or even stop their partner if he or she engages in an activity which might expose them to infection. Incidentally, it is worth mentioning that many people with HIV – and their partners – do not know exactly what risks of transmitting the virus they are running during "foreplay". These constraints and uncertainties rob the relationship of spontaneity and imagination, and give rise to anguish and frustration.

Recourse to precautionary measures generally involves discussing the matter with one's partner. This step is particularly important for people with HIV who do not want to declare their HIV status for fear of being rejected. They particularly dread situations in which a refusal on the part of their partner to adopt protective measures would oblige them to insist and therefore run a greater risk of revealing that they have HIV. In circumstances of this kind, and when uninformed partners refuse to engage in protected sex, they feel it is unfair that they have to bear the entire burden of adopting protective behaviour. It is even worse when they have to face the angry reactions of partners who suddenly realise that they have had sexual relations – albeit protected – with a person infected with HIV. People with HIV cannot understand such reactions, thinking that the purpose of prevention campaigns is to make people understand that such situations may in fact occur, and that amazement when they do is therefore not an appropriate reaction.

Protecting one's partner against HIV creates different dilemmas for men and women. Some of the men said they hesitated to insist on protected sex because they feared this would reveal that they had HIV. However, they said they were very willing to use condoms if their partners requested it. In their opinion, the woman was best placed to insist on use of protection since she could claim it was to avoid an unwanted pregnancy – a reason both convincing and lacking any "moral" connotation. Although they took on this role, some women thought that as men generally took the initiative in sexual matters, they should also be expected to do so where protection was concerned. These statements showed that men and women can entertain contradictory expectations, and misunderstanding of the psychology of the opposite sex can militate against effective protection. Situations may arise in which each partner is counting on the other, with the result that in the end no protective measures are taken.

When people are looking for sexual partners, **risk-taking** arises mainly in situations where the person with HIV is torn between his sense of responsibility – which demands that he do all he can to protect his partner – and the desire not to lose an opportunity. It is generally when faced with the insistence of a partner who is not aware of the situation and wants unprotected sex that a person with HIV gives in. Risks are also taken in situations where the use of alcohol or drugs causes people with HIV to lose control of events, or in places where it is implicitly understood that each person is expected to take full responsibility for his own protection ("pick-up" spots).

Finally, risk-taking also occurs when a person completely denies that he has contracted HIV, whether unconsciously ("denial" in the true sense), or consciously with the idea that acting "as if nothing were wrong" and not seeing himself as a person with HIV will enable him to maintain his psychological integrity and preserve his capacity to fight against the disease.

In stable relationships, risk-taking is connected with the difficulty of living together in the long term while always adopting protective behaviour. It arises from factors dependent on the person who has HIV (the awareness of imposing frustrations on his partner, fear of being dropped), and factors dependent on or imputed to the person who is free of the disease (difficulty in accepting the limitations imposed on the expression of his or her sexuality, the obstacle of the condom). Risk-taking then represents an attempt to adapt to the imperatives of being HIV positive, when the person with HIV abandons many of his demands. Given the discomfort and anguish unprotected sex causes for both partners, this kind of risk-taking episode is usually of fairly short duration.

The desire to **have a child** was always suppressed during the early years of the epidemic. This attitude was explained by the probability of bearing an HIV-positive child and the fear of not being able to assume responsibility for its upbringing. A very few of our respondents nevertheless felt so strong a desire to have a child that they had unprotected sex and, in one case, fulfilled their dream. The advent of new treatments, the prospects they offer of prolonged life expectancy, and the much reduced likelihood of passing the disease on to a child, have brought about a change in the situation. Having a child can now be envisaged again, even though it often remains a matter of wishful thinking.

There remains little provision of **sexual counselling** for people with HIV. Very few of our respondents said they had had the opportunity to discuss this subject with a professional (doctor or other qualified person), and in even fewer cases had their partner been included in counselling of this kind. Even though many of our respondents said they encountered enormous difficulties in managing their sex lives on a day-to-day basis, they seemed little inclined to make explicit requests for assistance and advice. For their part, some professionals are reticent about tackling this subject and generally limit their efforts to giving advice on the adoption of protective measures.

Conclusions

- People living with HIV/AIDS face major difficulties in their sex lives. This is true whether they are seeking to form a new relationship or living in a steady relationship with a partner who is free of HIV.

- People with HIV may feel unworthy of being loved by others, and unable to satisfy their partner. Fearing rejection, they often dare not declare their HIV status to a new partner.

- The desire to have as normal and satisfying a sex life as possible, and the obstacles to realising this desire, may sometimes lead couples in which one partner has HIV to take risks. The behaviour of a partner with HIV who finds it difficult to accept the imperatives of protection may also be a factor in risk-taking.

Recommandations

- Make assistance and counselling services more easily accessible to people living with HIV/AIDS, and to their partners, by :
  - ensuring that there are more professionals able to provide information and support in the areas of sexual and emotional need
  - spreading information via the professional network, so that all persons with HIV are aware of the assistance and counselling available and encouraged to request it.

- Render professionals who are regularly in contact with persons living with HIV/AIDS aware of the emotional and sexual difficulties faced by people with HIV.

- Improve the quality and distribution of information intended for professionals and people with HIV. In particular, draw up and send out clear recommendations on :
  - the risks connected with sexual practices other than penetration ;
  - the situations in which PEP (post-exposure prophylaxis) can be given, the requirements of such treatment, its consequences (in particular the side effects), the circumstances in which it can be given (to whom ? when ?) and how it can be obtained (organisations dispensing it) ;
  - protection measures which offer a satisfactory level of safety and comfort : choice and quality of condoms and lubricants and, if appropriate, the right way to use them ;
  - the risks of re-infection connected with unprotected sex between two persons with HIV ;
  - the side effects of some drugs as regards sexual potency, and ways of limiting these effects.

17

Co-operation between the political partners in AIDS-prevention

The FOPH asked the Laboratoire de recherches sociales et politiques appliquées (Applied Political and Social Research Laboratory) of the University of Geneva to propose a system for monitoring HIV/AIDS prevention and treatment activities in the Swiss cantons[a]. These activities were recorded and published in the form of a report, with an appendix relating to the different cantons[1].

In 1997, an effort to verify and evaluate the data that had been gathered was made in five cantonal or supra-cantonal entities (Fribourg, Geneva, Central Switzerland, Ticino, Thurgau). Meetings were organised, attended by representatives of the cantons concerned, the FOPH, and by the researchers themselves. This phase of the research project resulted in a better understanding of the problems faced by the cantons[2]. In particular, it brought to light the following problems[b]:

- *"concern as to the consequences of the triple combination therapy for the care of persons living with HIV/AIDS, in particular the danger of the psycho-social approach becoming less important than the medical approach;*
- *the lack of a body to pilot changes, which means that the cantons and municipalities are obliged to proceed by trial and error; and a lack of contingency plans;*
- *a lack of managerial continuity at all levels of the federal administration and in every organisation, resulting in the loss of skills and information;*
- *poor co-ordination between the persons directly concerned and between public bodies, with the attendant danger of services being delivered ineffectively;*
- *a lack of awareness of the situation in the cantons (as regards the social organisation of the territory, the epidemiological situation, and specific local circumstances), which makes it difficult for the authorities and those concerned with AIDS generally to develop adequate action plans;*
- *a lack of funding to enable the cantons and municipalities to carry on the work of dealing with the problems relating to HIV/AIDS."*

The participants also expressed the following considerations and expectations of the Confederation:

- *"the importance of Confederation aid for local and cantonal projects, and also of the Confederation's commitment to offer longer-term support to the most useful projects by cofunding them;*
- *the importance of the Confederation as a source of information and legitimacy;*
- *the lack of a co-ordinated programme linking AIDS and school-based education."*

The authors of the study concluded that there was agreement regarding an active pilot structure – or platform – at cantonal level which the Confederation could implement. They explored several ways in which a platform of this kind might be set up.

[a] Directly mandated by the FOPH, in addition to the global evaluation.

[b] The passages in inverted commas and in italics are quotations taken from the summary of the report.

Conclusions

- **There is no opposition to FOPH leadership in formulating prevention policy. The FOPH has the necessary expertise, along with the support of various experts and ad hoc committees, in particular the Committee responsible for questions relating to AIDS.**

- **However, the cantons are looking for improvements in the co-ordination of activities and exchange of information, and for financial support.**

Recommandations

- **From the point of view of the global evaluation, and in the light of past experience, the proposal for a platform to foster co-operation and co-ordinate the efforts of the various parties involved (the Confederation, towns, cantons, representatives of national and local associations, experts) would seem to be a good idea, provided that :**
  - **its role is clearly defined (exchange of information, co-ordination, consultation and dialogue, active surveillance of prevention activities),**
  - **it is specifically concerned with the problem of AIDS ; however, co-ordination with other areas of prevention/health promotion should be part of its remit,**
  - **it is able to act as a surveillance system (ensuring that on-going AIDS-prevention activities are kept up in an appropriate form),**
  - **it is a simple means of ensuring co-ordination, rather than an independent and expensive new structure,**
  - **the FOPH provides the secretarial facilities, by virtue of the Federal Law on Epidemics.**

- **Quite apart from any decisions taken to establish a platform of this kind, the FOPH (with other national players such as the ASS) should continue to maintain bilateral relations with the cantons (regular visits).**

18

The problem of HIV/AIDS as presented by the Swiss press

The media have a crucial role to play in the development of the epidemic. By passing on prevention messages, they reinforce the work of the public authorities and voluntary bodies engaged in the struggle against AIDS. The way in which they present the epidemic has a determining influence on the way the disease is discussed and therefore on its social context. An analysis[a], of the presentation of HIV/AIDS in the print media[1] was carried out for the period from 1 January 1987 to 31 October 1996. The aim was to establish the extent to which press articles could take up and disseminate prevention messages. The study sought to answer the following questions:

- What are the main topics relating to HIV/AIDS dealt with in the press?
- Have these topics changed over time?
- What sources of information are used by the press?
- What prevention messages are disseminated, and how are they judged by the press?

In all, 1168 articles were reviewed. An analysis of their content was carried out in three stages:

- sampling of "basic information" – a study of 450 dispatches issued by the Agence Télégraphique Suisse (ATS),
- sampling of "longer articles" – a study of 450 articles from 10 Swiss daily newspapers with a wide circulation and high standards of journalism,
- a study of 268 articles published in 17 Swiss daily newspapers from different language regions and of different cultural levels.

The analysis showed that the articles were devoted mainly to epidemiological information (in 31 % of cases), the subject of risk situations (22 %) and the issue of "political will and decisions" (19 %). In the early years of the epidemic, the emphasis was more on prevention messages and the STOP AIDS campaign.

Information was derived primarily from political sources or from government departments (37 %), in particular the FOPH. Other frequently used sources were voluntary bodies engaged in combating AIDS (22 %) and research institutions (19 %). Media coverage of the subject was stimulated principally by statements and press releases by government and other executive bodies (21 %), events relating to HIV/AIDS (11 %), and public debates (in Parliament, the courts, etc., 11 %).

The measures adopted as part of the national prevention strategy were generally presented as relevant and effective. Measures to inform and communicate were featured in 38 % of the articles. The exchange of syringes and other similar measures received less coverage (19 %).

The message that condoms afford protection was the most often repeated, while those concerning prevention generally, drug abuse and solidarity were given less emphasis. In terms of depth, the information disseminated did not go beyond a certain point: explicit rules for safer sex were rarely presented. Similarly, articles rarely told readers how to obtain further information on this subject.

Generally, the articles only reported newsworthy information. The journalists expressed a personal opinion in only 0,4 % of the articles. Moreover, there were virtually no articles written entirely by journalists themselves. Whatever the region and cultural level, articles on HIV/AIDS followed much the same pattern. Nevertheless, there were sometimes differences of emphasis. For example, the issue of syringes was less frequently touched on in the French-speaking region and in the popular press. On the other hand, the popular press gave more prominence to the message that condoms afford protection.

[a] Direct mandate from the FOPH, in addition to the global evaluation.

Conclusions

- **The press continues to be an important partner in the struggle against AIDS. It passes on prevention messages by presenting them as relevant.**
- **The topic of HIV/AIDS tends to feature in the print media as a result of press releases, high-profile prevention activities, AIDS-related events, statements by the public authorities and other bodies, and the publication of research data (the "PR effect").**
- **The information published in the press is mainly factual in content.**

Recommandations

- **Given that the "PR" effect serves to attract media attention to the subject of HIV/AIDS, the various players involved need to remain active in keeping up contacts with journalists and supplying them with newsworthy information at every opportunity.**
- **As some prevention messages are emphasised more than others, ways need to be found of encouraging journalists to broaden their scope of interest and to treat the subject in greater depth.**
- **Study of the print media is essential for understanding how to exploit the prevention/press partnership to best advantage.**

19

HIV/AIDS prevention : results of the first ten years and future prospects

Results

What results have been achieved after more than 10 years of AIDS prevention in Switzerland ?

Firstly, if we take the three levels of intervention defined by the strategy, we can state that prevention has been successfully established, albeit unevenly, at each level :

- Where measures targeting the general population are concerned, the centrepiece of the strategy has been the STOP AIDS campaign. This has continued to remind people of the main themes of AIDS prevention and is still regarded as useful by the population as a whole.
- Prevention activities aimed at specific target groups have also flourished, often in the form of special programmes launched by the federal government (programmes for migrants, women, etc.), NGOs (homosexuals, male and female prostitutes, etc.), and the cantons (distribution of injection equipment to drug users, sex education etc.).
- The third level of the strategy – in-depth measures based on individual counselling[a] – has also developed, but more slowly. For example, we noted in 1995 that doctors had begun to include AIDS prevention as part of their practice. On the other hand, we pointed out that the quality of these interventions was not always as good as it might be, for example, in the field of counselling (with pregnant women, persons requesting an HIV test, persons with HIV, etc.). The effectiveness of the – voluntary – role played by professionals as multipliers of prevention messages in the context of their daily work (as carers, social workers, teachers, etc.) depends very much on the training they are given and their perception of the importance of their role in combating the epidemic.

If we now consider the **achievements of the prevention strategy,** it is possible to make the following observations :

- The incidence of new cases of infection has progressively decreased since the beginning of the decade ; there have been changes in the way that these are distributed among different population groups.
- Forms of preventive behaviour have been adopted in all the population groups under study, and levels of protection are high. In particular, there is no major prevention deficit in any of the main population groups. Moreover, social inequalities in relation to prevention are disappearing.
- However, prevention behaviour seems to have reached a ceiling. This is apparent among members of the general population over 35 and in the homosexual community. The phenomenon is difficult to interpret : have we just reached a plateau ? Is this a sign of indifference, a prelude to a decline in cautious behaviour due to a climate where AIDS is no longer of primary public concern ?
- These major changes in protective behaviour were not initially matched by corresponding changes in sexual activity. Only recently have we seen a tendency for young people to become sexually active at a later stage and to have fewer partners, and for people in general to be more cautious in forming new sexual relationships.
- Increasingly, prevention has also become a matter of individual management, with people adapting their preventive behaviour to the circumstances of their relationship, and according to their personal characteristics and preferences.
- Where drug use is concerned, making sterile injection equipment more readily available has considerably reduced the risk of HIV transmission, without a concomitant increase in the practice of injecting drugs. This also applies to drug use in prisons.

[a] See studies of the sexuality of people with HIV and institutional discrimination related to HIV.

- Institutional discrimination in relation to AIDS is uncommon, but stigmatising attitudes persist. There are still major problems associated with insurance, employment and, in the medical field, with confidentiality and the quality of information and counselling (HIV testing), though this is also true for other types of illness.

The importance of prevention and future prospects

Some aspects of the overall situation are still the same as when the epidemic began ; others have changed.

What has not (yet) changed

First of all, HIV/AIDS is still a major public health problem. The general population needs to be reminded of this, as do decision-makers. Although there has been a gradual decrease in new cases, people are still being infected (approximately 700 in 1998). The number of people living with HIV may even be increasing because of a decrease in the number of AIDS-related deaths. **In the long term, the human and material cost of HIV/AIDS will be considerable.** To this we need to add the danger that people who become infected at a late stage of the epidemic, "when everyone was supposed to be aware of the risks and take precautionary measures", may suffer stigmatisation.

Finally, it should be pointed out that the advent of new combined therapies does not diminish the need for **prevention, which remains the only effective way of combating the epidemic.** It is now more important than ever to maintain prevention activities in the long term.

What is now changing

The epidemiological situation is changing in some respects. Five aspects – widely discussed during the most recent International AIDS Conference – deserve our attention :

- the increasing complexity and diversity of individual prevention management ;
- the consequences of the advent of powerful anti-retroviral treatments ;
- changes in the social aspects of AIDS ;
- the complex phenomenon of "normalisation";
- the need for an on-going prevention strategy.

Individual prevention management : complexity and diversity

One of the successes of the prevention strategy is to have convinced most people that prevention is necessary, even in their own case.

However, there is evidence of a tendency to interpret/adapt the prevention messages in an individual way, in accordance with individual circumstances, with more or less successful results. The principle of "always with a condom" seems to be giving way to other practices : variable protective measures according to type of partner, couples discontinuing the use of condoms after being tested for HIV[b], etc. These practices may change over time, depending on life histories and the dynamics of the relationship. They may not be entirely adequate (couples discontinuing the use of condoms on the basis of an appraisal of risks run in the past, without first being tested), or totally inadequate (undergoing repeated testing without taking protective measures, for instance). The former strategy can at least be regarded as reducing the risk to some extent.

Given this situation, prevention messages need to be refined and differentiated[c]. For this reason, the quality of the counselling available is particularly important,

[b] In 1997, more than one third of the population aged 17-45 had been tested for HIV, more than one half if we include blood donors.

[c] For example, by being more aware of what approach is appropriate to the specific circumstances.

the purpose being to help each individual to choose the form of prevention that is safest and best suited to his/her situation. Only in this way is it possible to arrive at a protective strategy which is accepted and sustainable.

First of all, this means providing fresh information, geared to current realities. Careful thought also needs to be given to the way in which it is distributed. Very simple information can be disseminated by organising campaigns (e.g. the importance of continuing to take precautionary measures, the promotion of condoms). Other information is more specific, being addressed to particular groups, and requires a more targeted approach (e.g. issues of communication between partners, HIV-testing among homosexuals, or preventing the sexual transmission of HIV between drug users). Still more complex information is best provided through individual counselling (e.g. the advice appropriate to a couple who want to stop using condoms, the type of contraception appropriate during the early years of a young person's sexual career, the type of advice needed by couples who have different HIV status). It is essential that the channels used for disseminating information complement one another and be used appropriately for best results.

It may also be necessary to provide fresh information to the population as a whole. For example a brochure could be sent again to all households[d], giving an update of the situation in the light of new knowledge and explaining the possible pitfalls should the epidemic become perceived as banal.

One unforeseen consequence of the prevention strategy's success is the emergence of problems resulting from the massive use of condoms. Even though failure rates are low, more and more people are experiencing "accidents" when using this form of protection (breakages, etc.) [e] and are having to deal with them. We need to ensure that such incidents do not discourage people, causing them to give up using condoms, the effectiveness of which is not in question. Practical answers need to be found to these problems in several fields :

- the quality of condoms, the range of models available, instructions for use ;
- emergency contraception ;
- post-exposure prophylactics (PEP) in situations where there is a high risk of HIV being transmitted.

More generally, there is a need to improve the quality of counselling.

Consequences of the advent of powerful anti-retroviral therapies

The new anti-retroviral therapies have changed people's perception of the disease and could also change their perception about the need for prevention[f]. For instance, there is a general feeling among those who have heard of the new therapies that people are being less careful about protection. However, only a very small percentage of the people actually questioned about this said that they now protect themselves less. This is confirmed by trends in the incidence of protective behaviour, which, among the population groups covered by our surveys, has generally reached the highest levels recorded since the epidemic began. Nevertheless, we must ask ourselves whether this perceived relaxation of prevention might be a precursor to a real lapse which has not as yet been observed.

It is also possible that the combined therapies (and PEP) might in the long run have implications for the HIV antibody test. If it was definitely established that early treatment improved the chances of long-term survival, testing to detect HIV might be more generally advocated – though not, of course, imposed.

Finally, post-exposure prophylaxis (PEP) is an additional, albeit modest, weapon in the battle against infection, particularly for the partners of people with HIV and for care personnel.

[d] As in 1986, before the prevention strategy was launched.

[e] In 1997, one person in three had used condoms ii the previous 6 months. The breakage rate was 0,3 %, the slippage rate 0,6 %.

[f] It should be noted however that – in 1998 – the hope placed in these new therapies was increasingly moderated by the difficulties associated with the severity of the treatments and the appearance of serious side-effects.

Social inequalities in relation to HIV/AIDS ?

As is apparent from the unequal distribution of the epidemic throughout the world, AIDS has become a disease of poverty. In developing countries, the most disadvantaged and vulnerable groups are the most seriously affected, and the gap is widening. It is a familiar phenomenon where other infectious diseases are concerned.

In Switzerland, we find a social gradient of this kind in the case of unwanted pregnancies, with marginalised girls and migrant women more likely to be affected. Alcohol consumption and the use of tobacco also tend to be heaviest among the socially disadvantaged.

For the time being, however, there do not seem to be any real social inequalities in Switzerland where AIDS is concerned. Although there are some small differences in levels of protection between one social group and another, these are tending to disappear[9]. The growing uniformity of preventive behaviour could well be one of the most remarkable achievements of the prevention strategy. As an indication of some form of solidarity, this is in contrast to the tendency found in many other areas of prevention. This situation is certainly due in part to :

- the intensive media coverage given to HIV/AIDS ;
- the fact that the prevention messages have penetrated all social strata (equality of access and extensive coverage) ;
- the complementarity of the levels of prevention and the consistency of the messages disseminated ;
- community mobilisation and the creation of a social consensus as to the importance of prevention.

We need to monitor these developments by gathering adequate social statistics (as part of the monitoring system and in all the population surveys). It is vital to continue to investigate whether there are still groups which remain particularly vulnerable to the risk of contracting HIV or, worse, whose situation is deteriorating in relation to that of other groups. In situations of this kind, it may be that access to information and methods of prevention – which must be guaranteed to all – is not alone sufficient. It then becomes necessary to tackle the problem of the social environment, and the personal circumstances giving rise to the vulnerability. For this reason, it is important to gain a deeper insight into situations of group vulnerability (migrant workers living apart from their families, for instance) and individual vulnerability (people looking for a new partner, suffering from depression, living with HIV and fearing stigmatisation, etc.), and tackle them in an appropriate way.

Tackling the conditions which make groups or individuals vulnerable is nevertheless a long-term undertaking, beyond the scope of normal health promotion activities and AIDS-prevention work alone. It requires commitment at another level and with other partners. It represents an additional task, and should not replace any of the initiatives undertaken to date.

Normalisation : positive or negative implications ?[1]

The term “normalisation” is often used in describing the course of the epidemic. It can be understood in various ways. Taken to mean that the epidemic has become an everyday fact of life (normality, habit, quantitative change) it may have two possible consequences : indifference or integration. Used with reference to established rules and norms, it may have two further consequences : return to an earlier norm or acknowledgement and extension of a new norm (qualitative change).

Normalisation in the sense that the epidemic has become a fact of life. AIDS has become a fact of life ; people are less afraid of it ; they have got used to it. Less caution **(indifference)** could have negative consequences for prevention, as prevention might appear less important in the eyes of the general public (less need to take precautions) and politicians (less need to provide funding). This possibility needs to be taken very seriously as it threatens the credibility of prevention work and the continuance of existing programmes, and it could lead to indifference to the suffering of people affected by HIV/AIDS.

9 Of course, it is always possible that certain restricted sub-groups – not reached by our surveys or not identified by analysis – are in a more difficult situation where prevention is concerned.

But normalisation in this sense can also have a more positive consequence : **integration.** HIV is one of the diseases or problems against which people need to protect themselves in the long term. AIDS prevention needs to be integrated into on-going prevention activities and the training of the relevant professionals. This is what is happening with sex education and health education courses. It is also gradually happening in professional training in the fields of health, education and social work. Integration can also mean **relating the content of AIDS-prevention work to other areas,** for example combining the prevention of AIDS, STDs and unwanted pregnancies to achieve an integrated approach to sexual and reproductive health, combining the prevention of AIDS and hepatitis C in work with drug users (through teaching regarding the risk of these diseases being transmitted by exchanges of blood and sexual relations), or combining the prevention of AIDS and STD's in the case of homosexuals.

The fact that AIDS has become a fact of life also has consequences for the work of voluntary organisations. There has been a fall in the level of personal commitment to this particular "cause" (negative aspect), but it has been accompanied by the adoption of a more professional approach by voluntary bodies, thereby ensuring stability (positive aspect). For people living with HIV/AIDS, its acceptance as a fact of life can also have dual consequences : they are less likely to be rejected (the disease is less frightening), but also less likely to experience compassion and solidarity from people generally.

Whilst HIV/AIDS may appear to be becoming "banal", this is not in itself necessarily disturbing ; the importance is to be aware of what negative consequences this may give rise to. These must be overcome, in particular by a judicious allocation of resources. We shall deal with this later.

When **normalisation is considered in relation to established rules and norms,** the implication is that AIDS was an exceptional situation calling for exceptional measures. Right from the start, the struggle against AIDS departed from the"conventional" methods used to combat sexually transmissible diseases (systematic screening, contact tracing, etc.), in view of their technical and ethical limitations. It was also acknowledged that AIDS was a social as well as a medical problem. The struggle against AIDS could not therefore be simply a matter for (medical) specialists ; it required the widest possible participation of the communities concerned. **The issue here with normalisation is whether it means a return to an earlier norm or the adoption of a new norm.** The negative alternative would be a return to the conventional, old-fashioned pattern adopted in fighting against STDs. There is a real risk of this happening. There are signs of a degree of "re-medicalisation" of AIDS, and we have evidence of systematic screening being practised without informed consent (in the case of pregnant women, for example). On the other hand, the outcome of normalisation would be positive if what has become the norm were to remain so, and if the lessons learned from this experience were to be extended to other fields (adoption and extension of a new norm). For example, this would mean extending the advances made in the provision of care, such as actively involving those affected, giving more careful consideration to the issue of terminal care, providing support for individual patients by voluntary workers, etc.

This battle has not yet been won. Careful attention therefore needs to be paid to the many experiments which sprang up in the prevention and treatment of AIDS : to sort through the methods and approaches that were tried and concentrate resources on those which proved most effective.

The overall conclusion is that a degree of "normalisation" is inevitable, and is neither good nor bad in itself. It can lead in various directions, depending on the **choices** made by professionals, voluntary organisations, politicians and the general public.

Ensuring the sustainability of prevention activities and programmes

No one doubts the need to continue prevention work, but opinions differ on how this should be done and what funding is required. We have to avoid two closely related pitfalls :

- overconfidence that in the long term prevention will automatically become an integral part of people's way of life, and of professional and voluntary organisational practice ;
- too rapid a withdrawal of the considerable material and human resources that have made it possible to obtain initial results in the struggle against HIV/AIDS.

The experience gained from campaigns and programmes that have been run for more than ten years now provide some obvious guidelines.

For the population as a whole, clearly the campaigns no longer really contribute to the acquisition of knowledge. They serve rather as **reminders**[h]. They should be continued for a few more years, possibly in a less intensive way, to fulfil this important function. Similarly, continued contact with the media is important : journalists are useful in reflecting events related to HIV/AIDS.

It is essential to ensure that new generations **acquire – and stick to – appropriate preventive behaviour** when they become sexually active. In this area, the phenomenon of integration will be of vital importance. It is logical to expect that integration will result from professionals (sex education counsellors, teachers, social work professionals, doctors, etc.) being trained and taking responsibility for prevention as a new, routine aspect of their work. But this is not happening at present : the basic professional training does not really contain an element relating to AIDS prevention and the tasks that derive from it, and the knowledge acquired is not really being put into practice. Nor are these professionals yet ready to perform this long-term task, which is essential but not always easy to assume. It is therefore very important to **plug any gaps in training courses and establish a system to monitor the effective implementation of these measures and the quality of the services provided.**

This very "generalised" form of prevention will still require **more specific and concentrated inputs in relation to groups which are especially vulnerable** (drug users, homosexuals, male and female prostitutes, etc.) **or groups which are not especially vulnerable but which might have difficulty in accessing prevention facilities** (migrants). Experience shows that programmes which have progressed beyond the pilot stage and been recognised as useful, have certain characteristics in common : they tend to have a (national) centre which defines, supports and legitimises the movement (by organising nationwide activities, producing material, etc.), which co-ordinates and advises, and which has links with stable regional structures that provide local anchor points and independently gear their activities to the particular context. The fact that the two levels are complementary makes it possible to meet precise needs, ensures that both parties assume responsibility for the work, and results in greater creativity. It will require **dialogue and co-operation** to ensure the sustainability of these programmes.

In the medium term, the aim will be to maintain these programmes how and wherever necessary, possibly at differing degrees of intensity (e.g. more vigorously in large urban centres). The federal government, the cantons and the voluntary organisations (in particular the ASS) will have to get together to define needs, ensure that the programmes provide adequate cover, and define responsibilities – particularly as regards long-term funding – and the sharing of the work load, bearing in mind that larger centres often cover the needs of more peripheral regions.

[h] Advertising generally works on this "reminder" principal : companies do not stop promoting a product just because it is selling well.

General conclusions

- **Clearly, prevention activities continue to be visible, present and legitimate.**

- **The AIDS prevention strategy has achieved some lasting results. There has been no relapse in preventive behaviour, despite some changes in the way AIDS is viewed due to the recent successes in treatment. New infections continue to be on the decrease. However, the epidemic is still far from under control, and is spreading in other parts of the world.**

- **Despite differences in the way activities are organised at cantonal level, there does not seem to be any significant difference in preventive behaviour from one region to another, whatever group we take into consideration (general population, drug users, young people, homosexuals). The inequalities that have existed (between town and country, levels of educational attainment, etc.) are tending to disappear. Practices have become more uniform.**

- **The legitimacy of the federal government's initiatives in the field of HIV/AIDS is not questioned. There is even a demand (for information, co-ordination, co-funding) from the cantons and voluntary organisations. The available resources (information, equipment, training, etc.) are being used.**

- **It is generally agreed that prevention activities should be continued. Debate and concern are focused on how this can be done without jeopardising what has already been achieved. Continued funding and the integration of HIV/AIDS prevention into other related or routine activities are the main issues being considered.**

Recommandations

- **"If it ain't broke, don't fix it". There is no reason to change a policy which works ; better to eliminate its imperfections and adapt it to changing circumstances. The next challenge is "normalisation", to ensure that prevention activities continue in the future.**

- **In the medium term, the federal government may envisage a transition whereby AIDS prevention becomes a part of wider prevention concerns, but it must assure the population that :**
  - **it is monitoring the situation, has it under control, is proposing necessary adjustments[i] in conjunction with its national and cantonal partners and is supporting their involvement ;**
  - **it will not abandon a national HIV/AIDS programme until it is sure that all the necessary specific activities have been adopted as a matter of routine, at the appropriate levels, for all the population groups concerned, and covering all groups and areas fairly so as not to create inequalities (continuance of prevention activities for the general population and for specific groups).**

- **Solidarity should continue to be a major component of prevention strategy. It needs to be viewed in several ways :**
  - **Solidarity with persons with HIV/AIDS, as in the past ;**
  - **Solidarity with sick people generally, with a view to putting an end to the discrimination and dubious practices which still exist in the fields of employment, insurance and quality of care (confidentiality and informed consent) ;**
  - **Solidarity with countries that lack the resources to provide prevention facilities and treatment for their own population.**

[i] Leadership and responsibility conferred by the Law on Epidemics.

Appendix 1 of chapter 1

Previously published reports

Hausser D, Lehmann Ph, Gutzwiller F, Burnand B, Rickenbach M. *Evaluation de l'impact de la brochure tous ménages d'information sur le SIDA distribuée par l'OFSP (Evaluation of the impact of the AIDS information brochure distributed to all households by the FOPH). October 1986.* Lausanne University Institute of Social and Preventive Medicine, 1986. (Cah Rech Doc IUMSP, No. 7).

Hausser D, Lehmann Ph, Dubois-Arber F, Gutzwiller F. *Evaluation des campagnes de prévention contre le SIDA en Suisse (Evaluation of Swiss AIDS-prevention campaigns). December 1987.* Lausanne University Institute of Social and Preventive Medicine, 1987. (Cah Rech Doc IUMSP, No. 23).

Dubois-Arber F, Lehmann Ph, Hausser D, Gutzwiller F. *Evaluation des campagnes de prévention du SIDA en Suisse. Deuxième rapport de synthèse (Evaluation of Swiss AIDS-prevention campaigns. Second synthesis report). December 1988.* Lausanne University Institute of Social and Preventive Medicine, 1989. (Cah Rech Doc IUMSP, No. 39).

Hausser D, Zimmermann E, Dubois-Arber F, Paccaud F. *Evaluation de la stratégie de prévention du sida en Suisse, troisième rapport de synthèse, 1989-1990 (Evaluation of Swiss AIDS-prevention strategy, third synthesis report, 1989-1990).* Lausanne University Institute of Social and Preventive Medicine, 1990. (Cah Rech Doc IUMSP, No. 52).

Dubois-Arber F, Jeannin A, Meystre-Agustoni G, Gruet F, Paccaud F. *Evaluation de la stratégie de prévention du sida en Suisse sur mandat de l'Office fédéral de la santé publique. Quatrième rapport de synthèse 1991-1992 (Evaluation of Swiss AIDS-prevention strategy as commissioned by the Federal Office of Public Health. Fourth synthesis report 1991-1992).* Lausanne University Institute of Social and Preventive Medicine, 1993. (Cah Rech Doc IUMSP, No. 82).

Dubois-Arber F, Jeannin A, Meystre-Agustoni G, Moreau-Gruet F, Haour-Knipe M, Spencer B, Paccaud F. *Evaluation de la stratégie de prévention du sida en Suisse sur mandat de l'Office fédéral de la santé publique. Cinquième rapport de synthèse 1993-1995 (Evaluation of Swiss AIDS-prevention strategy as commissioned by the Federal Office of Public Health. Fifth synthesis report 1993-1995).* Lausanne University Institute of Social and Preventive Medicine, 1996 (Cah Rech Doc IUMSP, No. 120).

Appendix 2 of chapter 1

Schedule of evaluation studies (1987-1998), by type of study and phase of the evaluation programme

Annual monitoring or repeated studies using identical methods and indicators (trend measures)					
1987	**1988**	**1989-1990**	**1991-1992**	**1993-1995**	**1996-1998**
Behaviour, age 17-30	Behaviour, age 17-30	Behaviour, age 17-45	Behaviour, age 17-45	Behaviour, age 17-45	Behaviour, age 17-45
Condom market	Condom market	Condom market	Condom market	Condom market	Condom market
Media	Media	Media		Activity of low-threshold centres for drug users	Activity of low-threshold centres for drug users
MSM (behaviour)		MSM (behaviour)	MSM (behaviour)	MSM (behaviour)	MSM (behaviour)
				Drug users (behaviour)	Drug users (behaviour)
Apprentices	Sex education	Apprentices	Sex education		
		Parental prevention activity*	Parental prevention activity*		
		Foreign sutdents	Foreign sutdents		
		Doctors (quantitative)		Doctors (quantitative)	
		Solidarity*		Solidarity*	
			HIV testing*	HIV testing*	HIV testing*
		Image of condoms*	Image of condoms *	Image of condoms*	
		"Sex tourists"*			"Sex tourists"
				Condom failure*	Condom failure*
		AIDS prevention at the doctor's surgery from patients'viewpoint*	AIDS prevention at the doctor's surgery from patients'viewpoint*		
Series of studies on the same topic but with different approaches					
1987	**1988**	**1989-1990**	**1991-1992**	**1993-1995**	**1996-1998**
STOP AIDS campaign	STOP AIDS campaign	STOP AIDS campaign	STOP AIDS campaign	STOP AIDS campaign	STOP AIDS campaign
	School programmes	School programmes	School programmes		
Drug users		Drug users	Drug users		
	Prevention programmes for drug users	Prevention programmes for drug users	Prevention programmes for drug users	Prevention programmes for drug users	Prevention programmes for drug users
Cantonal policies	Cantonal policies				Cantonal policies**
	Migrants	Migrants	Migrants	Migrants	
		Prevention in prisons**			Prevention in prisons
	Training of non-hospital staff and volunteers			Training of non-hospital staff and volunteers	
	Hospital staff (attitudes)			Hospital staff (occupational risk)	
Complementary, one-off studies					
1987	**1988**	**1989-1990**	**1991-1992**	**1993-1995**	**1996-1998**
Womanisers	Marginal groups of young people	Parents	Medical students	Foreign prostitutes	Women programme
Doctors'patients "Sentinel" programme	Educators and social workers		Campaigns aimed at prostitutes'clients		MSM new programme
Opinion leaders	Military recruits		Campaign aimed at parents	Adolescents : sexual initiation and gender differences as regards sexuality (secondary analyses)	Sexuality of PLWHAs
	Representations of sexuality		Heterosexual adults		Mediators
"Sex tourists"**	Doctors (qualitative)		Prostitutes'clients		AIDS-prevention project in the travel industry **
	HIV test centres				Institutional Discrimination
	Feedback				HIV/AIDS as presented by the press**

* module included in the behavioural survey of 17-45 year olds

** studies mandated by the FOPH, conducted by other institutions outside the evaluation programme

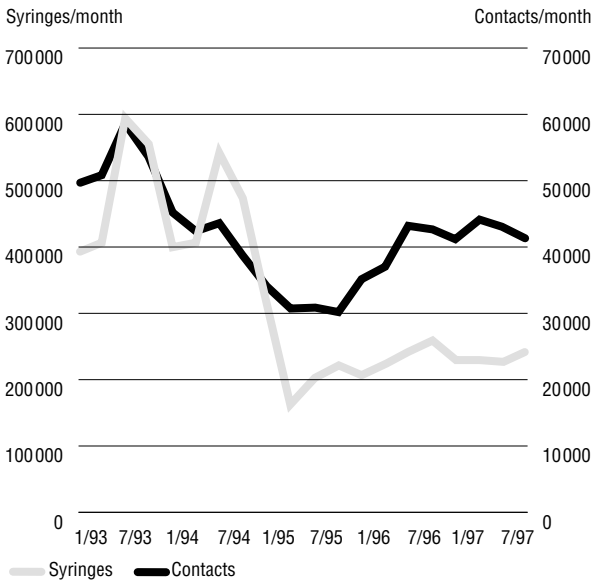
Appendix 3 of chapter 1
Methods used in the various studies

Study	Coverage*	Collective	n	Methods
General population aged 17-45	Switzerland	Random sample	2800	Telephone questionnaire consisting of a basic module (attitudes and behaviour, HIV test, solidarity) and special modules
				Risk management
				Sex tourism
				New treatments
Condom sales	Switzerland	Market		Sales information from major distributors
Homo/bisexuals	Switzerland	Volunteers	1097	Questionnaire distributed by the gay press and gay associations, with modules on
				Risk management
				New treatments
				Solidarity/discrimination interview
Homosexual couples[a]	GS, FS	Volunteers	32	Interviews
			48	FAST projective test (indiv. and couple)
Drug users, clients of low-threshold facilities	Switzerland	Volunteers	2970	Partly self-administered questionnaire
Women's action programme I	Switzerland	FOPH, programme managers	12	Interviews Analysis of documents
Women's action programme II	Switzerland	Programme managers and partners, decision-makers	20	Interviews Analysis of documents
MSM I	Switzerland	Programme managers and "outreach workers (ORWs)"	25	Interviews Analysis of documents
MSM II	Switzerland	Programme managers and partners, ORWs	40	Interviews Analysis of documents
Risk-reduction programmes for drug users	Switzerland	Existing programmes	Approx. 20	Monthly report on activities and syringe distribution
Sale of syringes in pharmacies	Switzerland	Volunteers	**61-73 %	Estimate of number sold over last three months of year
AIDS prevention in prison	Switzerland and abroad	Documents		Review of existing data
Mediators	Switzerland	Existing programmes	31	Interviews Review of the literature
PAMiR programme	GS	Travel industry professionals	25	Interviews
			114	Questionnaires
Sexuality of persons living with HIV/AIDS	GS, FS	Literature		Review of the literature
		Persons working in the AIDS field	19	Interviews
		Person living with HIV/AIDS	25	Interviews
Discrimination	Cantons VD, GE	Informants	> 200	Interviews and analysis of documents
		Persons living with HIV/AIDS	31	Interviews
Cantonal policies[b]	Switzerland	5 cantons/regional entities		Consultation procedure
				Seminars
The press	Switzerland	Sample of articles published 1.1.87 - 31.10.96	1168	Content analysis

* FS : French-speaking region, GS German-speaking region, IS Italian-speaking region.
** Participation rate
[a] Study conducted separately from the evaluation programme, funded by the AIDS Monitoring and Research Committee
[b] Studies mandated by the FOPH, conducted by other institutions outside the evaluation programme

Appendix 1 of chapter 3

Distribution of syringes and number of contacts made in LTFs in Switzerland, 1993-1997*



* Number of LTFs: 1993: N = 28, 1994: N = 23, 1995: N = 23, 1996: N = 24, 1997: N = 25.

Appendix 2 of chapter 3

Perception of the usefulness of an injection room

Injection rooms were seen by the care workers and drug users concerned as having positive aspects and yet also as raising issues which need to be resolved.

Opinion of the management and care workers :	
Positive aspects	**Issues to be resolved**
Drug use accepted within the injection facility	Drug use at odds with standards of outside world (society, the law)
Improved conditions for injecting : hygiene, sterile equipment, tranquillity, less stress, more human environment	Conditions unsuitable for injecting at times when LTF not open
	Need to wait at busy times
Medical supervision (safety, first aid facilities available)	Used to test the quality of the substance or the dosage
Disposal of used equipment	Encouragement to collect filters
Preventive/educational messages appropriate to observed risks given direct to target group at time of injection	Preventive/educational messages already known to users, refusal to accept advice from non-users, difficulties in changing habits
Place to relax, café facilities	Concentration of users around injection room
Users less visible in town	Concentration of users in one street or district
Opinion of clients :	
Positive aspects	**Issues to be resolved**
Safety when injecting : hygienic conditions, tranquillity (undisturbed by police), supervision, first aid available	(No negative aspects)
Certainty of finding desired drug : less stress, fewer problems with police	Easy access can influence frequency of drug use
Some clients : better control of drug use	Some clients : poorer control of drug use
Reduced drug use	Increased drug use
Small amounts of drugs sold to users on the premises	Drug dealing raises political questions about the existence of LTFs

Appendix of chapter 4

Experience of imprisonment in LTF attenders in Switzerland : 1993 to 1996

	1993 N = 1119	1994 N = 907	1996 N = 764
Imprisonment during lifetime			
% already imprisoned at some time in past	68 % N = 716	60 % N = 458	68 % N = 640
Average number of months spent in prison	12	14	
% having spent less than one month in prison	27 %	22 %	
Imprisoned during the previous two years (1995-1996)			
% having spent time in prison during previous two years (95-96)			36 % N = 333
Average number of months spent in prison			4
% having spent less than one month in prison			30 %

Use and sharing of injection equipment Clients of low-threshold facilities in Switzerland : 1994, 1996

Question in 1994 : During most recent stay in prison … **Question in 1996 : During the last two years (1995-1996), in prison …**			**1994** N = 458	**1996** N = 333
% having injected drugs			26 %	27 %
Once			4 %	5 %
Several times			22 %	23 %
Syringe sharing in prison ref. Injecting drug users having spent time in prison	1994 N = 415	1996 N = 299	8 %	6 %
Syringe sharing in prison ref. Injecting drug users having injected in prison	1994 N = 109	1996 N = 83	28 %	20 %
Single sharing of syringe in prison (once only) ref. injecting drug users having injected once in prison	1994 N = 17	1996 N = 14	18 %	14 %
Syringe sharing in prison ref. Injecting drug users having injected several times in prison	1994 N = 92	1996 N = 69	30 %	22 %
Single sharing of syringe in prison (once only) ref. injecting drug users having injected several times in prison	1994 N = 92	1996 N = 69	6 %	9 %
Multiple syringe sharing in prison (several times) ref. injecting drug users having injected several times in prison	1994 N = 92	1996 N = 69	24 %	13 %

Appendix of chapter 5

Activities of the "Women's Health – HIV/AIDS Prevention" action programme 1/4

	Code	Output	Language	Distribution channels Number of copies printed Number of people reached	Coverage	Funding from the Programme itself	External funding
Materials	**M-1**	Brochure: 6 questions		Zurich trams, medical reviews, doctors'surgeries, paramedical organisations, AIDS Info Docu	National	5 800.–	10 000.– (Federal Printing and Supplies Office)
				1st print run 2nd print run			
			German	50 000 50 000			
			French	30 000 30 000			
			Italian	10 000 10 000 (first print run used up after 10 months)			
	M-2	Brochure: "OK Ragazze" "Ho les filles"		Schools, parents, peers and sex education counsellors, family planning consultations, gynaecologists, paediatricians, AIDS groups, pharmacies	National	50 000.–	
			Italian	10 000 + 6 000			
			French	15 000			
	M-3	"Kit" project phase I		Gynaecologists, pharmacies, counsellors	National	70 000.–	80 000.– (FSPS)
			German French	150 000			
		"Kit" project phase II				182 000.–	Several sources[a]
	M-4	Film production	German	Schools	National	10 000.–	Total: 47 000.– (schools and FOPH health projects)
	M-5	Brochure for lesbian and bisexual women		(Beginning 7.98) lesbian organisations, events, counsellors	National	38 100.–	Residual funding of approx. 30 000.– still to be found
			German	8 000			
			French	4 000			
			Italian	2 000 (if sponsors can be found)			
	M-6	Radio programmes		Saturday mornings, Wednesday evenings (for girls) and afternoons	Ticino	Staff salaries	
			Italian	15 programmes			
	M-7	Inventory of resources relating to issues of women's sexual health			National	Staff salaries	
	M-8	Health brochure for trainees	German	Schools 25 000		Staff salaries	
	M-9	"Prävo" (Edel) prevention brochure	German	Schools 40 000		Staff salaries	
	M-10	Consensus: contraception and HIV/AIDS prevention	German French Italian	Specialised journals (forthcoming), Swiss Med. Ass. gynaecologists (40), conferences: Swiss Assn. Child Psychology (9.97, 30), Family Planning (10.97, 40), social aspects of AIDS in Europe (1.98, 100)	National	Staff salaries	Staff partly funded under a mandate from Swiss Nat. Science Foundation, consultations by experts given free of charge

[a] Fondation Suisse pour la Promotion de la Santé (80 000), Horten-Stiftung (30 000), ASS (25 000), PTT (30 000), Solothurn Canton (7 000), Aargau Canton (10 000).

Activities of the "Women's Health – HIV/AIDS Prevention" action programme 2/4

	Code	Output	Language	Distribution channels Number of copies printed Number of people reached	Coverage	Funding from the Programme itself	External funding
Projects	**P-1**	"FrauenOASE" – shelter for women from drugs scene	German	114 (1995 and 1996)	Basle City	30 000.–	Total : 145 800.– (FOPH)
	P-2	"Entrelaçar" – Pilot project for Portuguese women • In-house evaluation	Portu-guese	850	Vaud	20 000.– 2 000.–	Initial funding by FOPH Migrants Project, balance covered from local sources
	P-3	"Close to risk" girls	French	500 women and girls	French - spea - king Switzerland	22 000.–	
	P-4	St. Gallen "Women and AIDS" (for women in a rural setting) • Evaluation	German	Women's centre information bulletin, prevention information mailshot, articles in the local press, indirectly : 3 000 Information, meetings and courses Directly : 220	Canton of St. Gallen	48 000.– 24 000.– 16 800.–	10 000.– Canton of St. Gallen
	P-5	Mediators, Drug users	Italian	Courses for 4 women given by 2 professional mediators Also training of mediators by social workers	Bellinzona	7 500.–	
	P-6	"Girls and Health" youth centres	German	50	Basle City	3 600.–	500.– (local funding)
	P-7	Youth centres, drama and discussion	German	18 performances followed by discussion 130 girls	German - spea - king Switzerland	10 700.–	7 300.– (local funding)
	P-8	Youth centres, in-service training of leaders	German	20 sessions (11 for women, 9 for men) 170 (45 men)	Basle Country	12 000.–	13 000.– (local funding)
	P-9	Discussions with parents	Italian	Approx. 20	Lugano region	800.–	
	P-11	Contact with au pair girls	Italian	23 au pair girls in 2 sessions	Lugano, Ascona	2 400.–	
	P-12	Health course for Turkish women	Turkish	29	Winterthur	4 300.–	1 200.–
Training	**WB-1**	Information and net - working for women working in the AIDS and sexual health fields	French	74 in 3 sessions The professionals trained during these sessions now pass on their knowledge to their clients and pupils	French-spea - king Switzerland	13 600.–	2 250.– (local funding)
	WB-2	Courses for mediators (women and men) Development	German	Approx. 60 in 4 courses	German-spea - king Switzerland	13 000.–	
		Block course				32 000.–	Approx. 24 000.– to be found
	WB-3	Training of mediators, drug users	German	4 trained mediators 50 drug users	St. Gallen Town	8 000.–	

Activities of the "Women's Health – HIV/AIDS Prevention" action programme 3/4

	Code	Output	Language	Distribution channels Number of copies printed Number of people reached	Coverage	Funding from the Programme itself	External funding
	WB-4	Training of mediators, health professionals:	Italian		Ticino	2100.–	
	a	Voluntary workers, women's centres		37 (2 centres)		A percentage of the total	
	b	Student nurses		48		A percentage of the total	
	c	Counsellors, La Leche Ligue		20		A percentage of the total	
	d	Voluntary workers, hospital staff		15		A percentage of the total	
	e	Care assistants		8		Staff salaries	
	f	Voluntary workers, association		12		A percentage of the total	
	WB-5	Feedback sessions for professionals in sexual health,	French	30	National		
			German	0			
		ASPFES, Phase I				61900.–	
		ASPFES, Phase II				80000.–	
	WB-6	Workshops, social workers and youth leaders	German	52	Zurich Canton	12200.–	10800.– (local funding)
	WB-7	Meetings of experts: contraception and HIV prevention for young women		20-25	National	Staff salaries	
	WB-8	Meeting devoted to specific research of this kind		42	National	1700.–	Enrolment fees paid by participants
Research	**F-1**	Health and young adults aged 20, secondary analysis			National	30000.–	
	F-2	Differences in the spread of HIV according to sex, secondary analysis			National	20000.–	
	F-3	Adolescents, contraception and condoms, secondary analysis and study of the available literature			National	22500.–	
	F-4	Evaluation of needs and feasibility: "Kit" project			ZG AG FR GE	30000.–	

Activities of the "Women's Health – HIV/AIDS Prevention" action programme 4/4

	Code	Output	Language	Distribution channels Number of copies printed Number of people reached	Coverage	Funding from the Programme itself	External funding
	F-5	Evaluation of needs and available information : brochure for lesbians and bisexuals			French and German-speaking Switzerland	9 000.–	
	F-6	Evaluation of needs and feasibility : available information relating to sexual health				Staff salaries	
Public relations	**PR-1**	Press conference (8.11.1995) & information	German French Italian	280 invitations with press kit 8 journalists present 50 articles published	National	8 000.–	
	PR-2	Information brochure about the programme		Mailshot to professionals (address list as per M7)	National	12 100.–	
			German	2 000			
			French	1 200			
			Italian	750			
	PR-3	Workshop for health professionals : "Women and Health – from theory to practice"	German	1 830 invitations + advertisements in the FOPH Bulletin 36 (1 journalist)	German-speaking Switzerland	14 700.–	
	PR-4	Information events for women, general population	Italian	70	Bellinzona	Staff salaries	
	PR-5	Information about the programme via the media				16 000.–	
	PR-6	Information stand, hospital open days	German	20 000 visitors, stand well attended	Basle City	100.–	
	PR-7	Publications in specialised reviews			International	Staff salaries	
	PR-8a	Reports : national conferences			National	Staff salaries	
	PR-8b	Reports : international conferences			International	Staff salaries	
	PR-9	Information stand, care staff conference		1 200 participants (mostly nurses)	National	500.–	
			German	700			
			French	400			
			Italian	100			
	PR-10	Concept of public relations			National	6000.–	
	PR-11	Brochure describing the programme	German	3 500	National	Staff salaries	
			French	1 500			
			Italian	350			

Appendix 1 of chapter 8
Principal Swiss projects involving mediators

	Organisation responsible	Target population
Projects targeting a whole population		
Men who have sex with other men (HSH): AIDS prevention	Swiss AIDS Federation	Men who have sex with other men (national level)
Migrants Project: AIDS prevention, then prevention of AIDS and of substance abuse	Federal Office of Public Health (FOPH)	Communities in Switzerland:
		Spanish
		Portuguese
		Turkish
		Italian
		Albanian-speaking
Parks Project: AIDS prevention	Migrants Project and Geneva AIDS Group	Spanish-speaking Latin-American women living in Geneva
Entrelaçar: sexual health, then health promotion	FOPH Migrants Project, FOPH Women's Programme, canton of Vaud	Portuguese women, canton of Vaud
Appartenances	Association	Mediator training, cultural interpretation
Projects targeting a very specific group		
MEDIA Project: AIDS prevention, low-risk injection	Aids-Hilfe St. Gallen, then private organisation	Concept which could be applied to all target groups, offered to individual workers and organisations who might wish to adopt it. The mediator approaches the target population with the offer of a "gift" (a box containing articles useful for prevention, information, toiletries, etc.). Individuals approached fill in a questionnaire which enables the mediator to establish how well the person understands AIDS prevention, and to gear the prevention message to the individual's needs.
Pilot projects at St. Gallen:	IGL Verein Lebensfreude	Former drug users
	PROVE, responsible for the Programme in St. Gallen	Persons taking part in heroin distribution programme
	ISPM BASEL, "Hilfe für Drogenabhängige" Foundation	Women on methadone
Saxerriet prison project	Saxerriet prison	Prisoners, St. Gallen
Bostadel prison project	AIDS-Hilfe Zug, FOPH Migrants project	Prisoners, Zug
Other projects with drug users		
Overdose	Drop-In, Bienne	Drug users (Training in first aid)
Donne a confronto	Antenna Icaro, Bellinzona	Women drug users

	Organisation responsible	Target group
Projects targeting prostitution		
Barfüsserfrauen in the cantons of: Geneva, Ticino, Vaud, Basle, St. Gallen, Berne, Zurich, Graubünden, Aargau, Solothurn, Lucerne, and in Winterthur	Swiss AIDS Federation, Zurich	Migrant sex workers. The women are usually invited to listen to a cassette providing information, and are given condoms and information relevant to their situation (addresses of centres providing advice and assistance, etc.). They sometimes fill in a questionnaire on first contact.
Boulevards	ASPASIE, Geneva AIDS Group	Bus offering shelter and information to female sex workers and drug users
Male sex workers (MSW) Zurich, Basle, Berne, Geneva	Swiss AIDS Federation	Male sex workers
"Multiplier" Projects[a]		
Women's Programme: Training mediators, Ticino	Women's Programme	Training course for social workers in women's hostels, home helps, nurses, La Leche Ligue counsellors, voluntary workers in the field of public health
Einfach schwierig	Swiss AIDS Federation, Zurich AIDS-Infostelle Winterthur	Training course for educators and specialists working with young people
PAMiR	Institute of Social and Preventive Medicine, Berne	Training for guides and other people working in the tourism industry

[a] Projects which inform or increase the awareness of persons in professional contact with people potentially at risk

Appendix 2 of chapter 8

Types of project involving mediators

Target of the intervention	Whole population	Specific group, marginalised or difficult to reach			
Type	**A**	**B1**	**B1**	**B1**	**B2**
Mediator's link with target group	*From the same background*	*From the same background*	*From the same background*	*From the same background*	*Not from the same background*
Nature of the project	Strongly structured	Strongly structured	Strongly structured	Weakly structured	Strongly structured
	Goal orientated	Goal orientated	Goal orientated	Means orientated (marketing)	Goal orientated
	Top-down	Top-down	Top-down		Top-down
	Long-term	Long-term	Long-term	Short-term	Long-term
	Community expected to participate	Participation not expected	Participation not expected	Means offered/ requested by prevention professionals or voluntary organisations	Community expected to participate
Role of mediator	Diverse : from co-ordination of regional activities (permanent paid post) to different kinds of voluntary work (distribution of materials, manning a stand, courses, etc.)	Peer education	To legitimise work among mediator's peers/form a link between the local programme manager and the target population	To educate peers by approaching them with a "prevention kit"	To approach a specific population to which the mediator does not belong but with which he/she has something in common
Position when working in the field	Alone or accompanied, depending on function being performed	Alone (may be accompanied by a supervisor from time to time)	Not alone	Alone (may be accompanied by a supervisor from time to time)	Alone (may be accompanied by a supervisor from time to time)
Swiss projects belonging to this category	• Migrants • Men who have sex with other men (HSH)	• Barfüsserfrauen in German-speaking Switzerland • Prison project at St. Gallen • Male sex workers (MSW)	• Barfüsserfrauen Lausanne (introduces the co-ordinator to the sex workers) • Boulevard GE (goes out in the area around the bus, legitimises this activity in the eyes of other sex workers)	• MEDIA	• Barfüsserfrauen Ticino, Geneva (point in common : language/culture) • Male sex workers (MSW) (point in common with target group and clients : men who have sex with other men)
Special cases	**Training professionals** to become **multipliers of prevention messages among their clients** • PAMiR (tourists) • Social work professionals (women)		• Fleur de pavé Lausanne, bus **jointly managed** by sex workers and social workers. The mediator does not go outside the bus, but legitimises the work in the eyes of other sex workers.		**Training members of the target groups** to become **role models for their peers** • Bienne, Drop-in for drug users : action to take in the event of an overdose

Appendix of chapter 9

Proportions (%) of condom users having experienced condom tearing or slippage during the previous six months

	Tearing			Slippage			Never any problem
	0	1	2 or more	0	1	2 or more	
1994 n = 794	94 ± 2	4 ± 1	2 ± 1	90 ± 2	5 ± 1	5 ± 1	86 ± 2
1997 n = 799	90 ± 2	7 ± 2	4 ± 1	88 ± 2	7 ± 2	5 ± 2	82 ± 3

Appendix of chapter 10

Distribution (%) of total number of lifetime partners among 17-20 year olds. General population surveys

Total number of partners	Jan. 87 n=344	Oct. 87 n=353	Oct. 88 n=353	Oct. 89 n=428	Oct. 90 n=422	Oct. 91 n=484	Oct. 92 n=492	Oct. 94 n=328	Oct. 97 n=331
None	34±5	32±5	32±5	32±4	32±4	30±4	35±4	34±5	35±5
1 partner	20±4	22±4	23±4	30±4	26±4	25±4	24±4	27±5	24±5
2 partners	10±3	11±3	13±3	10±3	10±3	14±3	11±3	14±4	16±4
3 or more partners	33±5	26±5	31±5	26±4	25±4	27±4	29±4	25±5	24±5
No reply	3	9	1	2	7	4	1	0	0

Indicators (%) of potential risk of infection with HIV and protective behaviour among 17-20 year olds. General population surveys

	Jan. 87 n=344	Oct. 87 n=353	Oct. 88 n=353	Oct. 89 n=428	Oct. 90 n=422	Oct. 91 n=484	Oct. 92 n=492	Oct. 94 n=328	Oct. 97 n=331
New steady partner*			27±5	22±4	28±4	21±4	22±4	22±5	17±4
Using condoms with new steady partner, at least at first			42±10	47±10	58±9	60±10	75±8	59±11	69±12
1 or more casual partners**	17±4	15±4	17±4	14±3	9±3	16±3	15±3	12±4	9±3
Using condoms with casual partners									
Always	16±9	20±11	51±13	53±13	73±14	58±11	69±11	69±15	85±13
Sometimes	41±13	57±13	43±13	23±11	16±12	18±9	20±9	19±12	11±11
Never	44±13	23±11	7±6	25±11	11±10	24±10	11±7	23±13	4±17
Respondents who were sexually active	65±5	65±5	71±5	67±5	65±5	69±4	64±4	66±5	65±5
Sexually active respondents who used a condom for most recent sexual contact						47±5	51±6	56±7	61±7
Respondents who had undergone HIV test							11±3	12±4	15±4

* During the year

** During the previous 6 months

Appendix of chapter 12

Syringe sharing and HIV antibody tests – reported or measured – among different populations of drug users : 1989-1997

Place	Year	N	Average age	% sharing 6 months	% tested	VIH +
Low-threshold facilities (LTF)						
Zurich[1]	1989	106	27.4	13	82	24
Geneva[2]	1992	99	25*	44	89	17
Switzerland[3] (whole sample)	1993	1119	26.6	17	88	10
Switzerland[4] (whole sample)	1994	907	27.8	9	91	8
Switzerland[5] (whole sample)	1996	944	29.0	11	93	11
Outpatient treatment						
Switzerland,[6] SAMBAD statistics	1989	449	25		79	15
Switzerland, SAMBAD statistics	1996	690	26-27*	6	84	13
Switzerland, SAMBAD statistics	1997	412			89	10
Switzerland, PROVE programme (heroin)	93-96	1035	30.8			16
Residential treatment						
Zurich[7]	1990	205	23-25*			21
Zurich[8] (ambulatoire et résidentiel)	1991	340	26.1	4		
Zurich[9]	1993	293	23-25*			< 10
Switzerland, FOS statistics	1997	629	25.5			5
Hidden population						
Switzerland[10]	1994	165	28*	11	85	13

* Median age (woman-man)

Biographical references

1
Introduction

1 Dubois-Arber F, Jeannin A, Spencer B. *Long term global evaluation of a national AIDS prevention strategy : the case of Switzerland* (forthcoming).

2
The STOP AIDS campaign

1 *"Bericht zur Evaluation der 1997er STOP AIDS-Kampagne" (Report on the evaluation of the 1997 STOP AIDS campaign).* Zurich : RGS Motiv- und Marktanalyse GmbH ; 1997.

3
Reducing the risks associated with HIV/AIDS in the field of drug use

1 Uchtenhagen A. *Harm reduction : The case of Switzerland.* Eur Addict Res 1995 ; 1 : 86-91.
2 *Du travail et un logement pour les personnes évoluant dans le monde des drogues illégales : le nouveau manuel pour la mise sur pied de centres d'aide à la survie (Work and housing for people living in the world of illegal drugs : a new manual for setting up survival centres).* Zurich : Œuvre Suisse d'Entraide Ouvrière (OSEO) ; 1997.
3 Benninghoff F, Gervasoni J-P, Dubois-Arber F. *Monitoring des activités des structures à bas seuil d'accès pour les consommateurs de drogues en Suisse : remise de matériel d'injection stérile, résultats pour 1993 et quelques résultats cantonaux (Monitoring the activities of low-threshold facilities for drug users in Switzerland : distribution of sterile injection equipment, results for 1993 and some cantonal results).* Soz Praeventivmed, 1996 ; 41 (Suppl 1) : 5-14.
4 *IPSO Sozialforschung. Studie zur Spritzenabgabe durch Apotheken (Study of syringe dispensing inof syringes by pharnacies).* Dübendorf : IPSO ; 1995.
5 Chollet-Bornand A, Gervasoni J-P, Dubois-Arber F. *Enquête nationale des pharmacies (National survey of pharmacies) 1997.* Lausanne : University Institute of Social and Preventive Medicine (forthcoming).
6 Dobler-Mikola A, Schaaf S. *Spritzenautomaten : Zusammenstellung der Eckwerte (Vending machines for syringes : summary for key figures).* Zurich : Institut für Suchtforschung ; 1996.
7 Benninghoff F. *Monitoring des structures à bas seuil d'accès mettant à disposition du matériel d'injection stérile en Suisse (Monitoring low-threshold facilities distributing sterile injection equipment in Switzerland) 1993-1997.* Lausanne : University Institute of Social and Preventive Medicine ; 1998.
8 *Update : Syringe Exchange Programmes United States 1997,* MMWR, Vol. 47, No. 31, August 14, 1998.
9 Noël L, Parent R, Tremblay J, Coutier R. *Monitorage des clientèles des services des programmes de prévention du VIH chez les utilisateurs de drogues par injection au Québec (Monitoring the clients of HIV-prevention programme services for injecting drug users in Quebec).* Quebec : Quebec Public Health Centre ; 1998
10 Fahrenkrug H, Rehm J, Müller R, Klingemann H, Linder R. *Drogues illégales en Suisse (Illegal drugs in Switzerland) 1990-1993.* Zurich : Seismo ; 1995.
11 Lurie P, Gorsky R, Jones TS, Shomphe L. *An economic analysis of needle exchange and pharmacy-based programmes to increase sterile syringe availability for injection drug users.* J Acquir Immune Defic Syndr Hum Retrovirol 1998 ; 18 (Supp 1) : 126-32.
12 Rémis R, Leclerc P, Vandal A. *La situation du sida et de l'infection au VIH au Québec (The situation regarding AIDS and HIV infection in Quebec), 1996.* Montreal : Montreal Public Health Directorate – Centre for the Quebec Ministry of Health and Social Services ; 1998.
13 Geense R. *Evaluation of the federal measures to reduce the problems related to drug use. To have or to have not : that's the question. A qualitative study on four low threshold needle exchange services for drug users in Switzerland.* Lausanne : University Institute of Social and Preventive Medicine 1997 (Cah Rech Doc IUMSP, No. 111.11).

4
HIV/AIDS prevention in prisons

1 Hausser D. *Prévention de la transmission du VIH dans les prisons suisses. Analyse secondaire sur la base de la littérature disponible (Prevention of HIV transmission in Swiss prisons. Secondary analysis based on the available literature).* Lausanne University Institute of Social and Preventive Medicine (Raisons de Santé, forthcoming).

2 Federal Office of Public Health. *Prévention du VIH en Suisse : buts, stratégies, mesures (HIV prevention in Switzerland : aims, strategies, measures).* Berne : Federal Office of Public Health, Federal Committee for AIDS-related Problems ; 1993.

5
The "women's health – HIV/AIDS prevention" action programme 1994-1998

1 Federal Office of Public Health. *Prévention du VIH en Suisse : buts, stratégies, mesures (AIDS prevention in Switzerland : aims, strategies, measures).* Berne : Federal Office of Public Health ; Federal Committee for AIDS-related Problems, 1993 : 117-30.

2 Schmid M, Twisselmann W, Conzelmann C, Zemp E. *La santé des femmes – prévention du sida : informations sur le programme d'action du l'Office fédéral de la santé publique 1994 à 1997 (Women's health – AIDS prevention : information about the FOPH's action programme).* Berne : Federal Office of Public Health ; 1994.

3 Haour-Knipe M, Ernst M-L, Spencer B. *Rapid evaluation of an AIDS prevention programme for women. Lausanne University Institute of Social and Preventive Medicine ;* 1996. (Unpublished).

4 Ernst M-L, Haour-Knipe M, Spencer B. *"Gesundheit von Frauen Schwerpunkt HIV Prävention" Aktionsprogramm 1994-1997 : Evaluationsbericht (The "Women's Health – AIDS Prevention" Action Programme : Evaluation Report).* Lausanne ; University Institute of Social and Preventive Medicine, 1999.

5 Schmid M, Twisselman W, Jacquat BJ, Ledergerber B, Battegay M, Egger M. Geschlechtsunterschiede im Krankheitsverlauf : *Analyse der Schweizerischen HIV-Kohortenstudie (Gender differences in disease progression : analysis of the Swiss HIV cohort study).* Schweiz Med Wochenschr 1996 ; 126 : 2234-36.

6
The MSM programme ("Men who have having Sex with Men")

1 Landert C. *Das Projekt "Men having sex with men (MSM)" der Aids-Hilfe Schweiz (the "Men having sex with men (MSM)" project of Aide Suisse contre le sida) : Evaluation of Phase I.* Lausanne : University Institute of Social and Preventive Medicine, 1998. (Unpublished).

2 Thomas R, Dubois-Arber F. *Le projet HSH de l'Aide Suisse contre le sida (the MSM project of Aide Suisse contre le sida) : Evaluation of Phase II.* Lausanne : University Institute of Social and Preventive Medicine, 1999. (Forthcoming).

7
The PAMiR aids-prevention project in the travel industry

1 Page J, Gehring TM. *Evaluation PAMiR. Auswertung einer Schulung zur Ausbildung von Berufs-leuten in der Reisebranche als MediatorInnen in der HIV-Prävention : Schlussbericht (Evaluation of a course to train travel professionals as mediators in AIDS prevention : final report).* Zurich : University Institute of Social and Preventive Medicine ; 1998.

8
Working with "mediators" in AIDS prevention

1 Haour-Knipe M, Meystre-Agustoni G, Kessler D, Dubois-Arber F. *"Médiateurs" et prévention du VIH/sida ("Mediators" and HIV/AIDS prevention).* Lausanne : University Institute of Social and Preventive Medicine ; 1999. (Raisons de Santé, forthcoming).

9
The general population

1 Dubois-Arber F, Jeannin A, Konings E, Paccaud F. *Increased condom use without other major changes in sexual behavior among the general population in Switzerland.* Am J Public Health 1997 ; 87 : 558-66.
2 Messiah A, Dart T, Spencer B, Warszawski J, and the French National Survey on Sexual Behavior Group (ACSF). *Condom breakage and slippage during heterosexual intercourse : A French national survey.* Am J Public Health 1997 ; 87 (3) : 421-4.

10
Adolescents and young adults

1 *Periodic telephone survey of the general population in Switzerland to evaluate AIDS prevention (EPS). Lausanne : Institut of Social and Preventive Medicine* UEPP/Link ; 1997. (unpublished).
2 Narring F, Michaud P-A, Wydler H, Davatz F, Villaret M. *Sexualité des adolescents et sida : processus et négociations autour des relations sexuelles et du choix de la contraception (Adolescent sexuality and AIDS : process and negotiation in relation to sexual relations and choice of contraception).* Lausanne : University Institute of Social and Preventive Medicine ; 1997. (Raisons de santé, 4).
3 French Health Education Committee. *Baromètre santé jeunes 97/98 (Barometer of young people's health 97/98).* Paris/Vanves : Comité français d'éducation pour la santé ; 1998.

11
Men who have sex with other men

1 Dubois-Arber F. *Evaluation des campagnes de prévention contre le SIDA en Suisse. Rapport de l'étude: les homosexuels* (Evaluation of AIDS-prevention campaigns in Switzerland. Study report: homosexuals). November 1987. Lausanne University Institute of Social and Preventive Medicine, 1988 (Cah Rech Doc IUMSP, no. 23.6).
2 Masur JB, Dubois-Arber F. *Evaluation de la stratégie de prévention du sida en Suisse. Les homosexuels. Etude 1990* (Evaluation of the AIDS-prevention strategy in Switzerland. Homosexuals. 1990 study). Lausanne University Institute of Social and Preventive Medicine, 1991 (Cah Rech Doc IUMSP, no. 52.8).
3 Dubois-Arber F, Masur JB, Hausser D, Zimmermann E, Paccaud F. *Evaluation of AIDS prevention among homosexual and bisexual men in Switzerland.* Soc Sci Med 1993 ; 37(12):1539-44.
4 Moreau-Gruet F, Dubois-Arber F. *La prévention du sida chez les homosexuels en Suisse: adaptation au risque de sida selon le type de partenaire* (AIDS prevention among homosexuals in Switzerland: adapting to the AIDS risk according to type o f partner). Soz Praeventivmed 1996; 41:1-10.
5 Bochow M, Chiarotti F, Davies P, Dubois-Arber F, Dür W, Fouchard J, Gruet F, McManus T, Markert S, Sandfort T, Sasse H, Schiltz MA, Tielman R, Wasserfallen F. *Sexual behaviour of gay and bisexual men in eight European countries. EC-Concerted Action on AIDS/HIV Prevention Strategies, Working Group on Homo-Bisexual Men.* AIDS Care 1994; 5:533-49.
6 Moreau-Gruet F, Dubois-Arber F. *Evaluation de la stratégie de prévention du sida en Suisse: phase 6, 1993-1995. Les hommes aimant d'autres hommes : étude 1994* (Evaluation of the AIDS-prevention strategy in Switzerland: Phase 6, 1993–1995. Men having sex with other men: 1994 study). Lausanne University Institute of Social and Preventive Medicine, 1995 (Cah Rech Doc IUMSP, no. 120.5).
7 Moreau-Gruet F, Dubois-Arber F, Jeannin A. *Monitoring HIV/AIDS related behavioral change among men having sex with other men in Switzerland: 1987-1997.* (forthcoming).

8 Moreau-Gruet F, Cochand P, Vannotti M, Dubois-Arber F. *L'adaptation au risque VIH/sida chez les couples homosexuels: version abrégée* (Adaptation to the risk of HIV/AIDS among homosexual couples: abridged version). Lausanne: University Institute of Social and Preventive Medicine, 1998 (Raisons de santé, 13).

9 Bochow M, Lange M. *Homosexuelle Männer und AIDS* (Homosexual men and AIDS). Berlin: INTERSOFIA Gesellschaft für interdisziplinäre Sozialforschung in Anwendung (Society for applied nterdisciplinary social research); 1997.

12
Drug users

1 Dubois-Arber F, Konings E, Koffi-Blanchard M, Gervasoni JP, Hausser D. *Evaluating HIV prevention of low threshold needle exchange programmes in Switzerland.* In : Friedrich D, Heckmann W, eds. Aids in Europe : the behavioural aspect. Report of the Conference AIDS in Europe - The Behavioural Aspect, Berlin 26 - 29.9.1994. Berlin : Sigma, 1995 : 183-190.

2 Benninghoff F, Gervasoni JP, Spencer B, Dubois-Arber F. *Caractéristiques de la clientèle des structures à bas seuil d'accès pour toxicomanes mettant à disposition du matériel d'injection stérile en Suisse (Characteristics of the clients of low-threshold facilities for drug users providing sterile injection equipment in Switzerland).* Rev Epidemiol Santé Publique 1998 ; 46 : 205 -17.

3 Malatesta D, Joye D. *Toxicomanie et prévention du sida en milieu urbain : enquête auprès des usagers du bus itinérant de prévention du sida (Drug dependency and AIDS prevention in the urban setting : survey of users of the AIDS-prevention bus).* Lausanne : IREC/EPFL, 1993 (Research report No 110).

4 Benninghoff F. *Low-threshold facility statistics.* Lausanne : University Institute of Social and Preventive Medicine/UEPP, 1998 (Personal communication).

5 Sozialamt der Stadt Zürich. *Die Drogenszene in Zürich (The drug scene in Zurich).* Zurich : Sozialamt der Stadt Zürich, 1991 (Forschung und Dokumentation Nr. 2).

6 Tecklenburg U, Spinatsch M, Chilvers C. *Statistik der ambulanten Alkohol- und Drogenberatungstellen in der Schweiz (Statistics of the outpatient alcohol and drug advisory centres in Switzerland).* Lausanne : Schweizerische Fachstelle für Alkoholprobleme (ISPA), 1991.

7 *SAMBAD statistics (Statistik der ambulanten Alkohol- und Drogenberatungstellen in der Schweiz) (Statistics of the outpatient alcohol and drug advisory centres in Switzerland).* (Personal communication).

8 Kaufman B, Dobler-Mikola A. *Eine Beschreibung der Pool-Klientel des Forschungsverbunds therapeutischer Einrichtungen im Jahr 1991 (A description of the client pool of the research association of therapeutic facilities in 1991).* Zurich : Sozialpsychiatrischer Dienst Zürich, 1992 (Serie V, No. 6).

9 Schüpbach Wiedemann E, Eichenberger A. *Der Forschungsverbund therapeutischer Gemeinschaften im Jahre 1993 (The research association of therapeutic facilities).* Zürich : Sozialpsychiatrischer Dienst Zurich, 1994 (Serie V, Nr. 9).

10 Grichting E, Dobler-Mikola A, Reichlin M. *La Ligue pour l'évaluation de traitements résidentiels de la toxicomanie en 1997. Rapport d'activité (version abrégée).* Statistique annuelle globale. *League for the evaluation of residential treatments for drug dependency in 1997. Activity report (abridged).* Overall annual statistics. FOS. Research report of the Institute for Research into Drug Dependency No 61. Zurich, 1998.

11 Uchtenhagen A, Gutzwiller G, Dobler-Mikola A. *Essais de prescription médicale de stupéfiants. Rapport de synthèse (Experiments in the medical prescription of narcotic drugs. Synthesis report).* Institut für Suchtforschung (Institute for dependency research) Zurich : University Institute of Social and Preventive Medicine ; 1977.

12 Hunter GM, Donoghoe MC, Stimson GV, Rhodes T, Chalmers CP. *Changes in the injecting behaviour of injecting drug users in London 1990-1993,* AIDS 1995 ; 9 : 943-501

13 MacDonald M, Wodak AD, Ali R, Crofts N, Cunningham PH, Dolan HA, Kelaher M, Loxley WM, Beek I, Kaldor JM. *HIV prevalence and risk behaviour in needle exchange attenders : a national study.* Med J Aust 1997; 166 : 237-240.

14 Strathdee SA, Patrick DM, Currie SL, Cornelisse PGA, Rekart ML, Montaner JSG, Schechter MT, O'Shaughnessy MVO. *Needle exchange is not enough : lesson from the Vancouver injecting use study.* AIDS 1997 ; 11 : F59-F65

13
The epidemiology of HIV/AIDS in Switzerland

1 Federal Office of Public Health. Berne : *Bulletin FOPH 1999 ;* 80 (8).
2 Gebhardt M. *Sida et VIH en Suisse : situation épidémiologique fin 1997. (AIDS and HIV in Switzerland : the epidemiologial situation at the end of 1997).* Berne : Federal Office of Public Health ; 1998 (figure 7.2.2, page 28).

14
Discrimination, stigmatisation

1 Dubois-Arber F, Haour-Knipe M. *Identification des discrimination institutionnelles à l'encontre des personnnes vivant avec le VIH en Suisse (Identification of institutional discrimination against people living with HIV in Switzerland).* Lausanne : Institut universitaire de médecine sociale et préventive, 1998 (Raisons de santé, 18).

15
New treatments for AIDS : initial consequences for prevention

1 Hubert M, Huynen P, Jeannin A, Gremy I, Spencer B, Toppich J, Stigum H, and the European NEM Group. *Public awareness of the new treatments and changes in the perception of HIV risk : comparison of four European countries in 1997-1998.* Late breaker oral presentation at the 12th World AIDS Conference : bridging the gap ; 1998 Jun 28-Jul 3 ; Geneva, Switzerland.
2 Adam P, Moreau-Gruet F, Hamers F, Delmas MC, Brunet JB, Dubois-Arber F. *HIV/AIDS preventive attitudes and behaviour of French and Swiss gay men in the era of new treatments : A comparison of two national surveys.* Oral presentation at the 12th World AIDS Conference : bridging the gap ; 1998 Jun 28-Jul 3 ; Geneva, Switzerland.

16
The sexuality of persons living with HIV/AIDS

1 Meystre-Agustoni G, Thomas R, Häusermann M, Chollet-Bornand A, Dubois-Arber F, Spencer B. *La sexualité des personnes vivant avec le VIH/sida (The sexuality of persons living with HIV/AIDS).* Lausanne : Institut de médecine sociale et préventive, 1998 (Raisons de santé, 17).
2 Chollet-Bornand A, Spencer B, Dubois-Arber F. *Vécu de la sexualité des personnes vivant avec le VIH : revue de la littérature (The sexual experience of persons living with HIV : review of the literature).* Rev Med Suisse Romande 1997 ; 117 : 715-20.

17
Co-operation between the political partners in AIDS prevention

1 Vitali R, Cattacin S, in collaboration with Martin Abele and Charles Landert. *La prévention du sida dans les cantons suisses : une analyse organisationnelle (AIDS prevention in the Swiss cantons : an organisational analysis).* Müri : Société suisse pour la politique de la Santé ; 1997. (Cahiers d'études de la SSPS, no 55).
2 Cattacin S, Landert C. Monitoring AIDS : *le monitorage des réponses organisationnelles cantonales visant la prévention VIH/sida (Monitoring the organisational responses of the cantons in HIV/AIDS prevention).* Working paper 2/98. RESOP. Laboratoire de recherches sociales et politiques appliquées. Geneva, 1998.

18
The problem of HIV/AIDS as presented by the Swiss press

1 Schanne M. *10 Jahre HIV/Aids-Prävention im Rahmen journalistischer Berichterstattung (10 years of HIV/AIDS prevention in the context of journalistic reporting).* Zurich : Arbeitsgruppe für Kommunikationsforschung & - beratung (AGK) ; 1997.

19
HIV/AIDS prevention : results of the first ten years and future prospects

1 Rosenbrock R, Schaeffer D, Dubois-Arber F, Moers M, Pinell P, Setbon M. *The AIDS policy cycle in Western Europe : from exceptionalism to normalization.* Berlin : Wissenschaftszentrum Berlin für Sozialforschung 1999 (Veröffentlichungsreihe der Arbeitsgruppe Public Health, P99-201).

Appendices

1 Sozialamt der Stadt Zürich. *Die Drogenszene in Zürich (The drug scene in Zurich).* Zurich : Sozialamt der Stadt Zürich, 1991 (Forschung und Dokumentation Nr. 2).

2 Malatesta D, Joye D. *Toxicomanie et prévention du sida en milieu urbain : enquête auprès des usagers du bus itinérant de prévention du sida (Drug dependency and AIDS prevention in the urban setting : survey of users of the AIDS-prevention bus).* Lausanne : IREC/EPFL, 1993 (Research report No 110).

3 Gervasoni JP, Dubois-Arber F, Benninghoff F, Spencer B, Devos T, Paccaud F. *Evaluation des mesures de la Confédération destinées à réduire les problèmes liés à la toxicomanie. Deuxième rapport de synthèse 1990-1996 (Evaluation of federal measures to reduce the problems associated with drug dependency. Second synthesis report 1990-1996).* Lausanne : University Institute of Social and Preventive Medicine 1998 (Cah Rech Doc IUMSP, No 111).

4 Benninghoff F, Gervasoni JP, Spencer B, Dubois-Arber F. *Caractéristiques de la clientèle des structures à bas seuil d'accès pour toxicomanes mettant à disposition du matériel d'injection stérile en Suisse (Characteristics of the clients of low-threshold facilities for drug users providing sterile injection equipment in Switzerland).* Rev Epidem Sante Publique 1998 ; 46 : 205-17.

5 Benninghoff F. *Low-threshold facility statistics.* Lausanne University Institute of Social and Preventive Medicine. (Personal communication).

6 Tecklenburg U, Spinatsch M, Chilvers C. *Statistik der ambulanten Alkohol und Drogenberatungstellen in der Schweiz (Statistics of the outpatient alcohol and drug advisory centres in Switzerland)* Lausanne : Schweizerische Fachstelle für Alkoholprobleme (ISPA), 1991.

7 Kaufman B, Dobler-Mikola A. *Eine Beschreibung der Pool-Klientel des Forschungsverbunds therapeutischer Einrichtungen im Jahr 1991 (A description of the client pool of the research association of therapeutic facilities in 1991).* Zurich : Sozialpsychiatrischer Dienst Zürich, 1992 (Serie V, No. 6).

8 Sozialamt der Stadt Zürich. *Behandlungen von Drogenabhängigen in der Stadt Zürich. Ersterhebung des Indikators "erste Behandlungsanfragen" 1991 (Treatment of dependent drug users in the city of Zurich. First survey of the indicator "first treatment inquiries" 1991).* Zurich : Sozialamt der Stadt Zürich, 1992.

9 Schüpbach Wiedemann E, Eichenberger A. *Der Forschungsverbund therapeutischer Gemeinschaften im Jahre 1993 (The research association of therapeutic facilities in 1993).* Zurich : Sozialpsychiatrischer Dienst Zürich, 1994 (Serie V, Nr. 9).

10 Kübler D, Hausser D. *Consommateurs d'héroïne et/ou de cocaïne hors traitement médical. Etude exploratoire auprès d'une population cachée (Users of heroin and/or cocaine not undergoing medical treatment. Exploratory study of a hidden population).* Lausanne : University Institute of Social and Preventive Medicine, 1996 (Cah Rech Doc IUMSP, no 118.7).

List of tables

In appendix

List of figures

In appendix