

Evaluation of the AIDS prevention strategy in Switzerland

Fifth synthesis report 1993-1995

Abridged version

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The AIDS prevention strategy in Switzerland

Switzerland's AIDS prevention policy has three objectives :

- to prevent new infections ;
- 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, conveying information). These measures depend on persons whose situation or role makes them potential mediators to prevent the spread of the epidemic (doctors, parents, teachers etc.).

The strategy¹ 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 maintain existing preventive activities. Since the model also requires the development of an environment favourable to the prevention and management of AIDS, the strategy messages communicated stress the importance of solidarity. The strategy is also intended to be pragmatic, emphasising freedom of choice while pointing out available means of prevention, but nevertheless taking into account the existence of high-risk behaviour. Condoms are therefore promoted for sexual behaviour involving a potential risk of HIV infection, while injecting drug users are encouraged to use sterile injection material. Maintaining "safe" behaviour has also been promoted : faithful sexual partners are encouraged to remain so, while drug users are advised not to begin injecting.

¹ This strategy is developed in detail in the manual entitled "Prévention du sida en Suisse, buts, stratégies, mesures". FOPH, Berne, 1993.

Continuous evaluation

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 report is an abridged version of the synthesis report for 1993-1995 (sixth phase of the evaluation programme) ².

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. This involves progressively examining and elucidating the various components of both the strategy and its impact.

2 Previously-published reports :

- Hausser, D., Lehmann, Ph., Gutzwiller, F., Burnand, B., Rickenbach, M., *Evaluation of the effects of the household AIDS-information brochure distributed by the FOPH*. October 1986. Lausanne : University Institute of Social and Preventive Medicine, 1986. (CahRechDoc IUMSP no 7).
- Hausser, D., Lehmann, Ph., Dubois-Arber, F., Gutzwiller, F., *Evaluation of AIDS prevention campaigns in Switzerland*. December 1987. Lausanne : University Institute of Social and Preventive Medicine, 1987. (CahRechDoc IUMSP, no. 23).
- Dubois-Arber, F., Lehmann, Ph., Hausser, D., Gutzwiller, F., *Evaluation of AIDS prevention campaigns in Switzerland: second synthesis report*. December 1988. Lausanne : University Institute of Social and Preventive Medicine, 1989. (CahRechDoc IUMSP, no 39).
- Hausser, D., Zimmermann, E., Dubois-Arber, F., Paccaud, F., *Evaluation of the AIDS prevention strategy in Switzerland: third synthesis report, 1989-1990*. Lausanne : University Institute of Social and Preventive Medicine, 1990. (CahRechDoc IUMSP, no 52).
- Dubois-Arber, F., Jeannin, A., Meystre-Agustoni, G., Gruet, F., Paccaud, F., *Evaluation of the AIDS prevention strategy in Switzerland mandated by the Federal Office of Public Health: fourth synthesis report 1991-1992*. Lausanne : University Institute of Social and Preventive Medicine, 1993. (CahRechDoc IUMSP, no 82).

The main questions of the global evaluation are as follows :

Regarding the prevention process :

- **Which prevention activities are being established? How do they develop? With what difficulties and successes?**
- **Are there any gaps in prevention coverage (regional gaps, specific groups disproportionately affected, etc.)?**
- **Is prevention developing at all three levels? Are the FOPH's partners in the prevention field (such as cantons, associations, mediators, and certain professional groups) active?**
- **Are there elements in place that guarantee the long-term effectiveness and quality of prevention?**

Regarding the results of prevention :

- **Are behavioural changes taking place in the fields targeted by prevention efforts, such as sexual behaviour, methods of drug use, quality of counselling, etc., and is knowledge more widespread?**
- **Are attitudes of solidarity or of fear emerging?**
- **Is the epidemiological situation changing?**
- **Is prevention having any unexpected or unwanted side-effects?**

The evaluation programme consists of a series of successive phases, each lasting one year in the early stages and subsequently increased to two. Each phase consists of between 10 and 20 complementary studies, a synthesis of which forms the basis for a global evaluation of the effectiveness of the strategies adopted. It is impossible to report all the preventive measures directly initiated by the FOPH and its partners during each phase. Likewise, in a profusion of different measures, it is not always possible to isolate the effects of each measure or programme. Priorities are therefore defined for each phase. During each period, fields of activity for evaluation are jointly selected by the FOPH and the evaluators. The evaluation attempts to answer more specific questions in each field, as well as general questions such as those described above. Thus each phase combines new studies, studies that are repeated regularly (monitoring of measures or behaviour), and studies taking a new approach to fields that have

already been examined etc. (see the synoptic table of studies carried out since 1986 in Appendix 1).

The evaluation results are regularly submitted to the prevention authorities responsible to enable them to make any necessary adjustments to the prevention strategy. The evaluation programme thus complements the strategy and evolves as new questions emerge.

During the 1993-1995 phase of the evaluation programme, the following areas received priority attention:

a) 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 risk-reduction measures among drug users (an assessment of existing data in this area of targeted prevention is provided during each phase);
- 2 programmes/projects aimed at specific target populations:
 - the "Barfüßerfrauen" AIDS prevention programme for foreign prostitutes (evaluation of the pilot period of this new programme);
 - the Migrants Project (evaluation of the progress of the FOPH's prevention programme aimed at the Spanish, Portuguese and Turkish communities, following baseline evaluation and monitoring of the pilot period of the programme);
- AIDS prevention by primary care physicians (repetition of a study carried out in 1990 in order to observe changes of activity and attitudes);
- training programmes for volunteer workers and non-hospital medical and paramedical personnel (evaluation to help the FOPH decide whether to continue support for these programmes).

b) regarding the effectiveness of the measures adopted (results):

- changes in the knowledge, attitudes, and behaviour of the general population aged seventeen to forty-five; monitoring of condom sales (regularly repeated surveys to monitor medium-term trends and analyse other available data);
- behavioural changes among adolescents (secondary analysis of data from various studies);
- behavioural changes among homosexuals (regularly repeated studies to monitor medium-term trends);

- behavioural changes among drug users (secondary analysis of data from various studies);
- occupational risks of HIV contamination for hospital staff (new study, assessment of risk exposure and protective measures);
- variations in the number of people with HIV or AIDS (use of epidemiological data provided by monitoring system).

c) regarding assessing the AIDS prevention environment:

- solidarity with people infected with HIV (secondary analysis of data from studies carried out during the evaluation).

The methodological details of the various studies carried out during this phase of the evaluation are summarised in Appendix 2. Each area described is covered in the following chapters. The main questions for evaluation are followed by a summary of the data collected, the conclusions drawn from the investigation, and recommendations. Conclusions and recommendations concerning the overall strategy are included at the end. Readers requiring further information may refer to the general report or to the scientific reports on individual studies.

Contents

The prevention process

The main data relating to the prevention measures receiving priority attention during the current phase of the evaluation (general campaigns, campaigns aimed at specific groups, interventions by mediators) are summarised here. They have been gathered from studies in the evaluation programme, or from summaries of existing documents (activity reports, reports on local studies, etc.).

The nation-wide STOP AIDS campaign, 1993-1995

Priority issues: the continuity, visibility and acceptability of the campaign.

The STOP AIDS campaign, which targets the entire population, has progressed at a regular and sustained rate: five phases in 1993, six in 1994, and four in 1995. The subjects covered have remained the same: promotion of the use of condoms, reminders that mutual faithfulness is also a means of protection, abstinence from drugs or use of clean syringes, and support for those affected.

In 1995, 69 % of the population could recall having seen a phase of the year's campaign, while some 20 % to 40 % could accurately recall each of these phases (precise identification).

The campaign is still being very positively received: 60 % of the population feel that the campaign is still drawing attention, even though it will soon be ten years old, and 90 % believe that it should be continued.

AIDS prevention programmes aimed at drug users

- **How are risk-reduction measures being developed, particularly those involving the distribution of injection material?**
- **What problems, deficiencies, and regional disparities have been encountered?**
- **Which promising experiences could be developed further?**

Distribution of injection material by ad hoc structures

Since 1986, structures to contact and assist drug users have been gradually emerging in Switzerland. They are mainly dedicated to AIDS-related risk-reduction measures (counselling, distribution of condoms and injection material, sometimes with an injection area). Some also provide basic health care, facilities for personal hygiene, rest areas, and mini-cafeterias. They do not dispense treatment, but can guide their clients towards other appropriate centres. These structures do not require any commitment from drug users, are easily accessible and respect anonymity³. They may be either fixed or mobile (buses).

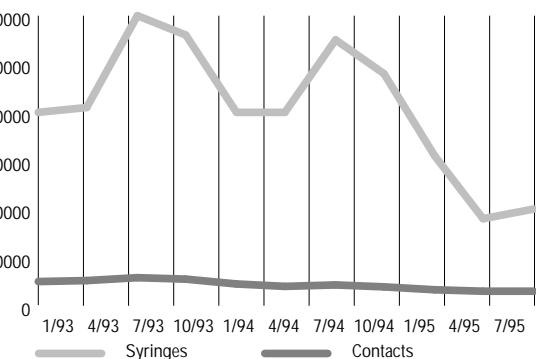
Due to the risk of HIV contamination, the Swiss population generally accepts the need to make sterile injection material accessible to drug users. However, these structures have given rise to controversy, and have provided focal points for various fears, such as those of encouraging drug use, promoting intravenous administration, and discouraging efforts to abstain from drug use. The neighbourhoods concerned have worried about public disorder and about attracting drug dealers, as well as drug users from other towns or regions. The polarisation in this debate has led to the rather chaotic development of these structures. Some have

shut down, while others opened up, and many have seen changes in location and management or modifications in the organisation of supply. In spite of these difficulties during their first few years of existence, a degree of continuity has been maintained in some towns and cities.

At the end of 1995, there were twenty-three such facilities in Switzerland, spread across nine cantons (AG, BE, BS, GE, LU, SG, SH, SO, ZH). Thirteen of these have an injection area (BE one; BS three, ZH six, SO two, SH one).

Most of these facilities are in the German-speaking regions of Switzerland. In some towns and cities in French-speaking regions, field workers occasionally issue sterile material to their clients (FR, JU, VD, for instance). But for the most part, such supplies are mainly obtained from pharmacies.

Distribution of syringes and number of contacts in "low-threshold" facilities in Switzerland: 1993-1995.



The continuous monitoring of activities carried out in these "low-threshold" facilities, which began in 1993, shows the following trends:

• about 7 million syringes were issued in 1993, 6.3 million in 1994, and 3.21 million in 1995. This represented some 17,000 to 19,000 syringes per day, or 500,000 to 700,000 per month in 1993-94, and 9,000 per day or 270,000 per month in 1995⁴ until the end of the year;

3 For these reasons, these are called "low-threshold structures".

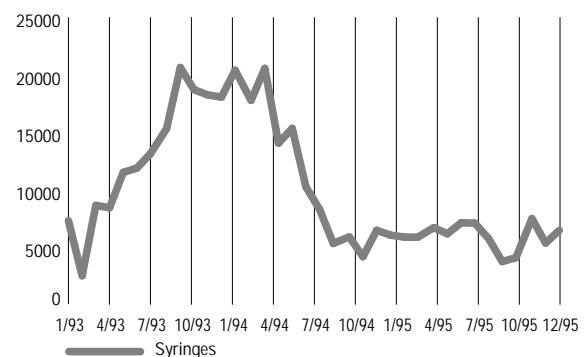
4 These data, slightly higher than those shown in the figure, also take account of syringes distributed in shelters.

- the number of contacts during which such material was distributed remained around 50,000 per month in 1993, declining gradually in 1994 and 1995 (slightly more than 30,000 per month at the end of 1995). Thus there has been no steady increase in demand for injection material, as had been feared by those who thought that issuing injection material would encourage drug users to begin administration by injection.

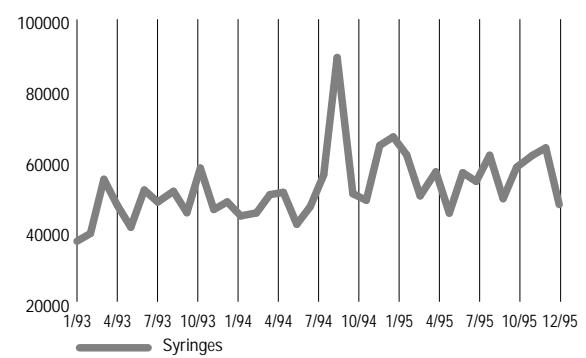
The distribution of syringes began to decline sharply at the end of 1994. This was accompanied by a slower decrease in the number of contacts, meaning that fewer syringes were taken away during each contact. This major long-term quantitative decrease in the distribution of injection material is mainly due to the closure of the Letten "open scene" in Zurich in February 1995. The decline in the distribution of syringes in the city was not offset by increased distribution by centres in neighbouring cantons. Similar results have been recorded in other towns and cities during sudden changes in local drug scenes (dispersion of drug scenes in St. Gallen, Olten, Solothurn) or in distribution methods (Lucerne: transition from a facility with an injection area to a mobile bus in April 1994). These caused long-term disorganisation in the syringe distribution system.

When sudden changes occur in the situation of such vulnerable groups (refuge centres closed, open scenes dispersed and repression increased), the insecurity of drug users rises. Obtaining drugs becomes a priority, and procuring injection material becomes less important. Doses are injected in more stressful situations, and in even less appropriate places. When the Platzpitz in Zurich was closed in 1992, the documented sharing of syringes increased. In 1995, syringes were lacking in Zurich, increasing the risk of HIV or other infection when drug users repeatedly utilised the same material. Reports by field workers confirm that drug users are reusing their syringes and taking fewer syringes when visiting "low-threshold" easy access facilities. In some centres in Zurich, the ratio of distributed needles to syringes has increased.

Syringes distributed: Lucerne.



Syringes distributed: Basle.



Such disorganisation in the distribution of sterile material has not been observed where the system has not been subjected to change. In such places (Basle, Bern, Geneva), the number of syringes issued has stabilised. These centres can therefore be said to have regular clients, most likely indicating situations which are more favourable to establishing more solid relationships of trust, which could perhaps lead to other types of care.

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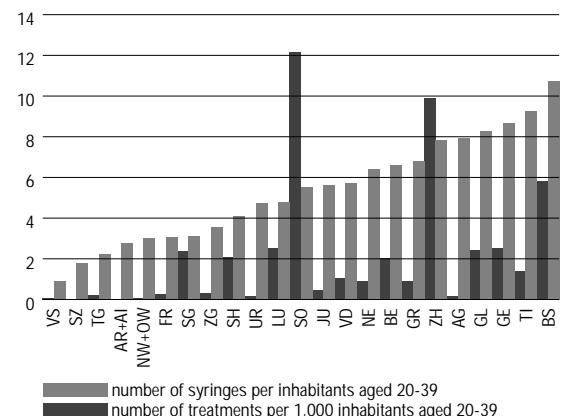
The distribution of syringes by pharmacies

In most Swiss cantons, pharmacies are the only local source of injection material. According to a comprehensive survey of Swiss pharmacies, it can be estimated that 100,000 syringes were retailed or sold in Flash-boxes every month throughout the country towards the end of 1994 (less than a quarter of the amount distributed through "low-threshold" easy access facilities for drug users).

The sale of syringes in pharmacies nevertheless raises problems: limited opening times, high prices, embarrassment of consumers when identifying themselves as drug users, and the reticence of some pharmacists towards clients deemed to be difficult. Nevertheless, pharmacists are generally open to the distribution of injection material to drug users. In the survey mentioned above, 80% of pharmacists approve the sale of syringes to drug users. In practice, 71% routinely sell them syringes, 23% do so under some conditions, while 5% refuse to do so, or do so only rarely. Of those who agree in principle to sell syringes, 41% do not restrict sales in any way. French-speakers are slightly more restrictive than their German- and Italian-speaking colleagues. However, a trend towards greater openness has been observed. For instance, sales of syringes by pharmacies in the canton of Vaud multiplied by a factor of six between 1991 and 1994. In several cantons (such as VD and GE), there have been initiatives to make pharmacists aware of the problems of drug users. These have roused considerable interest among pharmacists, who are ready to play a larger role in AIDS prevention, and who have often long been involved in methadone treatment. More generally, the sale of syringes in pharmacies seems to be gradually increasing.

Nevertheless, the supply of injection material is very unevenly distributed in various regions and cantons, and there is inadequate access to injection material in French-speaking regions, even taking into account the relatively high proportion of drug dependant consumers on oral methadone treatment (and therefore needing no, or fewer, injections in these cantons).

Number of ongoing methadone treatments in 1994, and number of syringes issued the same year: Swiss cantons.



Distribution of condoms by "low-threshold" facilities for drug users

"Low-threshold" easy access facilities for drug users all provide condoms. In general, condoms are not actively distributed, although available so that drug users can help themselves. Few such centres (Geneva, Lucerne, Basle) keep track of the number of condoms distributed, perhaps indicating the lack of interest in this aspect of AIDS prevention for drug users. Only the AIDS-prevention bus in Geneva has been very active in promoting condoms and counselling drug users on this subject.

In 1995, the average number of condoms distributed through contact was 1.3 in Geneva, 0.7 in Lucerne and 0.4 in Basle.

AIDS prevention in prison

Drug use and the sharing of injection material in prison has been documented in several studies. Four penal institutions make disinfection material available to inmates. In 1994, a pilot prevention programme at the Hindelbank women's prison was implemented for a one-year period. It offered information sessions and discussions to both inmates and personnel, as well as personalised consultation and counselling to inmates. Automatic dispensers for exchange of syringes were installed in six easily accessible locations in the prison. Evaluation of this programme showed that it was well received by both inmates and staff. More than 5,000 syringes were distributed (an average of fourteen per day). There was no uncontrolled increase in the use of syringes, nor any improper use of such material (syringes used as weapons, for instance). Furthermore, the evaluation showed that the programme did not encourage anyone to initiate drug use. Finally, the (low) number of people who admitted using syringes utilised by others in the previous month decreased (from eight to one) during the term of the pilot programme.

Projects aimed at specific types of drug user

Two AIDS prevention projects aimed at drug users working as prostitutes were recently initiated in Basle and Geneva. A pilot project to prevent the sexual transmission of AIDS among drug users, based on the principle of peer education (the MEDIA project), has begun in St.Gall and is currently being evaluated (see below).

Conclusions

- Most drug users use sterile syringes when available, particularly if they are easy to obtain.
- The availability of "low-threshold" easy access facilities specifically intended for drug users (providing injection equipment and injection areas) has expanded over the last few years, as have supplies provided by pharmacies. There is no evidence that the easy availability of syringes encourages new injecting drug use.
- A decline in syringe distribution has been observed when easy access facilities have been closed down or when the drug scene has been dispersed. This reflects insecurity, supply problems, and probably an increased exposure to the risk of infection (HIV, abscesses) for the drug users who are most disorganised and/or dependent.
- Injecting drug use is a fact of prison life. The Hindelbank pilot project has shown that the distribution of syringes in prison is acceptable, feasible, and useful, and does not present dangers.
- Prevention of the sexual transmission of HIV is still given inadequate attention in the fight against AIDS among drug users.

Recommendations

- Access to sterile injection equipment should be further expanded by the regular provision of complementary services made known to the public (distribution of syringes from easy access facilities, treatment centres, pharmacies, and automatic dispensers).
- If changes which could affect the availability of injection equipment can be anticipated in the drug scene, including the closure or transfer of facilities, transitional measures bringing together all those involved in the field (social workers, police, drug users) should be introduced sufficiently early on.
- Pharmacists should be made more aware of their role as partners in the prevention of AIDS among drug users (training, development of pharmacist advice networks, etc.), particularly as they are often also partners in methadone treatment prescribed to drug users.
- Facilities providing syringes and other injection equipment should constantly remind clients of the fact that equipment should never be shared (one injection per syringe), irrespective of the partner or situation.
- The question of special local services for drug-using prostitutes must be put back on the agenda in every major city.
- AIDS prevention in prisons should be expanded.
- Prevention of the sexual transmission of HIV should become a priority for facilities which care for drug users. Appropriate training should be available to their personnel.
- Complementary direct field measures (peer education, street work) concentrating on preventing the sexual transmission of HIV should be expanded and evaluated.

Contents

AIDS prevention programmes aimed at specific groups

For several years, the FOPH has been initiating or supporting prevention programmes based on the concept of peer education. This involves recruiting members of specific target groups (if possible, people perceived by their peers as leaders or people with experience) in order to train them in prevention techniques. Given some support, these people can then implement prevention measures appropriate to their milieu, either through individual or group contact. Two of these programmes have been evaluated: the "Barfüsserfrauen" Project, which is aimed at foreign prostitutes working in Switzerland, and the Migrants Project, which targeted the Spanish, Portuguese and Turkish communities in Switzerland during its pilot phase.

A third project, named "MEDIA", is still under evaluation. Developed by AIDS-Hilfe St.Gall, this project aims to recruit and train mediators who are themselves drug users or former drug users. These mediators are then to distribute information about AIDS within their scene (paying particular attention to preventing the sexual transmission of HIV and other STDs), as well as acting as advisers and even "role models" for their peers. To facilitate contact and dialogue, the mediators have "gift-boxes" which they give to their peers. These contain toilet accessories, condoms, disinfectants, etc. Operations such as this are expected to snowball.

During the pilot phase, the MEDIA project selected three specific target groups:

- the inmates of the Saxerriet semi-open prison, most of whom were imprisoned for drug-related offenses;
- former users in contact with self-help groups composed of former drug users;
- young second and third generation Italian immigrants who take drugs.

The experience with peer education programmes will be reviewed during the next phase of evaluation.

The " Barfüsserfrauen " Project : AIDS prevention for foreign prostitutes working in Switzerland

Several studies have shown that some categories of prostitute are particularly vulnerable ("non-professionals", dancers, drug users, etc.), especially migrant women who engage in prostitution. The Swiss AIDS Federation (SAF) set up the "Barfüsserfrauen" Project for such women in 1993. This project, based on peer education, recruits and gives appropriate training to prostitutes or former prostitutes from migrant populations. They subsequently provide information and counselling to women within their communities. The information is available in several languages on audiocassettes, which the mediators play to groups of women called together for free discussion of AIDS prevention and other questions, such as access to health care and social services, problems with the police, etc. These (paid) mediators devote about 10 hours per month to the project.

- **Is the peer-education model applicable in this milieu ?**
- **Is it possible to recruit, train and maintain mediators from these populations ?**
- **How can this project be transferred to local organisations in other Swiss towns and cities ?**

The project was evaluated during its operation in Zurich and Basle, before being extended to other regions in Switzerland. The evaluation concentrated on the feasibility of peer-education models in this milieu (recruiting, training, and maintaining mediators), and on how to transfer the project, initially centrally managed by SAF, to long-term management by partner organisations in other towns.

An initial rapid evaluation of the project took place in 1994. It confirmed the feasibility of the project, and exposed some operational problems. A second, more thorough phase of the evaluation began in 1995. At the time, five mediators had been working for the project in Zurich for more than a year (four women from the

Dominican Republic and one from Cameroon). Four had been prostitutes, and one was still working in a night club. Their ages ranged from twenty to fifty.

The work carried out by these mediators could not be entirely sufficiently described: questions still remain concerning its nature and quality. However, major operating features of the project have been analysed, as has the usefulness of the very concept of "mediators".

Recruiting is very difficult, and it is hard to find women from every major national group involved in this field in Switzerland. Although foreign prostitutes often speak many languages, and mediators target larger circles of women than their original national group alone, the range of national origins of the women recruited has remained limited. This is an obstacle to more diversified access to the target population. However, the women recruited are highly motivated and are still with the project (low turnover).

The training of the mediators is brief, mainly concentrating on methods of AIDS prevention. This leaves little room for questions about their actual work (how to discuss prevention, both individually and in groups, how to manage questions and requests for advice, etc.). In this respect, the training still only partially meets the needs of the mediators, who do not necessarily have the skills or knowledge required to deal with such situations. The way the monitoring of the mediators is currently organised (brief monthly meetings, no field presence, no in-depth individual support nor any regular group discussions) does not enable them to pass on the full wealth and diversity of their experience, nor does it permit the joint management of the project. Furthermore, it does not allow mediators to receive adequate counselling and to be able to discuss their problems.

The mediators and/or their task are known in the places they frequent. They each have their own way of working, and the recommended organisation of prevention activities (group meetings with previously contacted prostitutes) is not applied very often. In fact, they "adapt" the project to suit the circumstances. Their contact with prostitutes is sometimes limited to distributing condoms or information cassettes. Contacts are often individual and quite brief. Monitoring of their activities has shown that about 600 women were contacted

over a twelve-month period (January - December 1995), involving the distribution by ten mediators of 500 cassettes and 9,000 condoms in Zurich and Basle. The details of these contacts (whether individual or groups, amount of time spent, repeated contacts, etc.) are not recorded, and certainly vary greatly. According to data gathered by the project, about 1,500 women were contacted by mediators in Zurich and Basle between 1993 and 1995.

The target population is better informed than expected, although its knowledge is incomplete, particularly as regards the risk of contamination through kissing and oral-genital contact, or the use of HIV testing and its limits. Prostitutes generally report that they take precautions during sexual relations with clients, exceptions being due to their precarious condition (financial pressure, threats of violence by some clients) rather than a lack of knowledge. On the other hand, the use of condoms during private sexual relations remains taboo, and mediators have difficulty discussing this issue with the women they meet.

Research into how to transfer the long-term everyday management of the project to local organisations has shown how difficult it is to find organisations familiar with problems relating not only to prostitution but also to AIDS and migrants (cultural and linguistic problems, etc.). Additional training in these fields and financial support (to pay interpreters, for instance) are often required to enable such institutions to monitor and support the work of mediators.

Conclusions

- Despite the difficulties encountered, the "Barfüsserfrauen" Project has shown that the concept of peer education is fully applicable to AIDS prevention among foreign prostitutes in Switzerland. Within certain limits, it is possible to recruit, train, monitor and sustain the activity of mediators who are representative of target groups.

Recommendations

- The "Barfüsserfrauen" Project should be maintained and expanded. The training and supervision of mediators should be strengthened.
- When the project is transferred or set up in other cities, training and support for local manager(s) must be provided to enable them to tackle every aspect of the supervision of mediators, particularly in fields which do not fall within the primary skills of the selected local partner organisation (AIDS, prostitution, migration, social support).

Contents

The Migrants Project

This project, which was started in 1991, is based on the following principles :

- AIDS prevention for people of foreign origin in Switzerland is based on the universal right to know, intended to guarantee all residents equal access to prevention and to health maintenance resources ;
- only the well-informed and motivated can protect themselves and others against the spread of HIV. Information must be culturally appropriate ;
- only a participatory community-based prevention programme stands a chance of being accepted and understood. Programmes must be co-ordinated by people who belong to the target communities.

During its pilot phase (January 1991-December 1992), which was previously evaluated, this programme was aimed at three distinct communities : the large Spanish and Portuguese communities in Switzerland, and the Turkish community, which is culturally more distant. It was subsequently broadened to include other communities (Latin-American, Tamil, African) and situations (having applied for political asylum).

A general coordinator of Swiss nationality is responsible for the overall programme, backed by coordinators from each national group, who are responsible for introducing the programme into their community.

The programme is implemented in three phases in each community :

- heightening the awareness of the general population, and developing educational material adapted to the specific cultures ;
- recruiting and training mediators (a multiplication strategy) to implement measures within their own communities :
 - a) initially, prevention activities for the entire community ;
 - b) subsequently, prevention activities targeting groups most at risk within the community (e.g. : young drug users).

The needs assessment and the pilot period of the programme were studied during previous phases of the evaluation programme.

During the most recent phase, the main questions in evaluating the programme were :

- **How are the programme's activities being continued after the pilot phase ?**
- **Who are the mediators, and what do they do (profiles, activities, relations with the project, expressed needs, successes and problems encountered in their work) ?**
- **What is the current state of knowledge, attitudes and behaviour regarding AIDS prevention within the three communities targeted by the programme ? (This aspect of the evaluation is covered in the results section of this summary.)**

The programme's **activities** often snowballed within the three communities (demand generated by the measures implemented). Most of the programme's activities are aimed at the community's population in general (involvement in events, information meetings, articles in community newspapers, radio broadcasts, telephone hot-lines). Due to the increasing visibility of the programme, more specific requests or opportunities to take action have emerged. Mediators are asked about issues relating to people with HIV and have extended their work to include new groups (homosexuals, drug users). The programme is thus well established within the three communities.

Eighty-one **mediators** were contacted by telephone and asked about their work. In-depth interviews subsequently took place with eight of them.

In the Spanish and Portuguese communities, mediators are more likely to be women, and in the Turkish community men. They are aged thirty to forty-five, and have generally lived in Switzerland for many years. They are involved in community life, and are recruited from a wide range of trades or professions, but particularly from the medico-social or educational fields. Coordinators recruit mediators as opportunities arise, without predetermined profiles and without assigning particular tasks to mediators. Half of the mediators have followed courses on AIDS prevention (provided by the pro-

gramme or by other institutions), while a quarter were trained with their coordinators "on the job". Others received training during their professional activities, or trained themselves. There is no formal framework for the project's supervision of their activities. The pool of mediators varies, as some return to their country of origin.

Mediators may handle activities and relations with the programme in very different ways, and the very concept of "mediator" is somewhat vague and complex in practice. By the same token, the organisation of the mediators' work is unstructured. The programme's activity has developed along networks branching out from the three coordinators. Each coordinator has an individual style of working, and their networks are by nature extremely varied, combining formal and informal relationships. Mediators are therefore very diverse and have highly personalised networks. The geographic spread of mediators makes coordination by a single person difficult, leading to lack of contact and the isolation of mediators from both the programme and each other. Mediators only meet for training courses, and are vertically linked to their coordinator. There is no strictly established rule concerning remuneration: some mediators are paid (or rather reimbursed) while others are not.

Their roles and activities are extremely varied. Some facilitate contact between the programme and the communities (embassy staff, journalists, administrators of associations), but perform no specific prevention activities themselves.

The activities themselves can be classed into three main categories:

- **AIDS prevention in the context of professional activity** (for instance, teachers of language and culture who deal with the question of AIDS during their lessons). They need coordinators for AIDS training when they begin their activities, and to provide them with material (brochures etc.). Thereafter they tend to need relatively little monitoring or supervision;
- **prevention at a more individual level within the groups concerned**, or support for those with AIDS. Activity develops through networks, from person to person, depending on the needs which emerge in the field. Some of these mediators are very closely monitored by coordinators, while others work independently of the Migrants Project, only linking up with it occasionally;

- **staffing information stands** and chairing prevention sessions, for example, at the request of associations. Most of these mediators carry out their AIDS prevention activities in collaboration with coordinators, and are therefore supervised very directly. Two or three groups of such mediators, after following a series of training sessions, are beginning to operate more independently, in regions at some distance from the coordinators.

The operating conditions of mediators are thus flexible, rather creative, unevenly supervised. Their activity is irregular. After working for a while, active mediators often come to be considered as resource persons (contacts) for anything having to do with AIDS issues in their communities. This corresponds closely to the goals of the programme. However, individuals with serious problems in this realm also increasingly tend to refer to the mediators (although the mandate of the latter is prevention rather than HIV/AIDS support). It goes without saying that most mediators do not ignore such requests, although this can cause them to bear an increasingly heavy burden, aggravated by the fact that some of those relying on them for help are living with serious health problems in a foreign land (isolation, lack of rights, etc.).

The programme has managed to develop a network of mediators, which has both strengths and weaknesses. Its strengths are: the diversity of the mediators and their activity; sustained motivation among many of them; and a flexible and creative system. Its weaknesses are: dependence on ties to coordinators; the vague status of mediators; and training and monitoring that is sometimes inadequate. The fact that certain mediators have become advisers within their communities for AIDS-related questions other than prevention is a strength, but may also be a weakness if they are unable to mobilise the existing resources of their regional AIDS network. By the same token, the constant renewal of part of the pool of mediators may be considered a "plus" (renewal of operational networks) or a "minus" (cost of finding and training new mediators).

Conclusions

- The Migrants Project is developing in accordance with its objectives: to inform the non-Swiss population in general, to encourage solidarity before targeting particularly exposed groups within these communities, and to work with the community through existing networks. A network of mediators has been set up, and is operational.
- The project is known within the target communities, who feel concerned by both the problem of AIDS and that of drug abuse.

Recommendations

- Support for mediators must be strengthened (within the Migrants Project itself and through improved coordination with local resources).
- This project should be extended to other migrant communities living in Switzerland.

AIDS prevention by primary care physicians

General practitioners occupy a prominent position within the AIDS prevention system. The nature of the doctor-patient relationship favours personalised counselling, and the fruits of this are widely disseminated due to the high frequency of consultations among the population.

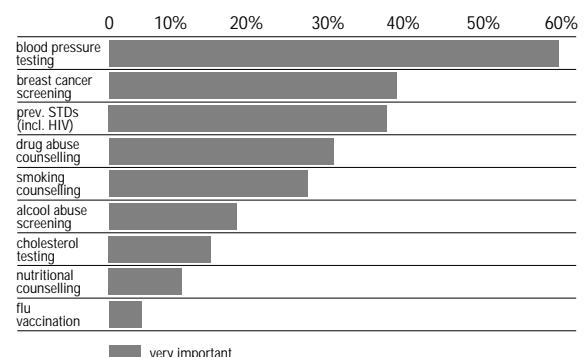
A study in 1995 examined general practitioners' activity in the field of AIDS prevention, comparing it with that of 1990. It explored factors associated with prevention and counselling activities, and sought to ascertain whether doctors would like to strengthen this aspect of their practice.

- **What are the AIDS prevention activities of primary care physicians ?**
- **Have these expanded over the last few years ?**
- **In general, what role do these activities play in their work ?**

The study has both quantitative and qualitative aspects (respectively, a questionnaire sent to 1,500 doctors, and interviews with thirty-two doctors). A priori, it concerns the specialities most concerned with AIDS and its prevention : general practitioners, internists, dermatologists and gynaecologists. Of these, 796 returned the questionnaire before the deadline, a response rate of 55 %.

Most doctors consider that **general prevention** is an important aspect of their work, although their practices and attitudes to prevention are extremely varied. Some act at the request of patients, while others are more interventionist. In terms of content, some prefer to depend on laboratory screening, while others prefer dialogue with patients, and prevention counselling. One-third of doctors consider the prevention of sexually transmitted diseases (including HIV) as very important in their own work.

Importance ascribed to various preventive measures in physicians' surgeries.



Asked what form their **AIDS prevention activity** might take, 87 % considered in-depth counselling for HIV-positive patients very important in avoiding new infections ; 56 % mentioned the investigation of risks during medical history-taking, offering advice, and if necessary proposing a test ; 48 % suggested briefly reminding all young patients of advice on protection.

In practice, some two-thirds of doctors (half in 1990) have brochures or posters about AIDS in their waiting rooms. One doctor in six generally leaves the initiative of mentioning AIDS to patients. One in five usually takes this initiative himself, while nearly two out of three adapt their behaviour to the situation, sharing the initiative with the patient.

Appropriate counselling requires knowledge of the patient's situation and a medical history including sexuality and drug use in order to reveal a possible risk of exposure to HIV transmission. Such **risk investigations** are not carried out systematically. For instance, when treating new young patients who do not have an urgent problem, 70 % of doctors state that they always or often bring up the issue of drugs, 68 % discuss contraception, 49 % mention sexuality, and 47 % sexually transmitted diseases (STDs). Urban doctors are more systematic than their rural colleagues.

More generally, doctors adopt various strategies to suit the circumstances. They pay particular attention to patients belonging to population groups conventionally associated with the epidemic : 95 % of doctors look for possible exposure to the virus when interviewing drug

users, 88 % when interviewing prostitutes, and 84 % when interviewing homosexuals. Since their presenting complaints indicate sexual risk-taking, patients suffering from STDs are also interviewed by a large proportion of doctors (91 %). People consulting their doctor for other reasons related to their sex lives (contraception 54 %, pregnancy 63 %) are less frequently examined for possible contact with the virus. Risk investigation is least systematically carried out in the case of categories of patients typical of the « general population » (adolescents and young adults; new patients; migrants; unmarried, separated, divorced or widowed patients). More attention should be paid to these cases, as doctors cannot *a priori* know the sexual habits of these people (new patients) and they might have reason to suspect that some have unstable emotional lives. Nevertheless, the situation improved markedly between 1990 and 1995. The proportion of doctors claiming to carry out systematic risk investigations for each category of the « general population » almost doubled. For instance, 55 % now investigate risks with their young patients, although only 23 % did so in 1990.

Systematic risk investigation trends among various types of patients or situations: 1990 - 1995.

	1990	1995	p
Drug users	93	95	n.s.
STD Patients	87	91	**
Homosexuals	70	85	***
Travellers to the tropics	54	61	*
Requests for contraception	52	54	n.s.
Patients with tattoos	46	27	***
Pregnancy	36	63	***
Separated or divorced patients	26	23	n.s.
New patients	23	41	***
Adolescents or young adults	23	55	***

* p < .05; ** p < .01; *** p < .001

Two hypothetical situations were presented to doctors in order to investigate advice given on prevention. These described circumstances requiring distinctly different advice. The first presupposed a consultation with a young adult known to be an intravenous heroin user. The second involved a young girl aged sixteen who at the time of consultation was having sexual relations with one sexual partner and was asking for contracep-

tion. In the first case, most doctors offer advice proposing the use of sterile injection material (87 %), the regular use of condoms (86 %), and taking an HIV test (73 %). Compared with 1990, the main change lies in the association of these three types of counselling. At this time, doctors were far less aware of the need to deal with the sex lives of their drug-using patients.

In the second case (a request for contraception from a young girl), only 56 % of doctors suggested a solution combining contraception and protection against HIV and other STDs (condoms + the pill, condoms alone, or condom + " morning after " pills in the event of an accident with a condom). The pill alone was advised by 38 %, while 7 % advocated abstinence. More than 50 % of doctors have already told some patients how to use condoms.

Various **obstacles** may **hinder the progress of HIV prevention at the physician's surgery**. Physicians attribute some of these to patients, others to the practitioners themselves, and still others to provisions relating to the reimbursement of medical acts.

Physicians see patients' reticence and lack of interest in talking about HIV prevention as the most important obstacle to prevention. However, the qualitative study suggests that patients rarely explicitly show reticence or lack of interest. Physicians seem to ascribe these reactions to them on the basis of rather vague arguments, some of which are merely projections of the reticence of the doctors themselves. Indeed, the fact that the HIV/AIDS issue is often raised on the patient's initiative shows that reticence and lack of interest, although they undeniably exist, are actually a minority attitude among the public.

One doctor in three, or less, sees as important any of the obstacles ascribable to doctors themselves (lack of time, knowledge or skills; embarrassment in talking about sexuality or drug use). Finally, fewer than one doctor in five sees the remuneration of prevention advice (a fundamental dimension of HIV/AIDS prevention) as a major obstacle.

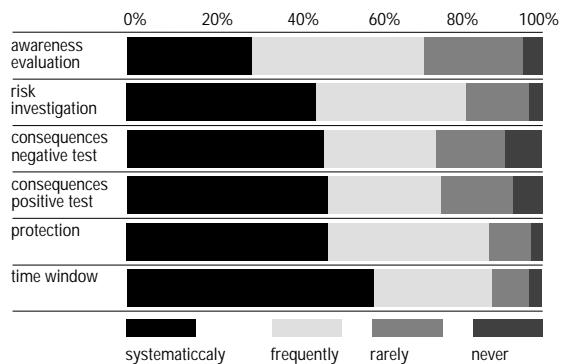
Physicians frequently make use of **HIV tests**. Almost all had prescribed at least one during the six months prior to the survey (an average of seventeen per doctor for this period). The profile of the patients tested varies with the medical speciality. Gynaecologists mainly prescribe tests when patients become pregnant or feel that they have taken risks, or during check-ups for couples. Dermatologists usually prescribe tests in the event of an overt risk (generally, a patient being treated for an STD), while general practitioners prescribe them during medical check-ups, at the request of life-insurance companies, and in the event of exposure to risk.

Reason(s) for the last test carried out at the physician's surgery (%)

	primary care physicians	gynaecologists	dermatologists
Risk perceived by the patient	30.2	26.8	48
Life insurance	21.5	2.4	0
Medical check-up	19.6	7.3	16
Check-up for couple	13.7	19.5	0
Risk perceived by the doctor	13.6	6.1	28
Pregnancy	4.7	57.3	0
Phobia	10.2	7.3	8
Suspicion of immune deficiency	5.2	0	20
Choice of contraception	2.9	7.3	0
Pre-operative check-up	0.3	1.2	0

In many cases, the request for a test raises the issue of HIV/AIDS during the consultation. **Pre-test counselling** is therefore particularly important, and should include an investigation of risk, an evaluation of the patient's knowledge about AIDS prevention, a discussion of the possible consequences of a positive or negative result, recommendations on prevention, and verification that the test is being carried out in conditions which allow a correct interpretation (no exposure to risk over the last three months).

Frequency of subjects discussed during pre-test counselling (n = 783).



On average, doctors devote slightly less than ten minutes to pre-test counselling and are not systematic. Only the question of the test's validity (three-month window) is routinely dealt with by more than one doctor in two, while three doctors in ten rarely or never mention the consequences for the patient of a positive or negative result.

The **communication of the test result** provides an opportunity to repeat advice on protection. In the case of a positive result, the patient is almost always told in person. This is less common for negative results, which can also be communicated by telephone or mail.

Although discriminatory attitudes towards people with HIV are rare among doctors, and are declining in comparison with 1990, they are still occasionally found. The issues involved include not obtaining consent to carry out tests, refusal to treat people with HIV or full-blown AIDS, compulsory periodic tests imposed on some segments of the population, and systematic testing every time a patient is hospitalised. These attitudes, which are partly due to fear, pose real ethical problems.

Conclusions

- Primary care physicians have substantially increased the amount of attention they pay to the prevention of HIV infection among the general population. Their legitimate interest in groups conventionally considered to be at risk has not weakened. There are still some deficiencies in their interviews with patients representative of the "general population", especially regarding sexual activity. Generally speaking, doctors seem able to provide appropriate counselling.
- Deficiencies still exist in counselling for HIV tests. Although doctors are generally careful never to test patients without their consent, the content of pre-test counselling often still seems incomplete. With a few exceptions, the results are communicated in an appropriate way.

Recommendations

- Physicians should regularly receive epidemiological information reminding them that the dissemination of HIV/AIDS among the population is not limited to groups conventionally considered to be affected by the epidemic.
- To enable them to provide more personal attention regarding prevention, the doctors' attention should be drawn to particular circumstances or psychosocial characteristics which increase the risk of infection. For example, the following information may be useful: characteristics of the emotional lives of adolescents and young adults (serial monogamy); the problems encountered by people who are divorced or experiencing marital problems when trying to start new relationships (the affective issue at stake may eclipse the need to take precautions); and current trends in sex tourism (most popular destinations).
- The HIV/AIDS epidemic has profoundly changed the issues at stake in the prevention of unwanted pregnancies. Physicians should be informed about contraceptive advice, particularly for adolescents. Such counselling should at least include the use of condoms (alone or in association with post-coital contraceptives in the event of a problem, or perhaps in association with the pill).
- HIV tests are not yet always well handled: a reminder is needed as to the need for pre-test counselling and its various dimensions.

Training programmes for volunteer workers and non-hospital medical and para-medical personnel

At the beginning of 1994, the FOPH requested an evaluation of the AIDS training programmes it finances for staff and volunteer workers operating outside hospitals. There have been two distinct mandates for these programmes since 1988, one for German-speaking Switzerland (the Spitex mandate, managed by the Swiss AIDS Federation), and the other for French-speaking Switzerland (managed by the Pro Familia medico-social center in Lausanne).

The evaluation brought to light successes and weaknesses (Pro Familia mandate), as well as major dysfunctions in the case of Spitex. Following the evaluation, decisions were taken on both programmes: in the case of Spitex, the contract with the SAF would not be renewed; in the case of Pro Familia, there were modifications to the rules governing the funding of courses.

In both cases, the FOPH has clarified its position, in terms both of its objectives and of the powers and responsibilities which it chooses to assume in this field. Although it is not yet possible to judge the appropriateness of the new guidelines, these are to be monitored.

Results of prevention measures

The main data on the results of prevention in population groups that were the subject of particular attention in the current phase of the evaluation (general population aged seventeen to forty-five, migrants, adolescents, homosexuals and bisexuals, drug users, hospital staff) are summarised here, as is the development of the epidemiological situation.

General questions, applicable to all the populations studied:

- **What is the current state of knowledge about AIDS?**
- **Has prevention modified sexual activity in general?**
- **How are (potential) risks of exposure to HIV transmission changing?**
- **How do individuals manage prevention, and how are their ways of managing risk changing?**
- **Are any unwanted side effects of prevention appearing?**

The general population

Since 1987, the overall results of AIDS prevention efforts among the general population have been monitored by a periodic telephone survey of the resident population. In 1992, the annual survey was replaced by a biennial survey, the last of which was in 1994 (n = 2,800). Information from the survey has been combined with data from other sources, making it possible to broaden and validate the overall picture.

The public's **knowledge** about HIV transmission and how to protect oneself was investigated by analysing spontaneous answers to an open question. More than 90% of the population mentioned condoms as an effective way to prevent AIDS, and means of protection are almost always mentioned more often than avoidance measures (for instance, use of condoms rather than abstinence or avoidance of contact with prostitutes; use of sterile syringes rather than giving up drug use). Although AIDS is increasingly present, as reflected in an increase in the number of people who know someone infected with the virus, AIDS-related **fear** has remained stable.

Sexual behaviour

AIDS prevention does not appear to have had any major impact on sexual activity. The frequency of sexual relations and the total number of partners did not change between 1987 and 1994. However, two trends are beginning to appear among young adults: a decline in the proportion of people with multiple partners and in the frequency of change of steady partners.

Trends in the incidence of situations raising the issue of protection, population aged seventeen to forty-five, 1987-1994 (%).

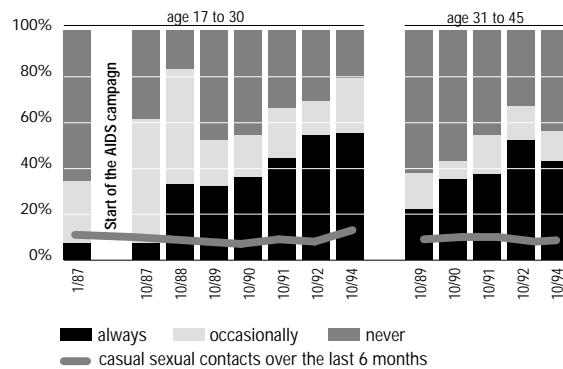
	1/87	10/87	10/88	10/89	10/90	10/91	10/92	10/94
New steady partner during the last year								
17-30			20	15	17	14	15	14
31-45				4	3	4	4	4
One or more casual partners during the last six months								
17-30	18	14	15	15	12	15	14	13
31-45				9	10	10	8	9
Experience with injecting drugs								
17-30	1	< 1	1	1	1	1	1	1
31-45				< 1	1	1	1	1
Contacts with prostitutes during the last six months (men)								
17-30	2	1	1	2	2	3	2	2
31-45					1	1	2	3

It should be noted that, at any given moment, a substantial fraction of the population faces situations which raise the question of AIDS prevention because of a change of partner, multiple or casual partners, or injecting drug use. In 1994, 14% of those aged seventeen to thirty changed their steady partner during the year, while 13% had one or more casual partners during the six months prior to the survey.

The most important behavioural change to have occurred since the beginning of AIDS prevention activities is the increased **use of condoms** when there is a potential risk of exposure to HIV infection:

- among people aged seventeen to thirty, the systematic use of condoms in the event of relations with **casual partners** increased from 8% in 1987 to 56% in 1994, and from 22% in 1989 to 42% in 1994 among those aged thirty-one to forty-five. The **use of condoms** has stabilised since 1992;
- the use of condoms at the beginning of relationships with **new steady partners** also increased: in 1994, 64% of people aged seventeen to thirty who had established new steady relationships used condoms, while the equivalent figure was 72% for those aged thirty-one to forty-five.

Use of condoms with casual partners, population aged seventeen to forty-five.



Moreover, a survey of the **foreign-born** population in Switzerland, who were the target of the Migrants Project (Spanish, Portuguese and Turkish communities), was carried out in 1995 as part of the evaluation of this project. It showed that the three communities now have the same degree of knowledge and level of protection

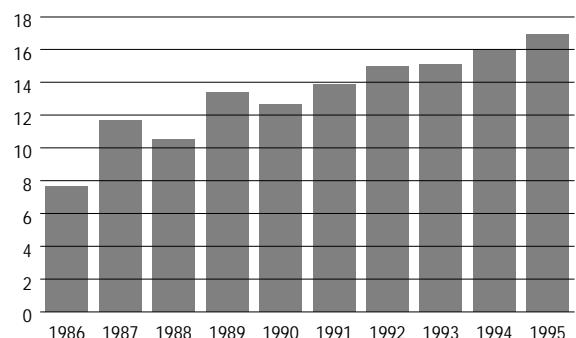
as the Swiss population. A comparison with previous studies in these communities indicates an improvement in knowledge and preventive behaviour between 1990 and 1995.

Women tend to be less often in situations involving a potential exposure to HIV infection. When confronted with such a situation, they nevertheless seem to use condoms less systematically than men. In 1994, 37% (± 9) of women and 57% (± 7) of men systematically used condoms with their casual partners; 61% (± 9) of women and 71% (± 8) of men systematically used condoms with their new steady partner (in this case, the difference is not significant). Overall, 21% (± 2) of women and 30% (± 3) of men used condoms the last time they had sexual intercourse.

Switzerland's linguistic regions show minor differences in protective behaviour and in the frequency of exposure to potential risk of infection. Trends in such situations over time do not suggest any increasing divergence or convergence.

The increasing use of condoms among the population is confirmed by figures for condom sales (90% of the market), which rose from 7.6 million in 1986 to 16.9 million in 1995.

Condom sales, in millions of units.



The condom: image and problems

Studied in population surveys since 1991, the image of the condom has many facets which have remained unchanged over the last few years. Condoms have a very high level of social acceptance, and are considered everyday objects. They are not viewed (by any age group) as "old-fashioned", nor specifically "for young people", and they do not cause embarrassment when bought. Their use does not appear to respondents to be "complicated".

There are still three problems, however. First of all, for almost one respondent in seven, condoms cause barriers within a relationship, because they "create doubts" or are deemed to be "not necessary if you're in love" (nearly one respondent in five). Another, more important, obstacle to their use is the personal consequences felt by the user: condoms "decrease pleasure" for 30% of respondents and seem "unnatural" to more than 40% of them. Finally, almost four respondents in ten doubt the effectiveness of condoms as a means of protection. The level of doubt is not growing, however.

These concerns should be compared with the actual problems reported in the regular behavioural survey of the seventeen to forty-five age group. In 1994, 68% of condom users had never experienced problems such as a slipped or torn condom, whereas, the remaining one-third had encountered such problems.

About one person in three had used condoms during the last six months. Among these users, the rate of slippage was estimated at 0,6% and the rate of breakage at 0,3%. Most such "accidents" occur with high-quality condoms during vaginal intercourse between long-term partners. They are not particularly concentrated in any identifiable sub-groups, and are therefore probably an unavoidable consequence of the large-scale use of condoms for AIDS prevention. There are no particular circumstances in which ruptures seem to occur more frequently. Half of those who had experienced condom breakage reported a loss of confidence in this means of protection, although two-thirds stated that they nevertheless intend to use them as much as before.

HIV testing

While there has been some stagnation in the use of condoms, there has been change in another area: **a large proportion of the population** (31% of men and 38% of women aged seventeen to forty-five) **has chosen to take HIV tests**. If tests carried out during blood donations are included, 56% of the population of this age group (61% of men and 51% of women) have already had an HIV test. Information from anonymous testing centres and general practitioners leads to the conclusion that some people may be starting to use HIV testing as a measure of individual prevention, including testing to check serological status within a couple before subsequently abandoning the use of condoms, or to check that an exposure to risk has not led to infection.

Conclusions

- A high level of protection with condoms has been attained without any substantial changes in sexual activity since the beginning of the prevention campaigns. Condom sales more than doubled between 1986 and 1995.
- The three populations of foreign origin studied in 1995 can generally be considered to have as high a degree of knowledge and of protection when exposed to a potential risk of HIV transmission, as the Swiss population.
- Women tend to be involved less often in situations involving potential exposure to HIV infection. When confronted with such situations, however, it seems that they do not use condoms as systematically as men.
- The slight regional differences in protection and in exposure to potential risks of infection do not require any special measures.
- Condoms are now considered everyday objects, but there are still doubts about their effectiveness as a means of protection. Nevertheless, the level of doubt is not growing.
- Accidents when using condoms (breakage and slippage) are a fact which should be taken into account.
- Voluntary HIV testing is becoming widespread in large segments of the population. Tests are frequently repeated. The population is resorting to voluntary HIV testing independently, as public health authorities have not broadly disseminated any clear advice on this subject.

Recommendations

- Clear answers to concrete problems faced by the population (the circumstances of HIV testing, problems with condoms, decisions to stop using condoms) must be found and communicated.
- AIDS prevention must integrate messages concerning sexually transmitted diseases and contraception.

Contents

Adolescents

Adolescents and young adults are one of the groups targeted by the AIDS prevention strategy. For many, debut into sexual life involves a period of searching for the ideal partner, which is reflected in changing partners, and thus a risk of exposure to HIV.

The data used to evaluate the behaviour of this group come from two main sources: the regular survey of the population aged seventeen to forty-five, and the Swiss Multicentric Adolescent Survey on Health carried out in 1992-1993 among 9,300 adolescents aged fifteen to twenty either attending school or training as apprentices. A review of the literature was carried out, together with a secondary analysis of data from existing studies on the sexuality of adolescents in Switzerland.

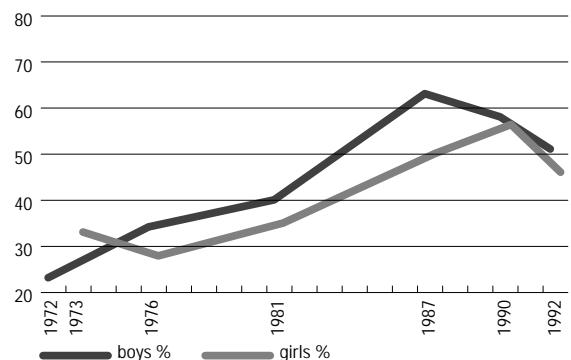
Sexual debut

Discussions with parents concerning sexuality are significantly more frequent among girls (68%) than among boys (50%).

12% percent of girls and 16% of boys had their **first sexual relations** before the age of fifteen, and 25% of adolescents aged fifteen to sixteen were sexually active. This proportion is the same among both boys and girls, but is higher among apprentices than among students.

Some have expressed fears that promoting the use of condoms would encourage adolescents to become sexually active at an earlier age, or to have more frequent partners (incentive effect, permissiveness). This has not occurred. The long-term downward trend in the age of sexual initiation (measured by changes in the proportion of sexually active young people aged seventeen) was reversed at the end of the 1980s, after the beginning of large-scale AIDS prevention. The proportion of sexually active seventeen-year-olds, which had gradually increased since the 1970s, actually started to decline.

Proportion of sexually active seventeen-year-olds in Switzerland, 1972-1992.



Sexual behaviour

As for the **frequency of sexual relations and the number of partners**:

- girls report more regular sexual relations than boys, although the weekly frequency of such relations nevertheless remains low: only 29% of sexually active young people aged seventeen to twenty have intercourse twice or more per week;
- boys report more partners than girls.

Various corroborating indicators suggest that the frequency of situations involving a **potential risk of HIV transmission** is decreasing among adolescents. The proportion of young people aged seventeen to twenty who had established relations with a new steady partner during the year of the study fell from 27% in 1988 to 22% in 1994. In 1987, 17% had had one casual partner or more over the previous six months. In 1994, the corresponding figure is 12%. Finally, the proportion of those who had had more than two partners in their lives also decreased from 34% in 1987 to 25% in 1994.

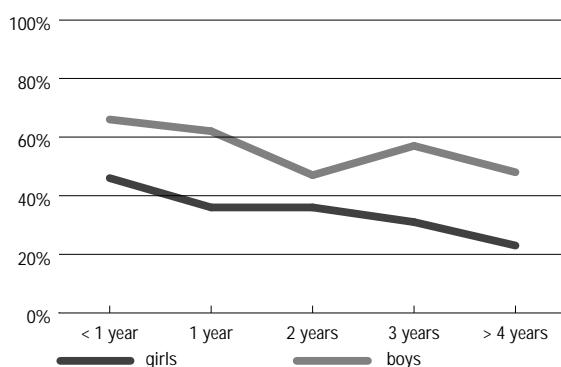
The increased use of condoms has been most marked among adolescents:

- among those aged seventeen to twenty, the systematic use of condoms in the event of sexual relations with a **casual partner** increased from 16% in 1987 to 69% in 1994;
- the use of condoms at the beginning of a relationship with a **new steady partner** also increased, from 42% in 1988 to 59% in 1994.

Contraception

80% of adolescents (almost the same proportion among both boys and girls) use some **method of contraception** the first time they have sex. Nevertheless, contraceptive use varies according to the age when this event took place, and is less frequent among those who started at a younger age. The type of contraceptive used was often a condom. A high proportion of adolescents use condoms as they become sexually active, although the proportion decreases as their sex lives prolong.

Condom use during the last sexual contact in relation to duration of sex life.



The decline in the use of condoms is more marked in girls, perhaps because they are not sufficiently encouraged to adopt condoms as a method of contraception (either associated with other methods or not), at least during the first few years of their sexual lives.

Finally, although condoms are often considered to be somewhat less effective than some other means of contraception, such as the pill for example, their widespread use has not been accompanied by an increase in unwanted pregnancies. Switzerland still has one of the lowest abortion rates in Europe for the overall population, and the long-term downtrend has continued over the last few years. Abortion data from several cantons, broken down according to age, do not indicate any recent increase in the number of abortions among adolescents and young adults.

These rather reassuring results concerning adolescents in general should nevertheless be kept in perspective: a

study of young people who "drop out" (leaving school or an apprenticeship, putting them in a precarious social situation) showed that such young people were far more exposed than others to all sorts of health risks, including those related to sexuality (unwanted pregnancies, sexual abuse, etc.).

Conclusions

- Various corroborating indicators suggest that the frequency of situations involving a potential risk of HIV transmission is decreasing among adolescents.
- Adolescents have been the most consistent of all population groups in adopting protective behaviour involving the systematic use of condoms. The rise in contraceptive use of condoms has not been accompanied by an increase in unwanted pregnancies.
- Promotion of the use of condoms and widespread sex education have not been accompanied by more marked sexual precociousness.
- Thus far, insufficient attention has been paid to the problem of contraception among young people in situations of serial monogamy.
- Some socially disadvantaged young people who "drop out" are particularly exposed to health risks.

Recommendations

- It is important to promote condoms as a means of contraception and of protection against AIDS and STDs. This applies particularly to young people during the period of sexual debut, and during the search for a partner that takes place in adolescence before a long-term relationship is formed. Girls and boys must therefore be offered opportunities to monitor contraception:
 - regular checks, counselling, access to "morning-after" post-coital contraceptives in the event of problems with condoms (omission, breakage), with perhaps use of the pill if sexual relations are regular, etc.
- Particular attention should be paid to young people in difficulty, who are not reached by prevention efforts in educational settings.

Contents

Homosexuals and bisexuals

Four studies investigating the prevention situation among homosexuals and bisexuals have been carried out since 1987. The most recent study, presented here, was carried out in 1994. A questionnaire published in the gay press was distributed by associations and in bars and saunas. 1,195 questionnaires were returned. In educational level, linguistic breakdown and place of residence, this sample is comparable to those studied in previous years, although the average age is slightly lower (1994: 35,3, 1992: 37,1) and the proportion of people in steady relationships is higher. In-depth interviews (32) were also carried out, concentrating on protection within couples.

The sexual activity of most respondents (>90%) is exclusively homosexual; 41% belong to homosexual associations, and 12% to AIDS prevention associations. Three-quarters know someone who is HIV positive, who has AIDS, or who has died of AIDS. This is considerably higher than average for the Swiss population (25%). One-third of those interviewed were in exclusive, steady relationships, while a further third were in steady relationships but had other sexual partners. The remaining one-third had no steady relationships.

Sexual activity and practices

Three percent of respondents had no partners at all during the previous twelve months, while 17% had only one. 32% had from two to five, 17% from six to ten, 15% from eleven to twenty, and 16% had more than twenty.

The most common sexual practice with all partners is masturbation. Fellatio and penetration are closely linked to the type of relationship: 76% of respondents practice penetration with their steady partner, for instance, whereas this is true of only 60% of respondents with their casual partners. 35% of respondents have sexual relations several times a week, 33% several times a

month, 17% only occasionally, and 15% irregularly, but with periods of intense activity.

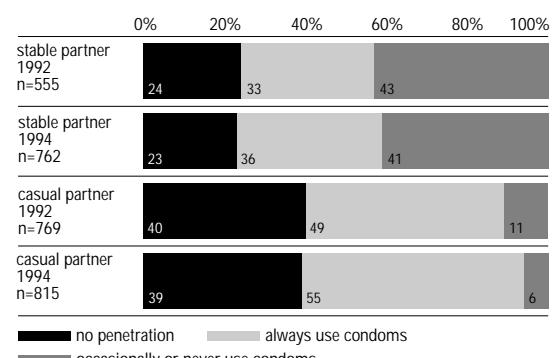
The frequency and distribution of sexual practices have not changed over the last few years.

Protection against HIV

The risk of infection through **fellatio** is managed better than in 1992. This is particularly the case with casual relations, in which 88% of respondents (as compared with 78% in 1992) stated that they neither had sperm in their mouths nor practised fellatio during the previous twelve months. With steady partners, the proportions are lower (65% in 1994, and 62% in 1992).

The present study shows that the level of protection against HIV in the case of **anal intercourse** is still high, particularly in relations with casual partners, as some 90% of respondents avoid exposure to the risk of HIV transmission by either avoiding penetration or systematically using condoms. Between steady partners, some 60% are not exposed to the risk of HIV transmission as they do not practice penetration or always use condoms, while the remaining 40% do not always use condoms.

Use of condoms during anal intercourse with both steady and casual partners over the previous twelve months: comparison 1992 vs.1994.



It is quite possible, however, that respondents underestimate their degree of exposure to risk, particularly with steady partners. Analyses show that a large proportion of those in steady relationships are aware

neither of their own serological status nor that of their partner, and practice anal intercourse without condoms.

Couples in steady relationships

Several results of the qualitative study confirm that homosexuals in steady relationships can also be exposed to the risk of HIV infection:

- anal intercourse is more common between steady partners, and condoms are used far less often. The frequency of sexual activity between steady partners is higher than between casual partners;
- about half of the 70% of the respondents in steady relationships have open relationships, involving several other partners during the year;
- one-third of the steady relationships last for a year or less. This implies frequent changes of partner. In one-third of steady relationships lasting for three months or less, consistent use of condoms has already been abandoned during anal intercourse. It therefore seems that the recommended procedure of waiting three months to take a test before subsequently abandoning the use of condoms is not always followed. Condom use during anal intercourse continues to decline the longer the relationship lasts;
- slightly more than half of homosexuals practising anal intercourse in steady relationships are aware of each other's serological status (57%). Knowledge of mutual serological status has a major influence on the use of condoms, which are not often used between HIV negative partners, and are nearly always used when one of the partners is HIV positive. On the other hand, about one-third of the couples who are not aware of their mutual serological status do not always use condoms, behaviour which is quite risky in a population with a high rate of HIV infection;
- age differences within couples are large, as couples involve a mixing of generations and the risk that some age groups "historically" more seriously affected by the infection could pass on the virus to younger generations if they do not follow protection guidelines;
- the more partners are in love, the less they protect themselves against HIV infection;
- interviews show that unspoken problems exist between partners in steady relationships. Behaviour involving a lack of protection could have emotional

causes (keeping the partner, difficulties in the relationship, unspoken problems, an ideal of faithfulness, etc.). Faithfulness is very often assumed: despite the greater liberty often said to be enjoyed by homosexuals with regard to other partners outside the couple, some consider faithfulness to be very important (especially younger people). It seems that in the case of steady partners and external relations, protection is often negotiated only after an exposure to risk. Few couples reach prior agreement concerning AIDS prevention in the event of external relations (use of condoms only with external partners and reintroduction of condoms into the couple if accidents or omissions occur, abstention from anal intercourse with external partners, etc.).

People with HIV

On average, homosexual respondents who report they are HIV-positive have more partners than those who are HIV-negative and who are untested, and they practice anal intercourse more often. Compared to the HIV-negative and the untested, they were more likely to admit exposure to the risk of transmission during the year. However, one should not exclude the possibility that people with HIV remember and report more than the HIV-negative and those who are untested, as they are aware of the serious potential consequences of not using condoms. In managing AIDS risks (frequency of sexual activity, number of partners, penetration, protection), people with HIV are not a homogeneous group. Moreover, the majority of HIV-positive respondents have informed their steady partner of their HIV infection, although casual partners are less often informed. It is apparently still difficult to discuss one's HIV infection due to fear of discrimination.

Young people (under twenty-five)

Questionnaire data indicates that young people do not take more risks than their elders. On the contrary, they are slightly more careful. Nevertheless, qualitative data show that the period of discovery of their homosexuality is a difficult one for many, and that some therefore view protection against HIV infection as a secondary concern.

HIV testing

73% of respondents have been tested for HIV, and 50% have been tested several times. Ten percent report being HIV positive, slightly less than in previous years. The prevalence of HIV infection seems to be stabilising. Nevertheless, the fact that some 10% of the respondents had had another sexually transmitted disease during the year clearly shows the potential for exposure to the risk of HIV.

Respondents tested for HIV and serological status.

	1994 n = 1195	1992 n = 934	1990 n = 720	1987 n = 795
% tested	73 % ± 3 %	72 % ± 3 %	67 % ± 3 %	57 % ± 3 %
• HIV-positive	10 % ± 2 %	11 % ± 2 %	13 % ± 2 %	14 % ± 2 %
• HIV-negative	87 % ± 2 %	87 % ± 2 %	81 % ± 2 %	77 % ± 3 %
• Do not wish to answer*	3 % ± 1 %	2 % ± 1 %	6 % ± 2 %	9 % ± 2 %

* or don't know

Problems encountered with condoms

Twenty-one percent of respondents had experienced at least one split condom during the previous year, while 12% had experienced slippage. Such accidents happen more often to respondents with many partners or frequent sexual relations. Respondents who always use lubricants during anal intercourse with their steady partner have slightly fewer accidents with condoms than those who do not. Systematic use of lubricants during anal intercourse increased from 63% in 1992 to 72% in 1994. However, inappropriate lubricants are still used by 6%.

Conclusions

- The degree of protection against HIV among homosexuals and bisexuals is still high.
- It is difficult to maintain appropriate long-term protection systematically. This applies particularly to steady partners. Within couples, clear agreement concerning prevention in the event of external sexual relations is often lacking.
- Young homosexuals take as many precautions as their elders, but describe "coming out" as a period when prevention may seem to be of secondary importance.
- There is a trend towards the stabilisation of HIV infections, but new infections are still occurring.

Recommendations

- It should be recalled that having a steady partner is not, in itself, a protection against HIV in a population with a high rate of infection. Couples who wish to stop using condoms should be encouraged to do so only after taking a test under suitable conditions.
- The importance of communication between steady partners and of clear agreement concerning prevention from the beginning of the relationship are both subjects for discussion which should be promoted within homosexual couples.
- Young homosexuals discovering their sexual orientation should be supported so that they do not neglect preventive behaviour during this difficult period. Homosexuals who have sex with young people starting their sexual lives should stress the need to take precautions from the very beginning (by way of example and through inter-generational solidarity).

Contents

Drug users

AIDS-prevention efforts among drug users aim to reduce risks of HIV transmission through blood (sharing of injection material) and sexual intercourse. The data below are drawn from studies carried out between 1989 and 1995.

Sharing of injection material

Each of the studies comparing lifetime sharing experiences with those during the previous month or six-month period reported a decrease in sharing syringes. Although not all of the studies were aimed at comparable populations (some were carried out among patients beginning withdrawal treatment, and others among people frequenting "low-threshold" easy access facilities where injection material is available), the downturn is widespread. Also worth noting is that it is more common to have shared material at least once in a lifetime in French-speaking Switzerland, where syringes are more difficult to obtain, and that currently only a minority of injecting drug users take this risk:

- of five studies carried out between 1993 and 1995 among various groups of drug users (people beginning out-patient treatment or frequenting syringe-distribution centres, hidden populations not undergoing treatment), the proportion of those who have shared injection material at least once in their life ranges from 39% to 51%;
- in these same studies, sharing over the previous six months varies from 11% to 17%.

It appears that sharing is more frequent among irregular drug users or beginners (less contact with structures offering sterile material?) and between partners or friends.

Preventing the sexual transmission of AIDS

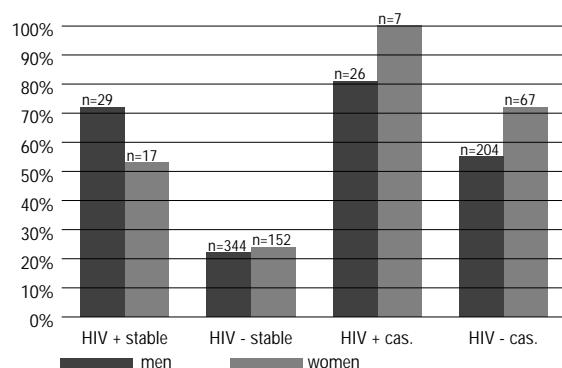
Progress in condom use has been recorded, clearly showing that drug users can also adapt their sexual

behaviour to the reality of the epidemic. Preventing the sexual transmission of HIV is nevertheless still a major problem among drug users, whose partners often do not inject, or even use drugs at all. This mainly concerns protection with steady partners. In view of the prevalence of HIV infection within this group, there has still not been enough change in behaviour. Sexual transmission could therefore become preponderant within this group, subsequently extending to other populations.

On the whole, protection with condoms is very frequent in the event of prostitution. Four studies carried out between 1989 and 1994 indicate proportions of systematic protection ranging from 46% (1989) to 87% (1995). With casual partners (non-clients), rates are similar to those in the general population. Nine studies carried out between 1989 and 1995 report systematic protection rates over the previous six months ranging from 38% (1989) to 77% (1992). Condoms are far less frequently used with steady partners (with whom there is repeated contact). The rate of systematic protection varies from 12% (1989) to 22% (1992) in the nine studies mentioned.

Drug users with HIV report using condoms more often than those without the virus, although some use condoms irregularly or not at all, regardless of the category of partner. Women take more precautions with their casual partners than men. The opposite is true in the case of steady relationships.

Drug users: Proportion of people who systematically use condoms, by sex, serological status and type of partner (steady or casual).



Prevalence of HIV infection

Relatively stable rates of HIV prevalence over the last few years indicate that the advance of the epidemic in this massively tested population may have started to decline. In 1989-1990, the prevalence reported in various studies stood at about 20%, while in 1993-1994, it was between 10% and 15%. It is still lower among people who started injecting drugs after 1986.

Conclusions

- **The sharing of syringes has declined substantially.**
- **Despite recorded progress in the use of condoms, prevention of the sexual transmission of HIV is still a major problem among drug users, whose partners often do not take drugs by injection or otherwise.**
- **These encouraging results can be ascribed to the considerable effort to establish easily accessible structures aimed at reducing risks.**

Recommendations

- **Viewed in the more general context of "sexual health" (integrating the prevention of STDs as well as of unwanted pregnancies, sexual violence, etc., along with issues relating to maternity), prevention of the sexual transmission of HIV should become a priority for structures which care for drug users. Appropriate training should be available to those who work in them.**
- **At the same time, other neighbourhood measures (peer education, field work) aimed at preventing the sexual transmission of HIV as described above should be developed and evaluated.**

Prevention and occupational risks of exposure to HIV among hospital staff

Within the health system, the emergence of AIDS has highlighted the issue of occupational exposure to HIV and other viral diseases spread through blood. The problem is not new: the transmission of hepatitis had already caused concern to hospital hygiene executives, although it did not give rise to such strong concerns among hospital staff as HIV. This is so despite the greater contagiousness of hepatitis viruses, and, prior to systematic vaccination against hepatitis B, the substantial rates of hepatitis morbidity and mortality among health-care workers. The risk of infection after percutaneous exposure is currently estimated to lie between 0.2% and 0.5% in the case of HIV; between 2% and 40% among non-immunised people in the case of hepatitis B; and between 3% and 10% in the case of hepatitis C.

In 1989, the FOPH set up a voluntary reporting system for every case of occupational exposure to blood contaminated (or presumed infected) with HIV, issuing recommendations on how to monitor cases and on preventive measures against diseases transmitted through blood.

Evaluation questions:

- **How many accidental needle sticks and cuts with contaminated⁵ material occur among staff?**
- **Under what circumstances do such accidents most often occur?**
- **Are staff aware of necessary protective measures, and how are they applied?**
- **How well does the accident reporting system set up according to FOPH directives work?**

A survey of nurses, surgeons, anaesthetists and hospital cleaners was carried out by questionnaire in seven Swiss hospitals. The overall rate of participation was 72%

(cleaners 74%, nurses 74%, doctors 59%). The sample includes 2,434 nurses, 314 doctors and 368 cleaners.

Nursing and medical staff described 440 accidents within the previous month (38% involved material contaminated with blood or body fluids). There were 35 accidents over the last twelve months among cleaners (94% with contaminated material). Only accidents with contaminated material were included in the statistics.

Annual number of accidents with contaminated material for various staff categories in Swiss hospitals, 1995.

	Annual accident rate per person		
	per day	per month	per year
Nurses n = 2434	2.23 (1.37-3.43)	0.49 (0.38-0.61)	
Surgeons n = 238	11.05 (5.57-19.72)	4.28 (3.37-5.36)	
Anaesthetists n = 76	3.14 (0.07-17.47)	2.11 (1.09-3.68)	
Cleaners n = 368		0.17 (0.05-0.42)	0.11 (0.07-0.15)

Between 2.1 and 8.2 accidents with contaminated material⁶ occur per 1,000 nurses per day, depending on whether the calculation is made for accidents reported for the last month or for the last day of work. In other words, this represents an average accident frequency of 0.49 to 2.23 annually per nurse. The highest rates occur in operating theatres (theatre nurses and anaesthetists). These rates are slightly higher than those recorded in the literature; however, the latter are generally based on official statements rather than on questionnaires.

For surgeons, the number of accidents with contaminated material is higher than among the nursing staff, ranging from 4.28 to 11.05 annual accidents per doctor. These rates are closer to those found in the literature (between 2.1 and 12.5).

5 In order to avoid confusion, we use the term 'infected' in connection with HIV and the term 'contaminated' when speaking of material which has been in contact with blood or body fluids.

6 For a description of the method of calculation, refer to the research report.

For cleaners, the number is lower: between 0,11 and 0,17 annually per person (comparable to rates in the literature), even though this staff category is not supposed to come into contact with contaminated material, which should be thrown away after use in order to avoid this type of incident.

The victims themselves state that some of these accidents are avoidable (by avoidance of dangerous gestures, more care when handling pointed and sharp objects, systematic use of appropriate containers). When the nature and circumstances of these accidents are considered, it can be seen that:

- most accidents occur in "normal" situations (no emergency, no particular nervousness or fatigue reported);
- surgeons are particularly exposed to such accidents, which often involve superficial wounds caused by suture needles. These are not hollow, and are therefore less likely to contain large quantities of potentially infectious material;
- individual nurses are slightly less exposed, but represent the majority of staff exposed to risk in hospitals. Most accidents involve hollow needles, and occur in a variety of places (usually at a patient's bedside). Disposal facilities should be distributed in such a way as to decrease the time and distance between the use of material and its disposal. The capping of needles still causes accidents despite clear instructions given by every hospital;
- cleaners are less exposed, but the accidents affecting them are more serious (a higher proportion of deep, bloody wounds). This is probably because they do not expect to come into contact with sharp material, which has usually been inadvertently or negligently deposited in inappropriate places (e.g.: waste bins);
- among surgeons (who wear double ply gloves) and cleaners, the wearing of gloves appears to be linked to the seriousness of the exposure (less serious wounds, and less blood inoculated through "wiping" of the instrument). On the other hand, this factor does not seem to have any influence on the occurrence of wounds.

The official reporting system in hospitals does not work very well. Although most cleaners report accidents to a superior or to the proper hospital official, only a few nurses do so, and even fewer doctors. Apparently, two

basic considerations influence hospital staff: their personal assessment of the situation, which seems to take into account the seriousness of the wound and the patient's degree of "risk" (based on what criteria?), and commonplace factors (lack of time, the fact that this type of accident occurs frequently, and that the reporting system is seen to be too complicated or restrictive). Thus, irrespective of directives issued by hospitals, the fact that the risk is very often assessed by the accident victim alone is not good enough.

Although hospital staff seem to be relatively well informed about prevention and the occupational risks of contamination by the hepatitis and AIDS viruses, they appear to be less well disposed to applying advice or directives, both in terms of protection and reporting accidents.

Conclusions

- Accidental needle sticks or cuts with contaminated material are more frequent than the reporting system introduced throughout Switzerland would seem to indicate. Some of these accidents are avoidable, particularly those affecting cleaners.
- The reporting of accidents by the staff affected is still inadequate.

Recommendations

- The awareness of health-care staff at every level must be heightened so that accidents do not become commonplace. In particular, the risk of hepatitis should be taken into account as much as the risk of HIV, and prevention should always respect the patient's rights (no stigma, informed consent if a test is carried out). Negligence leading to the deposit of contaminated material in inappropriate places must also be fought, as it causes accidents among cleaning staff.
- Staff information could be further improved, with the introduction of more appropriate material and better procedures.
- Any accident with contaminated material should be reported to a competent, trained person so that a more objective assessment of the situation can be made and a decision made as to what further steps should be taken (whether to continue the investigation, referral to a specialist). The reporting system must be made more easily accessible.

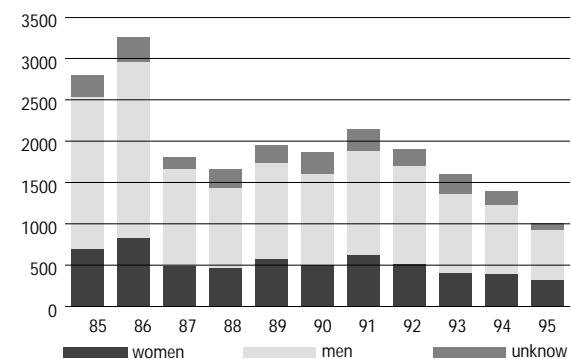
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Epidemiology of AIDS and of HIV

In view of the latent period between the moment of HIV infection and the appearance of AIDS, epidemiological data on the number of AIDS cases are of little interest for evaluation in attempting to detect early results during the years following the beginning of prevention activities. Nevertheless, there has been a decline in the growth rate of AIDS cases over the last few years. The proportion of cases among homosexuals and drug users decreased between 1992 and 1995 (from 38,9% to 32,6% among homosexuals, and from 40,9% to 34,8% among drug users), while the proportion of heterosexual cases increased from 16,9% in 1992 to 27% in 1995⁷. The proportion of women affected continued to rise (20,6% in 1987, 21,3% in 1992, 27,2% in 1995).

Epidemiological data on the new cases of HIV infection detected each year are slightly more useful, although they are still difficult to interpret. Nevertheless, a down-trend can be noted. In 1995, 1,008 tests were declared positive (the annual average since 1987 has been 1,705). In absolute figures, the trend is slightly downward. The proportion of positive tests among those carried out in anonymous testing centres (the only source for this type of data) has remained stable at about 1% over the last few years. In 1995, women accounted for 33% of the 926 positive tests for which the patient's sex is known (27% in 1992). Among heterosexuals, homosexuals and drug users, the proportion of positive tests in relation to the total number of tests carried out has declined since 1985, stabilising between 1990 and 1995. Fewer and fewer new cases are being detected among the under 30s.

HIV-positive results from laboratories in Switzerland by sex.



Generally speaking, since most of the population is heterosexual, it is hardly surprising that the proportion of heterosexual transmission is increasing. Current data do not indicate that the heterosexual transmission of HIV is causing a rapid expansion of the epidemic in Switzerland.

7 Situation as of 29.2.1996.

Solidarity and discrimination in the AIDS epidemic

From the very start, the promotion of solidarity towards people with HIV and AIDS was defined as one of the goals of the AIDS prevention strategy, and the issue of solidarity is usually a primary or secondary objective of prevention measures. The evaluation of attitudes and behaviour relating to solidarity and discrimination is mainly based on information provided by periodic studies of the general population. Other data concerning migrants and homosexuals are drawn from corresponding studies.

- **Are there any signs of either discrimination or of solidarity in the attitudes of the general population?**

The general population feels a degree of uneasiness towards people with HIV or AIDS, and this remained unchanged between 1990 and 1995. Part of the population believe that people with AIDS are rejected. Nevertheless, this uneasiness does not lead to personal attitudes of rejection. On the contrary, people with HIV are very broadly accepted in principle, both at work and in their private lives. This seeming unanimity should, however, be treated with caution: although it most likely reflects the existence of a very clear social norm, it cannot predict the details of individual behaviour.

In 1994, as in 1990, people who are HIV-positive, but who do not have AIDS mainly still have a social image as being incurable patients. About half of the population continue to perceive them as a danger to others, and as lonely, handicapped people. Only slightly more than one-third of the respondents view them as people in good health. This feeling that people with HIV are a danger to others is tempered by the opinion that they take precautions not to infect others. Their capacity to avoid endangering themselves and others was, and still is, highly acknowledged, today by more than 80% of respondents.

Spontaneous responses as to ways of protecting oneself against AIDS do not include the avoidance of particular social groups (prostitutes, homosexuals, people with HIV or AIDS) or places or circumstances (saunas, public toilets, and daily life in general) which could tend to be stigmatising. These data therefore indicate neither the existence nor emergence of stigmatisation processes linking specific groups to the image of the AIDS epidemic.

When asked what should be done to help people with HIV, the population routinely mention solidarity-type measures concerned with social and human aspects. There are no demands for stigmatising and discriminatory measures towards people with HIV.

The attitudes of the foreign population⁸ in Switzerland are on the whole similar to those of the general population. More than four respondents in five feel that people affected by HIV and AIDS need solidarity and support, and have a right to the best possible medical treatment. The vast majority (slightly less among Turkish respondents) reject isolation measures.

Other indirect signs of a supportive atmosphere can be discerned. In a study of drug problems in Switzerland carried out among the population aged eighteen to seventy, most respondents have a favourable opinion of the following proposals: providing help to young people in difficulty (98%), providing treatment for drug users (97%) and survival maintenance (92%); syringe exchange programmes (87%); establishing areas where drug users can inject drugs (73%).

The opinions of homosexuals, especially of those who are HIV positive, about discrimination and solidarity towards those infected with HIV cast a different light on this question. One-third of the respondents believe that employers or insurance companies carry out HIV tests without informing those concerned. Two-thirds of homosexuals also believe that violence towards them has increased over the last few years. Moreover, 15% claim to have been insulted or attacked during the last twelve months.

8 The data come from the evaluation of the "Migrants Project".

The responses given by homosexuals concerning discrimination towards people with HIV indicate that, although muted, it is indeed real. Two-thirds of the respondents feel that people with HIV are marginalised, even among homosexuals. Two-thirds of homosexuals also believe that those who are HIV positive should keep their status secret in order to avoid discrimination.

Conclusions

- **There seems to be a strong feeling of social solidarity in Switzerland, particularly attributable to the STOP AIDS campaigns. This hinders the emergence of overt rejection.**
- **On the other hand, individual solidarity, although unanimously proclaimed, is probably not without gaps.**

Recommendation

- **Solidarity should remain an essential component of AIDS prevention.**

General conclusions

By way of introduction, it can be asserted that nearly ten years after the initiation of large-scale measures in the field of AIDS prevention, the FOPH has been able to maintain a strong, continuous and consistent strategy, which is far from being the case in other European countries, for instance. It has also made an effort to reaffirm the "doctrinal" framework in AIDS prevention by publishing the "AIDS prevention in Switzerland" manual in 1993, and making it widely known.

It should also be stressed that for several years now the results of this strategy can be seen in every milieu, and some recent improvements have been confirmed.

Generally speaking, preventive behaviour has reached a high level, although improvements still need to be made.

Development of the strategy

Between 1993 and 1995, the strategy adopted in Switzerland was to maintain its AIDS prevention measures in every targeted field and at every level.

In particular, initiatives aimed at specific groups were continued, such as:

- the development of activity involving mediators who generally use the peer education model (the "Barfüsserfrauen" Project, MEDIA project);
- promotion of the work of the mediators, who are active in their milieu irrespective of whether such activities fall within their professional duties or not (doctors, migrants).

With reference to the three levels of intervention defined by the strategy, the following observations can be made:

- **Measures aimed at the general population (mainly the STOP AIDS campaign) continue to play their role of evoking the main themes of prevention, and continue to be well received by the population.** In this case, the FOPH plays a preponderant role. However, the campaign has not yet really succeeded in addressing the importance of relational aspects when implementing prevention measures. It has also not yet integrated into its messages the problematic of AIDS prevention with that of the prevention of other sexually transmitted diseases and of contraception.

Prevention aimed at specific target groups is expanding, often through special programmes funded totally (the Migrants Project, and the start of the "Barfüsserfrauen" Project) or partially (some injection-material distribution programmes) by the FOPH, or sometimes by the cantons (sex education programmes in schools, extremely varied from one location to another⁹). These programmes should be viewed in terms of their duration and coverage. The question of the role of the FOPH is then raised: how much responsibility will it accept? What role and degree of involvement will it choose? What ties will it establish with its partners? How much control does it wish to, or is it able to, exercise? Most of the programmes funded until now (with the exception of the sex education programmes) were in start-up, experimental phases, necessarily on a modest scale at first. The feasibility and acceptability of several such programmes were verified, while the effectiveness of others was tested.

They are now entering an expansionary phase in which these questions become very important, directly involving the financial and organisational capacities of the FOPH, as well as its leadership in the field of public health. There have been many ways to implement programmes. At present, evaluations have mainly revealed a few problems or advantages related to certain modes of operation. This question should be considered by the FOPH in ongoing evaluations of various projects.

The development of these programmes has also raised questions relating to the nature of AIDS prevention as an entity separate from other health or social problems. In nearly every population targeted by special programmes (e.g.: prostitutes, drug users, migrants), the

⁹ This aspect of prevention was assessed during the previous phases of the evaluation.

problem of AIDS is only one among many. This raises both the question of integrating AIDS into more global approaches to health, and the question of merging with existing related programmes (e.g.: relating to sexual health). This should be done at the proper rate, that is, without losing sight of particularly urgent aspects of AIDS prevention, and without diluting specific AIDS prevention in approaches which may be too global. The question of integrating - or of normalising - the AIDS problem is essential, and is not specific to prevention, as it is also present in the fields of training and health care.

- **The third level of the strategy, in-depth intervention during individual counselling, has also developed.** For instance, doctors' attitudes and practices in the field of prevention have changed for the better, and prevention has become more firmly rooted established as part of their routine practice. Sustained interest in complementary training programmes (cf. Pro Familia, for instance) also reflects this.

Results of the strategy

The following observations can be made concerning the results of the prevention strategy:

- **Preventive behaviour exists in every population group studied, and levels of protection are high (judged by their systematic nature).** In particular, there is no major lack of prevention in any large population group (e.g.: migrant populations or drug users), although there are differences between or within groups (e.g.: differences in protection between men and women). Nevertheless, it should be noted that the level of preventive behaviour seems to be reaching a ceiling, an observation which is difficult to interpret. Is such stagnation just a phase? In a context where AIDS is becoming less of a priority, is it an expression of inertia prior to regression? The long-term monitoring of both prevention measures and their overall results will tell. It is also difficult to express a value judgement concerning this ceiling, as the level of protection needed within a population to steadily slow or even reverse the progress of the epidemic is not known. The available epidemiological data indicate that the epidemic has stabilised, although the mechanisms are not always understood.

- **These major changes towards increased protection are not accompanied by major changes in sexual activity.** In particular, promotion of the use of condoms and widespread sex education have not been accompanied by more marked sexual precociousness or, it would seem, by a liberalisation of sexual mores. They could have led to an increase in the number of sexual partners, for instance, but on the contrary, among young people, the opposite seems to be occurring.

- **Increasingly, prevention is being individually managed. Individuals are adapting prevention to suit their situation, characteristics, and personal convenience.** The time of "condoms only" AIDS prevention is past; differential protective practices which vary according to the type of partners are expanding, as are repeated use of tests, etc. These are not always practised wisely (cf. the problems which differential protection raises within couples) or with complete awareness of the stakes involved (repeated tests without protection, for instance). However, they exist, and prevention should take them into account by fine-tuning its message and the quality of its counselling.

- **Problems caused by the massive use of condoms are also appearing.** Although the failure rate is low, more and more people have experienced and had to deal with "failures" when using condoms (breakage, etc.). These specific problems must be resolved, although they have hitherto not had any measurable impact on public health, such as an increase in unwanted pregnancies, nor do they call into question

public awareness of the need to use condoms. These incidents must not be allowed to encourage people to give up the use of condoms, the effectiveness of which is not put into question. They involve issues of contraception, HIV testing, appropriate counselling, information, condom quality, etc.

- **In the field of drug use, easier access to sterile injection material has not led to a major increase in injection of drugs.**

Context

- **Despite the ever increasing proximity and visibility of the epidemic, fear has not increased, and solidarity is the general rule, inasmuch as solidarity can be measured.**

Recommendations

- The three levels of intervention are still important, although targeted and individual prevention are becoming increasingly significant as the problem of AIDS becomes "normalised". The general population and young people in particular should of course continue to be targeted, however. The issue of prevention must continue to appear as a problem which concerns everyone, since widespread protection and the permanent awareness that AIDS concerns everyone form a sort of "safety net". Only widespread, continuous protection can stop the infection from propagating rapidly through new sectors of the population, or from expanding silently.
- Encouraging solidarity must remain a pillar of the prevention strategy.
- Strategic thinking should continue, differentiating between objectives attainable in the medium term and those attainable in the long term. At the same time, the means to attain these objectives should be defined more precisely, taking account of the desired degree of coverage and questions of equal access to prevention and to health care.
- The roles of partners in prevention should be specified, paying particular attention to the role and priorities of the FOPH (problems of delegation, supervision and monitoring, counselling, motivation, coordination, etc.), which may differ according to the fields considered.
- The long-term effectiveness of the measures taken should be considered. At the level of individual prevention, this process has already taken place to a certain extent (training and increased awareness of doctors and other actors in the field of prevention; standardisation of sex education in schools). This process needs to continue by maintaining contact with those responsible for training, developing prevention programmes in schools, etc.
- In the case of programmes aimed at specific groups (homosexuals, prostitutes, migrants, etc.), the question is slightly different. For the moment, most of such programmes still depend on ad hoc structures whose funding is regularly renewed (or not renewed). The future of these structures should be considered over the long term: either they obtain long-term stability and funding, or their activities should be integrated into other existing programmes to give them solid foundations. Such transitions may be difficult during a period of all-around budgetary restrictions. This means that these questions should be raised immediately for any substantial new action, programme or structure. As the moment for urgent measures has past, the criterion of sustainability should take precedence over other criteria when decisions are made.
- Local pilot programmes should be funded with a similar perspective. Such programmes should be funded if it is reasonable to suppose that their extension or generalisation is possible or even probable — in other words, if conditions encountered elsewhere are relatively similar or if the programme is easily adaptable. As this point in the epidemic, what good programmes should be seeking is sustainability.

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Contents

Appendix

Appendix 1

Schedule of evaluation studies

Evaluation of information brochure (all households)

1986

Periodic monitoring

1987	1988	1989-1990	1991-1992	1993-1995
behaviour, age 17-30	behaviour, age 17-30	behaviour, age 17-45	behaviour, age 17-45	behaviour, age 17-45
condom market				
media	media	media		low threshold centres activity

Repeated studies using identical methods (trend measures)

1987

1988

1989-1990

1991-1992

1993-1995

homo- bisexual		homo- bisexual	homo- bisexual	homo- bisexual
IVDUs		IVDUs	IVDUs	IVDUs
apprentices	sex education	apprentices	sex education	
		parents and prevention *	parents and prevention*	
		foreign students	foreign students	
		physicians (quantitative)		physicians (quantitative)
		solidarity*		solidarity*
			HIV test prevalence*	HIV test prevalence*
		AIDS prevention at the doctor's surgery from the patients'viewpoint*	AIDS prevention at the doctor's surgery from the patients'viewpoint*	
		condom image*	condom image*	condom image*

Series of studies on the same topic

1987

1988

1989-1990

1991-1992

1993-1995

STOP-AIDS campaign	STOP-AIDS campaign	STOP-AIDS campaign	STOP-AIDS campaign	STOP-AIDS campaign
	school programmes	school programmes	school programmes	
	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
	training of health care workers (extra-hosp)			training of health care workers (extra-hosp)
"sex tourists"**	health care workers (attitudes)	"sex tourists"**		health care workers (professional risk)

Complementary studies

1987

1988

1989-1990

1991-1992

1993-1995

womanisers	marginal groups	parents	medical students	foreign prostitutes
patients of "Sentinel" doctors	educators/social workers	prevention in prison**	clients of prostitutes campaign	implementation of 93-97 prevention strategy
informal leaders	recruits		parents campaign	adolescents: trends in sexuality (literature review)
	image of sexuality			
	physicians (qualitative)		heterosexual adults	condom breakage*
	testing centres		clients of prostitutes	adolescent sexuality: gender difference (secondary analyses)
	evaluation feedback			

* modules included in the 17-45 behavioural survey **studies conducted outside of the evaluation programme

Appendix 2

Methodological characteristics of the various studies

Study	Coverage*	Sample	n	Method
Risk reduction programmes for drug users	Switzerland	existing programme	about 20	monthly statement of activities
General practitioners	Switzerland	random sample	796	postal questionnaire
			31	interview
Barfüsserfrauen project	Zurich, Basle	programme participants	about 50	interview
Spitex training	GR	programme	20	interview
ProFamilia training	FR, IR	managers	6	interview
		clients	20,79	interview, postal questionnaire
Migrants	communities (FR,GR)	adults, stratified target samples		
	• Spanish		375	self-administered questionnaire
	• Portuguese		336	self-administered questionnaire
	• Turkish		132	self-administered questionnaire
	mediators in the three communities	mediators	81	telephone and personal interviews secondary analysis of data and documents
General population 17-45	Switzerland	random sample	2800	telephone questionnaire
Homosexuals & bisexuals	Switzerland	volunteers	1195	questionnaire distributed by the press and gay organisations
		volunteers	32	interview
Drug users	FR, GR	volunteers 1993	1119	partly self-administered questionnaire
	FR, GR	volunteers 1994	907	partly self-administered questionnaire
Hospital staff	FR, GR	6 hospitals	3116	questionnaire distributed by wards and by mail
Condom sales	Switzerland	marketing data from major distributors		biannual questionnaire

* FR: French Region; GR: German Region; IR: Italian Region.