

# National HIV/AIDS Programme 2004–2008



Swiss Federal Office  
of Public Health



# **National HIV/AIDS Programme 2004–2008**



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## **Imprint**

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# Introduction

**The first case of AIDS** in Switzerland was diagnosed in 1981. Since 1985 government agencies and NGOs have been active and, until recently, successful in their efforts to combat AIDS. Three achievements of AIDS work in Switzerland stand out, first: nation-wide consensus on objectives among all those involved; second: prevention (e.g. through the STOP AIDS campaign) and third: integrated HIV/AIDS research focusing on both health and disease (e.g. through the Swiss HIV Cohort Study). The National HIV/AIDS Programme 2004-2008 takes up where the National Programme for 1999-2003 left off. It continues the AIDS work already in progress in Switzerland, setting new priorities and initiating new developments to meet new challenges. It has been drawn up in partnership-based collaboration with the different players in the HIV/AIDS field and serves as basis for AIDS work in Switzerland.

## **Objectives of the programme**

The programme provides an overview of AIDS work in Switzerland, the current situation, the challenges to be faced, and serves as reference for players active in the HIV/AIDS field. It confirms the existing direction of AIDS work in Switzerland and initiates new developments where necessary and important. It sets national goals and specifies the players responsible for implementing them. It legitimizes measures and therefore facilitates fund-raising. It contributes towards implementing the United Nations guidelines on HIV/AIDS.

The programme concentrates on the three core fields of prevention, therapy and counselling, as well as solidarity. However these fields are integrated into broader thematic areas: sexual health and sexually transmitted infections, chronic diseases and human rights. Over a long period of time HIV/AIDS prevention in Switzerland was successful and is still regarded as exemplary all over the world. This success is based on innovative measures, cooperation among a wide range of players (organizations of people living with and affected by HIV/AIDS, professionals, politicians, cantonal and federal agencies and non-governmental organizations) and adequate financial and human resources. The number of reported new cases of positive HIV tests dropped extensively in the 1990s. The protective behaviour among the population as a whole ranks on a high level and many risk groups have adopted low-risk practices.

Antiretroviral combination therapies now enable many people with HIV in Switzerland and other industrialized countries to live for a long time without developing any symptoms. HIV has thus taken on the character of a severe chronic illness. The success of HIV prevention and treatment led to a certain "normalization" of the problem in the second half of the 1990s. Today the question is whether AIDS work in Switzerland entered a new phase from 2001 on: The reported new cases of positive HIV tests have been rising again – by several percent in 2001, 25% in 2002 and as much as 37% among men who have sex with men in 2002. At the same time the pressure to save money was never so great as in 2002 and 2003. It seems that dwindling investment in prevention activities since the mid-1990s evoked a fall in the pressure to achieve prevention and therefore possibly also a decline in protective behaviour. The elimination of the death threat removed a strong motive to adopt protective behaviour in industrial countries. Effective prevention of HIV infection dictates the development of new approaches without delay: motivating people to take care of their health without the threat of death in the background, making effective use of the limited (financial) resources available, attracting as much attention as possible, taking people's sexual needs into account and still reducing the risk of infection.

### Challenges

To continue the innovations of the last 20 years, provided they have not already fallen victim to "normalization".

To create new innovations – particularly in prevention – that will stop the rebound in new infections and bring down the statistics despite pressure to save money.

The present programme has been shaped essentially by the people and organizations active in the HIV/AIDS field, where its substance was developed in workshops. The programme underwent a wide-ranging consultation process before being finalized on the basis of the array of written opinions that were submitted and the intensive discussions that took place at the consultation meetings. It thus constitutes a jointly formulated strategic basis for AIDS work, and is at its most effective as such when all players gear their activities to a consensus-based strategy that they have drawn up together. Over and above the development of a common strategic thrust, one of the programme's major achievements was to assign roles and responsibilities for the implementation of the national objectives as the programme was being developed. Though binding for the Federal Administration, the national goals may be used by the other players as benchmarks to which they gear their activities. In the core field of prevention the Swiss Federal Office of Public Health (SFOPH) and the cantons are responsible by virtue of the Swiss Epidemics Act for ensuring that the number of reported new infections starts falling again. The SFOPH is pursuing this goal in close collaboration with the private-sector non-profit partner organizations

working in this field. And the SFOPH plays a coordinating role in the core fields of treatment and solidarity to ensure that these goals can be achieved as well.

We should like to thank the cantonal and municipal authorities, the Swiss AIDS Federation and its regional branches, the Swiss National AIDS Commission, the AIDS Special Commission of the Swiss National Science Foundation and all other participating institutions and individuals for their dedication and valuable contributions. It is thanks to their efforts that AIDS work in Switzerland can build on a common strategic basis, thereby assuring the professional, efficient continuation of the programme.

Swiss Federal Office of Public Health  
Director



Professor Thomas Zeltner

# History and basic framework of AIDS work



**Just over 20 years ago** the public – initially the medical public – was shocked by the emergence of a new disease. The hitherto unknown epidemic primarily affected young men in the prime of life. The first victims appeared to have only one thing in common: they were homosexuals living in two large metropolitan centres of the USA, New York and San Francisco. The frightening

witch-hunt against minorities."<sup>1</sup> These two fears shaped the political discourse, which focused principally on two issues: health and discrimination. And the association of AIDS with sexuality and death, with homosexuality, promiscuity, prostitution, addiction, drugs and HIV-positive individuals as "unrecognized enemies" brought together an impressive number of galvanizing topics.

euphoria triggered by the success of the new treatments nourished the belief – propounded mainly by the virologist David Ho<sup>3</sup> – that the virus could be eradicated, patients were advised to start treatment at the earliest possible stage of infection. Though the promise of a cure gradually faded – while the beginning of the therapy at a later rather than an earlier stage was increasingly being

# 1.1 Looking back

and mysterious disease was therefore initially designated "GRID", which stands for "gay-related immunodeficiency". Even though the name was to be short-lived, it associated a fatal infectious disease with homosexuality, and the immunodeficiency syndrome became the "gay plague". Renamed "AIDS" or "acquired immune deficiency syndrome", the condition soon counted injecting drug users as well as gay men among its principal victims. AIDS was therefore long associated with marginal groups and stigmatization of their reputed lifestyles – for instance the idea that those infected had only themselves to blame – and the victims suffered discrimination. This was in marked contrast to attitudes to haemophiliacs who had been infected with HIV from blood products. By the mid-1980s, the disease, the causative organism HIV (human immunodeficiency virus) and the transmission routes had been identified. It thus became evident that AIDS was a potential risk both to individual groups and to the population as a whole. "This, in conjunction with the uncertainties regarding understanding of the disease (which were much greater at the time), triggered profound anxiety throughout society. There were two pervasive fears: of an unstoppable health-related catastrophe and of a new

**"Compared with other health risks this constellation, evoking hysterical reactions at times, gave AIDS a prominence which cannot only be explained by the threat representing epidemiological figures. On the other hand it aroused a great readiness to take action and provide funds. Paradoxically, the political perception of the risk that AIDS represented for society proved to be productive, even though it was not necessarily rational in terms of health policy. The scale and direction of society's reactions can be understood only by realizing that they were driven by both health-policy and civil-rights concerns."**<sup>2</sup>

The enormous social and political energy that AIDS unleashed, especially through the efforts of the organizations of people living with or affected by HIV/AIDS, was in marked contrast to the powerlessness with which the medical profession addressed the disease. Given the absence of satisfactory treatment with which to combat the virus, doctors found themselves in the unaccustomed and often traumatically impotent role of having to watch many of their mostly young patients die. While they could do no more than treat opportunistic infections, growing importance was being attached to complementary medicine and psychosocial services. After AZT on its own or in combination with another medication had failed to bring about a breakthrough in the early 1990s, the introduction of protease inhibitors and with them the triple combination in the mid-1990s marked the turning point in the AIDS epidemic in Western countries. The

recommended - the new treatments succeeded in transforming the course of HIV infection into something closer to a chronic disease, and the number of AIDS patients and deaths due to AIDS plummeted. This turning point not only brought enormous relief to those directly infected but to the doctors as well unfolding new perspectives. But the "normalization" of AIDS (Chapter 5.1) also brought about a shift in the distribution of power: While doctors were liberated from their sense of impotence and the role of the pharmaceutical industry grew in importance, the organizations of people living with and affected by HIV/AIDS saw their influence decline in Western countries. The social and political dimension shifted to the international arena with the struggle to provide access to treatment in the countries of the South and East. Nevertheless the challenge will perpetually remain to address HIV/AIDS in Switzerland not only as a medical but as a social and political phenomenon as well.

<sup>1</sup> Rosenbrock (2002) Aidspolitik, Gesundheitspolitik und Schwulenpolitik, p.111.

<sup>2</sup> Rosenbrock (2002) Aidspolitik, Gesundheitspolitik und Schwulenpolitik, S.112.

<sup>3</sup> Ho (1995) Time to hit HIV, early and hard.



1.2

# The principle of the learning strategy

In the mid-1980s the health-policy debate in most Western countries on the question of the right AIDS policy to adopt – an issue that was crucial in terms of both medical policy and human rights – was conducted within specialized commissions and, to a lesser extent, in the public arena. The debate focused on two largely mutually exclusive options:

**"On the one hand there was the classic strategy used in epidemics, based on the 'old public health' paradigm, i.e. the individually oriented search strategy of 'control and containment'. This strategy is governed by the question: How do we identify most sources of infection in a minimum of time, and how do we control them? In contrast to this was the strategy of 'inclusion and cooperation', a community-based learning strategy' based on 'new public health', i.e. on modern scientific concepts developed in the health field. This strategy seeks and implements answers to the question: How do we organize, on as rapid, wide and sustainable a scale as possible, social learning processes that enable individuals, social groups, institutions and society as a whole to adapt, with maximum preventive effect and without discrimination of those affected, to live with a virus which, for the time being cannot be eliminated?"<sup>1</sup>**

As in most countries, the debate in Switzerland ended with a decision in favour of the learning strategy, despite sometimes fierce resistance, e.g. from "Aids-Aufklärung Schweiz" – an AIDS-enlightenment organization close to the "Verein zur Förderung der Psychologischen Menschenkenntnis" (VPM, Association for promoting the psychological understanding of mankind). In retrospect, the outcome can be regarded as a victory for reason in matters of health policy: In both human-rights and epidemiological terms it has yielded good results. For instance, reported new cases of positive HIV antibody tests showed a steady decline between 1990 and 2000. On the subject of discrimination of affected groups and of people with HIV, various studies have shown that systematic or regular discrimination at the legal level does not occur in Switzerland.<sup>2</sup>

<sup>1</sup> Rosenbrock (2002) Aidspolitik, Gesundheitspolitik und Schwulenpolitik, S.113.

<sup>2</sup> so z.B. Dubois-Arber et al. (1998) Identification des discriminations institutionnelles à l'encontre des personnes vivant avec le VIH en Suisse; Pärli et al. (2003) Aids, Recht und Geld. Eine Untersuchung der rechtlichen und wirtschaftlichen Probleme von Menschen mit HIV/Aids.

**AIDS work** has set new standards of interdisciplinary partnership-based cooperation in the health-care sector. In the 1980s, when it was a fatal infection without adequate treatment options, AIDS compelled players to seek new approaches and enter into new coalitions. The main thrust of their activities comprised prevention based on the provision of information to the general public and specific

The great success of the drug combinations from the mid-1990s on were welcomed with relief but also triggered fears of a "medicalization" of HIV. People living with or affected by HIV/AIDS and representatives of the target groups feared the loss of established cooperation networks and a demotion from "experts" to "patients". Activities in the field of primary prevention and solidarity with

1.3

# Interdisciplinary cooperation

target groups, the promotion of solidarity with those affected plus strengthening the rights of individuals living with or at risk from HIV/AIDS (data protection, voluntary testing, etc.). These measures were the result of cooperation between people living with or affected by HIV/AIDS, representatives of target groups, professionals from the prevention, epidemiology and medical fields, researchers and political authorities. At the institutional level, this interdisciplinary approach has been notable from the outset for intensive collaboration between state agencies and NGOs.

The development of AIDS work in Switzerland is a good example of the collaborative approach. Beside the introduction of a voluntary reporting system and the establishment of test and diagnostic facilities, the main efforts since the beginning of the epidemic have been focused on prevention. Key developments in this context were the founding of the Swiss AIDS Federation (AHS) in 1985 by representatives of gay organizations, the launch of the STOP AIDS campaign in 1987 by the Swiss Federal Office of Public Health and the Swiss AIDS Federation, the deployment by the Federal Council of the Swiss National AIDS Commission (EKAF) and its four special commissions (dealing with clinical, laboratory, psychosocial and health-care aspects respectively), which were set up in 1988<sup>1</sup>. The first "Concept for combating the AIDS epidemic in Switzerland", published in 1987, also included the subconcepts of "Monitoring of the epidemic", "Prevention" "Counselling and support", and "Research"<sup>2</sup>.

affected groups threatened to be overshadowed by medical treatment. Experience on both international and national level has shown that an integrated approach and the involvement of all players are essential to the success of AIDS work. This means on one hand that efforts must be continued to ensure the availability of both therapeutic and preventive services in countries with lesser resources. On the other hand, countries such as Switzerland, where people with HIV/AIDS have access to treatment, must not relax their efforts in the field of primary prevention nor should they be afraid of pursuing new approaches. The necessity is proven by the renewed rise in reported new cases of positive HIV tests in Switzerland since 2001. At the same time, the prospect of prolonged life offered by the combination treatments undermines the effort to ensure solidarity with, and equality of people with HIV/AIDS. Only interdisciplinary, partnership-based, multisectoral cooperation can ensure that these manifold tasks continue to be successfully managed.

<sup>1</sup> Somaini (2002) Die Erfindung einer Politik - ein persönlicher Bericht zur Entstehung der HIV/Aids-Politik in der Schweiz.

<sup>2</sup> Bundesamt für Gesundheitswesen (1987) Konzept zur Bekämpfung der Aids-Epidemie in der Schweiz.

### With a view to coordinate

HIV/AIDS research and to optimize its promotion, the Federal Council launched in 1988 the KKAF, a non-parliamentary commission for the control of AIDS research. A national HIV/AIDS research programme was initiated at the same time, with a framework budget of CHF 85 million for the 1990-1999 period. Responsibility for promoting HIV/AIDS rese-

The Swiss HIV Cohort Study (SHCS) is the focus of HIV/AIDS-related clinical and therapeutic research in Switzerland. The SHCS is a multicentred research project involving seven hospitals and seven laboratories. As an interdisciplinary, cooperative network it encompasses aspects of disease- and patient-oriented research as well as epidemiology and prevention. With its comparatively

secondary and tertiary prevention of HIV/AIDS, living with HIV from the viewpoints of affected individuals and society as a whole, treatment and support system, and the related social, economic, legal and political aspects. Close cooperation with the SFOPH, other national organizations and NGOs guarantee thus the acquired knowledge transfer to health policy and health-care provision. The journal "Aids-Forschung Schweiz" (Swiss AIDS research) was launched in early 1999 with the intention to make research findings available to a broader circle of interested people<sup>3</sup>. Regular conferences and meetings are held to ensure knowledge transfer and networking among researchers but also between research and practice. From 2004 onwards the Swiss National Foundation continues to pursue the HIV and AIDS research support in the sense of integrated research with the focus on both health and disease. This approach permits not only a comprehensive improvement of research activities but also the deployment of financial resources, ensuring knowledge transfer to the public health sector at the same time.

## 1.4 Integrated research

arch was transferred from the SFOPH to the Swiss National Science Foundation (SNSF) in early 2000. A credit amounting to CHF 27 million was made available for such research for the period of 2000–2003<sup>1</sup>. HIV/AIDS research promotion is geared to an integrated research model that focuses on both health and disease<sup>2</sup>. It is interdisciplinary and consists of three wide-ranging and closely related areas of research: clinical and therapeutic research, biomedical basic research and research in the social sciences and public health fields.

low-cost infrastructure, the SHCS is an effective instrument for investigating HIV infection, AIDS as an illness, and the course of the epidemic. It comprises a representative selection of Swiss HIV/AIDS patients. The multicentred SHCS studies on antiretroviral drugs and prophylactic treatment of related conditions serve as a means to establish a nationwide common approach and thus define the standard of care in Switzerland. As well as influencing the treatment modalities, the research findings also have a strong impact on treatment costs.

Basic HIV/AIDS research in Switzerland makes important contributions in areas such as the development of resistance, the dynamics of viral load and opportunistic infections, and the pathogenesis of and immune response to HIV. Without appropriate basic research there is no way of measuring the clinical effects of treatment. This requires optimal integration of basic and clinical therapeutic research.

Research activities in the social sciences and public health field are important components of Swiss HIV/AIDS research. Priority is given to promoting research on practice- and problem-centred questions of disease prevention and disease management. Projects are promoted on the following subjects: primary,

<sup>1</sup> [http://www.snf.ch/de/fop/spe/spe\\_hiv.asp](http://www.snf.ch/de/fop/spe/spe_hiv.asp)

<sup>2</sup> Fachkommission Aids des Schweizerischen Nationalfonds (2001) Konzept für eine integrierte gesundheits- und krankheitsbezogene Forschung in der Schweiz. Diskussionsbeitrag der Fachkommission Aids zum SNF-Workshop «Clinical Research in Switzerland» v. 22.6.2001.

<sup>3</sup> Im Volltext auf der Internetseite: [http://www.snf.ch/de/fop/spe/spe\\_hiv.asp](http://www.snf.ch/de/fop/spe/spe_hiv.asp)

**The efficacy of government action** is a subject of growing public interest. Evaluation studies are a means not only of reporting on how public money is spent, but also of judging policies, programmes, projects and other measures in order to identify and to draw the necessary conclusions from the concerned relevant changes. Studies as such provide a basis for decisions in order to initiate

(IUMSP)<sup>1</sup>, while other researchers have been mandated with individual evaluation studies. The evaluations focus on the following key questions:

1. In relation to processes: What prevention measures are being implemented, how are they evolving, what problems do they encounter and how successful are they?

# 1.5 Evaluation and monitoring

remedial action. Questions relating to the relevance, quality, efficacy and cost-effectiveness (efficiency) of measures are of particular interest. In order to integrate decision-bearing knowledge and to obtain maximum benefit, evaluations are included into the main planning and implementation phases of policies. It is therefore important that programmes, policies, etc., are observed and assessed by external, impartial and independent evaluators. The insights gained are used to shape opinion among the players concerned and thereby influence the direction of any future action. Thus the goals of government action can be "measured", evaluated and implemented and their success reviewed.

HIV/AIDS prevention activities in Switzerland have from the outset been evaluated and then adapted in accordance with the findings. Since 1987 the task of conducting a global evaluation has been entrusted into the hands of the research group of the Unit for the Evaluation of Prevention Programmes (UEPP) at the University Institute of Social and Preventive Medicine, Lausanne

2. In relation to outcomes: In what ways are knowledge and protective behaviour changing in the field of HIV/AIDS? Are people with HIV/AIDS subjected to discrimination? How is the epidemiological situation changing? Are adverse side effects being encountered?

Evaluations have for instance shown that the provision of clean injection equipment has not led to an increase in intravenous drug use. By virtue of these data, harm reduction measures in the drug-related field acquired greater legitimacy and have been institutionalized. Evaluations also showed that HIV prevention activities have improved protective behaviour among young people and in the population as a whole, though without fundamentally changing sexual behaviour (see statements next to vertical bar, p. 14). It has thus been possible to defuse widespread fears regarding adverse consequences of HIV prevention efforts.

<sup>1</sup> Die folgenden Informationen zur Evaluation der HIV/Aids-Prävention basieren auf einem Übersichtsartikel der Forschungsgruppe am IUMSP Lausanne: Dubois-Arber et al. (1999) Long term global evaluation of a national AIDS prevention strategy: the case of Switzerland. Weitere Referenzen finden sich in diesem Artikel.

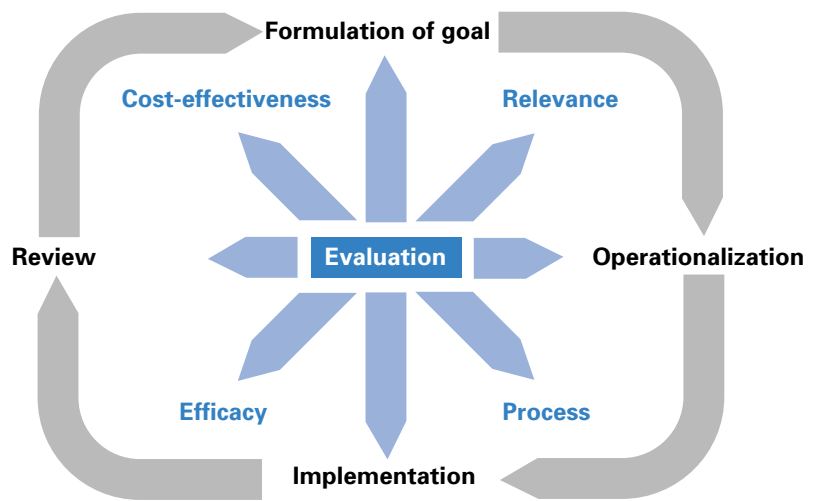


Figure 1: The role of evaluation

**HIV prevention activities improve protective practices without changing sexual behaviour**

As the evaluation of the HIV/AIDS prevention strategy in Switzerland has shown, HIV prevention activities improve protective practices in the population as a whole but without changing sexual behaviour in other respects. For instance, the number of casual partners among 17-30 year olds has not increased. Among young people, HIV prevention did not lead to earlier sexual activity, and the number of premature terminations in this group has not increased in parallel with the general rise in condom use.

Monitoring of behavioural patterns, particularly of protective behaviour, used to be included in the evaluations<sup>1</sup>. The National HIV/AIDS Programme 2004-2008 envisages a strategy that employs evaluation, reporting, monitoring and HIV/AIDS research as separate knowledge-acquisition components. These elements will be coordinated to complement one another. Thus it will be made possible to gear evaluation to specific aspects of the intervention strategy and programme implementation within a limited time frame.

<sup>1</sup> Monitoring is the routine collection of predefined data designed to keep project and programme managers and other participants regularly informed on the processes, progress and achievements of their projects or programmes. The project and programme managers determine what kind of information they need and when and how frequently they need it (monitoring system) in order to be able to check outcomes against planned targets.

# Legal framework

## Historical development

In historical terms, the measures taken to combat AIDS and their legal legitimacy evolved in a process in which experts, administrators and politicians took part: "On the basis of a parliamentary interpellation, Parliament discusses AIDS for the first time in the 1983 autumn session. (...) At the end of 1986 the SFOPH finalized the 'Concept for combating the AIDS epidemic in Switzerland', which had previously been discussed and accepted by the commission of experts on AIDS questions and by the cantonal health directors. This concept, submitted to the Federal Council in January 1987, served as the basis for drawing up a request for additional financial resources amounting to CHF 8.3 million for urgent measures in the AIDS prevention and information fields. On 25 March 1987, the Federal Council approved the 'Concept for combating the AIDS epidemic in Switzerland' and the supplementary credit for the 1987 budget.<sup>1</sup> In this Federal Council decision (BRB), or rather in the affixed submission by the Federal Department of Home Affairs (DHA), the Epidemics Act is specifically referred to as the legal basis: "The detailed concept paper on combating AIDS describes the strategies, goal and measures that can be taken or, in terms of financial and human resources, be supported by the Federal Council on the basis of the Epidemics Act (of 18 December 1970) and the Research Act (of 7 October 1983).<sup>2</sup>

The basis to combat AIDS is the Epidemics Act of 18 December 1970 (EpG; SR 818.101). According to Art. 1 EpG, the Confederation and the cantons are responsible to take the necessary steps to combat transmissible diseases in humans. 'Transmissible diseases' in the sense of this Act are pathogen-induced diseases that can be directly or indirectly transmitted to humans (Art. 2 EpG). AIDS is caused by the human immunodeficiency virus (HIV), and therefore falls under the scope of the EpG. The Epidemics Act distinguishes between federal and cantonal measures. The implementing tasks are assigned largely to the cantons (except for those that the Act explicitly assigns to the Confederation). Therefore the cantons are primarily responsible for combating transmissible diseases. The question as to whether the measures laid down in the EpG are also suitable for combating AIDS cannot be answered in a general fashion but requires case-to-case consideration. Obviously, any measures ordered on the basis of the EpG have to comply with the constitutional limits of administrative action and therefore have to respect the principle of conformity with the law, protection of the public interest, proportionality and the requirements enshrined in Art. 8 and 9 of the Federal Constitution (equality before the law, protection against arbitrariness and protection of the principle of good faith).

The SFOPH's main tasks include keeping the authorities, the medical profession and the public informed (cf. Art. 3 EpG). The SFOPH is therefore basically empowered to issue recommendations and guidelines on combating and preventing AIDS. The measures laid down in the EpG are defined in the corresponding federal ordinances, particularly the Ordinance on Notification (SR 818.141.1) and the Ordinance on Physician and Laboratory Notification (SR 818.141.11), which, among other things, regulate the obligation to report cases of HIV infection and AIDS, and the Ordinance on HIV Studies (SR 818.116), which deals with the gathering of HIV-related data for epidemiological studies. Besides the EpG and its related ordinances, other government orders have to be taken into account in AIDS work. For instance, Art. 18 of the Ordinance on the Authorization of Medicines (AMBV; SR 812.212.1), in conjunction with Art. 25 of the Ordinance on the Control of Transplants (SR 818.111.3), lays down the obligation to test blood, blood products and transplants for HIV.

<sup>1</sup> Bachmann et al. (2002) Risikoverwaltung: Lernen aus der eidgenössischen Politik im Umgang mit Gesundheitsrisiken: HIV/Aids, Hepatitis C und BSE im Vergleich, S. 40.

<sup>2</sup> Schweizerischer Bundesrat (1987) Bundesratsbeschluss vom 25. März 1987: Weitere dringende Massnahmen zur Bekämpfung der AIDS-Krankheit.

# The three core fields of activity in AIDS work

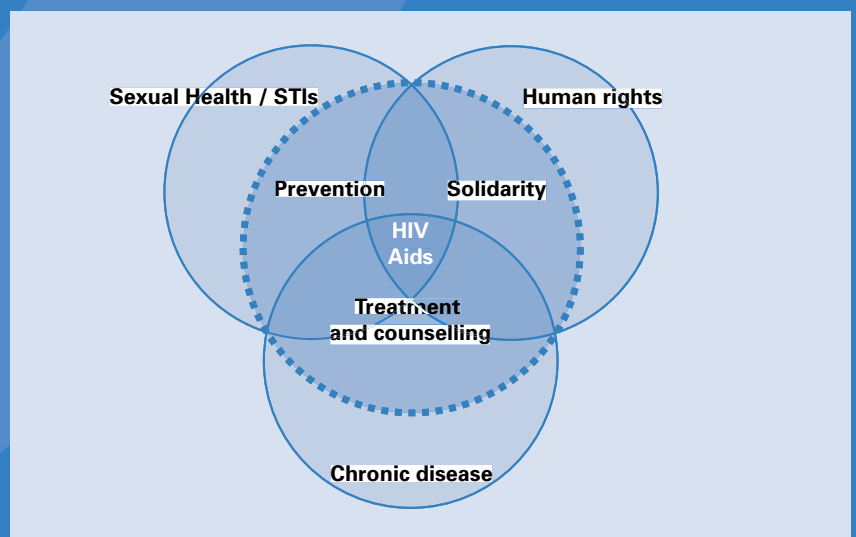


Figure 2: Core fields of activity of the Swiss Confederation's National HIV/AIDS Programme 2004-2008

Hatched area: the scope of the National HIV/AIDS Programme 2004-2008

**The five-year programme** for the 2004–2008 period envisages three core fields of activity. They pursue the general goals which are in effect since 1987 (cf. Chapter 7.3: "Preventing the spread of HIV", "Reducing the negative effects", "Promoting solidarity") and lay down the following new areas of emphasis:

### 1. Preventing the spread of HIV

Behaviour protecting the individual and his or her sexual partner(s) against HIV must be continually supported by suitable prevention and health-promotion measures. Favourable general conditions have to be created to reduce vulnerability to infection. "Prevention" in this context is synonymous with "primary prevention" or prevention of the spread of HIV. Efforts to prevent the spread of HIV are based on an approach to prevention (avoidance of infection) derived from a broad understanding of what constitutes health promotion (particularly with regard to empowerment of groups at risk).

The core field "prevention" is embedded in a number of broader areas of activity. In the case of sexual transmission it is an element of the prevention of sexually transmitted infections, STIs<sup>1</sup> and – particularly in the area of sex education in schools – comes under the category of promotion of sexual health. Since sexual contact is the most common mode of transmission, the core field "prevention" has been presented in this context in Figure 2. In the case of transmission as a result of intravenous drug use, HIV prevention can be assigned to the context of drug-related harm reduction (Chapter 3.4), while prevention of HIV infection in medical staff, from mother to child and via blood products has to be part of the corresponding professional standards as well as basic and further training plus continuing education.

### 2. Treatment and counselling in HIV infection and AIDS

Access to counselling and social care, treatment and nursing care for people with HIV/AIDS has to be continually assured. Empowerment in the form of interdisciplinary medical and psychosocial counselling and assistance is needed to improve quality of life. Treatment in this context comprises all measures that can have a beneficial effect on morbidity and mortality in persons who are already HIV-positive.

The treatments available have increasingly transformed infection with HIV from a fatal to a chronic disease. The core field of activity "treatment and counselling" is therefore part of the medical and psychosocial management of chronic disease.

### 3. Solidarity with individuals at risk of infection and those with HIV and AIDS

The promotion of solidarity with people living with or affected by HIV/AIDS and of their equality with non-infected persons includes preventing discrimination and stigmatization and eliminating inequality at the workplace and in the social insurance system. It also includes the fostering of international solidarity in respect of HIV/AIDS. Other important prerequisites for effective prevention are the promotion of solidarity with risk groups and of acceptance of them in society as a whole.

Promoting solidarity in respect of HIV/AIDS is an aspect of human-rights promotion and must be integrated and institutionalized in this context.

Figure 2 shows the scope of the National HIV/AIDS Programme and the three core fields "prevention", "treatment and counselling" and "solidarity" and their position in broader areas of activity, particularly those of sexual health and STIs, chronic disease and human rights. The National HIV/AIDS Programme focuses on HIV/AIDS. But because the core fields are integral to broader areas of activity, the sustainability of the projects and activities in these broader contexts and the transfer of knowledge from and to these areas are important.

<sup>1</sup> There is a tendency today to refer to "sexually transmitted infections" (STIs) rather than to "sexually transmitted diseases" (STDs) because the infections often do not present as diseases.



# Models of AIDS prevention



# The three levels of communication in prevention

**HIV/AIDS prevention** is based on three levels of intervention:

1. Information aimed at the general public (wide impact): The entire population of Switzerland is regularly provided with information on HIV/AIDS as well as on their protection options (cf. Chapter 3.2)
2. Information and motivation of target groups (wide and in-depth impact): People who engage in risk behaviour, belonging to a group with a high prevalence of HIV/AIDS or are at risk (vulnerable) as a result of their living situation, are provided with appropriate information about their situation and motivated to adopt preventive practices (cf. Chapter 3.3).
3. Individual prevention and counselling (in-depth impact): availability of decentralized services providing information, motivation to adopt preventive behaviour and counselling which are tailored to the needs of the individual client (cf. Chapter 3.5).

This model based on the perception that for many people a knowledge of HIV infection, the possible modes of transmission (as well those that are not possible) and protective beha-

viour already has a sufficiently preventive effect since they hardly ever expose themselves to risks. For people who engage in high-risk behaviour or whose living situation puts them at risk of infection, the messages aimed at the general public are not sufficient to provide the information they need or to motivate them to practise prevention or to support them in changing their behaviour. Individual counselling is aimed at people whose personal questions and problems (e.g. uncontrollable fear of AIDS, problems with the use of condoms, questions about the HIV test, problems with relationships, etc.) require individual clarification and solution. The prevention messages referred to in Chapter 3.5 have therefore to be communicated, contextualized and adapted in order to meet individual needs at the appropriate level.

Over and above this, the campaign's messages confirm and reinforce the desired preventive behaviour. The process beginning with the perceptive faculty of information and culminating in a change of behaviour is a long one and requires constant revitalization of the messages and continuation of the campaign. After all, between seventy and a hundred thousand young people reach the

## 3.2 The STOP AIDS campaign

Since 1987 the SFOPH and the Swiss AIDS Federation (AHS) have been running the STOP AIDS campaign to keep the Swiss public regularly informed on HIV/AIDS and protective behaviour.

The STOP AIDS campaign fulfils three functions:

1. It keeps the general public informed and motivates to adopt protective behaviour.
2. It makes a visible political statement that AIDS is a problem of national significance that has to be taken seriously.
3. It creates a common brand for AIDS prevention activities, motivates the SFOPH's partners in their prevention activities and supports them in their efforts on the local level.

The STOP AIDS campaign is the best known prevention campaign in Switzerland. It enjoys a recall value of between 70 and 80% (assisted and unassisted)<sup>1</sup>.

The STOP AIDS campaign has an impact on all three elements in the chain of effects: creating awareness, changing attitudes and influencing behaviour. Its effect is greatest on the first two elements:

1. It creates and maintains awareness of AIDS. Awareness is a precondition for the uptake of information.
2. It promotes a positive attitude towards AIDS prevention and the use of condoms. To achieve this result, the message must be remembered and it must be convincing.

age of sexual maturity each year and thus become new targets of the campaign.

All in all, the campaign helps to bring about acceptance of a social norm under which people take responsibility for themselves by adopting protective behaviour and which does not disregard the need for equal treatment for everyone, whether HIV-positive or HIV-negative. STOP AIDS is already a label that stands for values such as "open, active and provocative information", "social commitment" and "mutual protection". The label has therefore repeatedly proved attractive in the past for the co-branding strategies of numerous organizations, where brands and companies hope to benefit from the positive image transfer resulting from a joint presence in the marketplace<sup>2</sup>. This potential should be exploited to a greater extent in further editions of the campaign, especially since trend analyses show that the assumption of social responsibility will increasingly constitute important added value for brands.

<sup>1</sup> Post-tests of the STOP AIDS campaigns 1995, 1997, 1999, 2001 (representative surveys).

<sup>2</sup> STOP AIDS and H&M (Catch the Sperm), condom brands (Ceylor, Cosano), Internet providers (Bluewin, Tiscali), Expo.02, APG.

3.3

**Not all sections of the population** are at equal risk of contracting HIV. HIV is transmitted primarily by sexual contact and contaminated blood. Persons who are not sexually active and do not come into contact with contaminated blood cannot be infected with HIV, except by the mother-to-child route. The risk (or probability  $P_{Tr-HIV}$ ) of HIV being transmitted as a result of

developed, following the observation that particular living situations put certain people more at risk than others. Personal, social and situational factors can influence individual vulnerability to HIV infection, for instance belonging to a social group with an increased prevalence of HIV (gays, injecting drug users, migrants from high-prevalence countries), poor

Individuals with increased vulnerability to HIV infection tend not to belong to stable or homogeneous groups. Within a specific group there may be different subgroups associated with different levels of risk (accumulation of the factors indicated above). Groups should therefore be observed by means of appropriate instruments to determine which of them, and which subgroups, are associated

# Prevention in specific target groups

sexual contact can be expressed as a product of several probabilities:

access to prevention material (condoms, clean injection equipment),

with higher levels of factors that indicate increased vulnerability (monitoring).

The need for prevention is currently greatest among:

- homosexual and other men (and young people) who engage in unprotected anal intercourse
- migrants from countries with a high prevalence of HIV, and their sexual partners
- injecting drug users
- sex workers
- sex workers' clients, and travellers to endemic regions who do not protect themselves.

$$P_{Tr-HIV} = P_{Partner\ infected} \times P_{Infectivity\ of\ Partner} \times P_{Tr-efficiency} \times (1 - P_{Efficiency\ of\ protection}) \times P_{Susceptibility}$$

$P_{Partner\ infected}$	Probability of partner being infected = prevalence in the corresponding group
$P_{Infectivity\ of\ Partner}$	Infectivity of partner, depends on the stage of the HIV infection and on the efficacy of any treatment taken
$P_{Tr-efficiency}$	Transmission efficiency of the type of (sexual) contact
$P_{Efficiency\ of\ protection}$	Probability of a means of protection (condom) being used and of its being effective (if no protection is used, this factor equals 0)
$P_{Susceptibility}$	Probability that contact with HIV will result in infection

In this model a high degree of probability of HIV infection ( $P_{Tr-HIV}$ ) depends primarily on the following factors: high prevalence, high level of infectivity, (sexual) practices with a high level of transmission efficiency (particularly receptive anal intercourse or use of a contaminated needle) and non-use or incorrect use of a condom. Susceptibility to the virus appears to be substantially increased by other STIs, and genetic predispositions are also thought to exist. The more frequent the contact, the greater the likelihood of infection. In the early days of the HIV epidemic, the concept of target groups was used to explain the fact that the risk of infection was not evenly spread over the population as a whole. The drawbacks of this approach were soon apparent: The risk of individuals contracting HIV depends not so much on their belonging to a specific social group as to their behaviour. In particular, the fact of not belonging to a "risk group" does not in itself confer protection against HIV. It was soon no longer fashionable to think in terms of risk groups, and the concept of "high-risk behaviour" began to achieve wider currency. Later the concept of "vulnerable" groups was

power and dependency relationships (e.g. sex work), loss of self-control (alcohol, other drugs), emotional factors (pleasure in taking risks, indifference) and lack of access to information (language). Each of these factors can increase the risk of HIV infection. It stands to reason that groups with an increased risk of HIV infection must be designated as such and addressed by prevention messages geared to their respective needs. This approach always entails a risk of stigmatization. Participation, differentiation and sensitivity are therefore important prerequisites of prevention activities. Appropriate prevention methods and interventions should be developed and implemented for and with the consensus of these groups. Greater importance should be attached to structural prevention. In the context of sex work, for instance, this could mean increased targeting of sex workers' clients and pimps and therefore exploration of new forms of cooperation, for instance with the police. Generally speaking, this implies an increasingly political approach – including, if necessary, legislation – and a greater focus on prevention geared to structural factors.

On account of the prevention potential, there is also an increased need for action among people living with HIV/AIDS.

Finally there are also settings in which individuals at increased risk of HIV infection are represented in greater numbers, for instance prisons, juvenile residential facilities and drug-dependence treatment centres. In the field of trafficking in women, the risk factors accumulate for the women concerned.

As an example of prevention geared to the needs of a specific target group, the next chapter describes harm reduction activities among injecting drug users. This approach exemplifies the combination of behavioural and structural aspects of prevention.

## 3.4 Harm reduction among drug users

**In the mid-1980s** it was recognized in Switzerland that the services provided at the time to help drug users were reaching only a fraction (those interested in achieving abstinence) of dependent drug users. It was the time of the open drug scenes ("Needle Park" in Zurich, Kocher Park in Berne, etc.). The emotional and physical condition of dependent drug users was grim, drug overdoses

condoms as well as injection equipment. Condoms are also available at the points of access for drug users who engage in prostitution. All facilities offer information material on hygienic drug use. Injection material can be obtained from pharmacies throughout Switzerland. There is also a large range of low-threshold dispensing facilities, plus automatic dispensers, where

# ong injecting

reached a tragic peak and many users contracted HIV and hepatitis. Against this backdrop, low-threshold facilities for drug users, without the objective of abstinence, were set up, initially in the affected towns. The aim of these facilities was to help dependent drug users get through, and therefore survive their dependence phase with a minimum of harm in physical, emotional and also social terms.

If drug users are to be prevented from contracting HIV, hepatitis or other infectious diseases, prevention also has to extend to sexual behaviour. In Switzerland, the facilities mentioned above also dispense

injection equipment can be obtained, mostly on an exchange basis. On the other hand, there are also centres where dependent drug users are offered counselling and support, without any demands being made in terms of abstinence. Some 3,500,000 syringes were issued or sold in Switzerland in 2002, about 25% of them at pharmacies. Gaps in the dispensing of needles exist above all in rural areas, in prisons or when needles are confiscated. Twelve of the points of access and contact centres surveyed in 2002 had injection rooms. Users are allowed to inject, or in some cases inhale their own drugs under supervision and in hygienic conditions.

The core aim of current harm reduction efforts is to achieve a balance between the needs of those directly affected (secondary prevention) and of society (law and order policies) and the demands made on society (drug policy). The basic objective of work in this field must be to promote social integration of people from the illegal drugs milieu, particularly by measures to promote health based on a global concept of health.

**Individual prevention counselling** belongs to the third level of communication in prevention work (cf. Chapter 3.1). Regardless of whether or not an HIV test is performed, individual counselling can be useful and important in dispelling uncertainty about the rules of safer sex or in integrating prevention into personal lifestyles, etc. It is offered primarily by specialized facilities such as family

a long time because they felt protected against infection<sup>4</sup>. So a close link between the HIV test and individual counselling is desirable in health-policy terms. This association – VCT, or voluntary counselling and testing – is therefore under discussion all over the world. VCT was developed in the mid-1980s as the standard procedure for all persons wishing to know their HIV status. The core elements are

nary counselling because, though the risk of HIV infection may be small, the consequences of an undiagnosed HIV infection are serious in terms of subsequent decisions and measures. Even then, the voluntary nature of the test, informed consent and maintenance of confidentiality are absolute requirements of the procedure.

Major obstacles to more effective implementation of VCT are, on the one hand, lack of trained staff familiar with client-centred approaches to pre-and post-test counselling and, on the other, lack of time and financial resources at the centres entrusted with VCT.

3.5

# Individual prevention counselling

planning centres, HIV counselling and test centres, regional AIDS Federation branches and in medical practices. However, prevention counselling is often linked with the performance of an HIV test.

A growing number of people are having themselves tested at a relatively late stage in the course of an HIV infection, for instance only after an AIDS-related illness has developed<sup>1</sup>. Late testing is a missed opportunity in terms of both prevention and treatment. A negative test result can be used as an opportunity for detailed counselling on risk situations. In the event of a positive HIV test, the client can be counselled on preventive measures – including prevention of mother-to-child transmission – and on the nursing, treatment and assistance services available. On the subject of antiretroviral treatments, experts now agree that they should be instituted before the occurrence of any AIDS-related illnesses<sup>2</sup>.

However, these opportunities can be used only if the test is combined with individual counselling. The findings of the "Santé Gaie" study show that this link is too often lacking: 44% of homosexual men tested in 2002 were not given counselling either before or after the test<sup>3</sup>. If this opportunity is not grasped, a negative result can lead to mistaken ideas about immunity to infection. Evaluations conducted in the USA of people with HIV/AIDS who had been tested at a late stage in the 2000-2003 period demonstrated that, after a first negative test, a second retest was not taken into consideration for

laid down in the guidelines of various health-care organizations<sup>4</sup>. Counselling must be client-centred, which means supplying the client with HIV-related information. Clients have to be given help to develop a risk reduction plan, while strategies for ensuring confidentiality as well as social solidarity have to be discussed.

The counselling is closely associated with the test to ensure the client's informed consent. Informed consent must always be obtained in connection with HIV testing because a positive result represents a change that can have serious, far-reaching implications – including in psychosocial terms – for the person concerned. Counselling and testing must therefore also be closely linked with medical treatment and social support services to minimize any negative consequences.

Procedurally, VCT consists of an HIV counselling session, followed if required by a test and then post-test counselling. Until recently it was assumed that VCR should follow the same procedure in all situations. In practice, however, different models have been developed to meet the needs of different settings; after all, conditions are not identical in a voluntary counselling centre, an obstetric clinic or an acute-care hospital. The focus in voluntary counselling centres is on independent decision-making. This is not the case in situations in which people attend medical facilities because they are seriously ill or require pre-natal investigations. In such settings the HIV test may well have to be routinely offered without in-depth prelimi-

<sup>1</sup> Feuz et al. (2002) Time elapsing between the first positive HIV-test and AIDS diagnosis in Switzerland is decreasing. Poster TuPeC4717, XIV International AIDS Conference, Barcelona July 7-12 2002.

<sup>2</sup> Egger et al. (2002) Prognosis of HIV-1 infected patients starting highly active antiretroviral therapy: a collaborative analysis of prospective studies.

<sup>3</sup> Häusermann et al. (2003) projet santé gaie. Les premiers résultats de l'enquête sur la santé des hommes gais de Genève.

<sup>4</sup> CDC (2003) Late versus early testing of HIV - 16 Sites, United States, 2000-2003.

<sup>5</sup> Siehe dazu u.a. folgende Publikationen: WHO (2002) Increasing access to knowledge of HIV status: conclusions of a WHO consultation, 3-4 December 2001; UNAIDS (2002) Voluntary Counselling and Testing: a gateway to prevention and care. UNAIDS Case study; CDC (2001) Revised Guidelines for HIV Counseling, Testing, and Referral (CTR) and Revised Recommendations for HIV Screening of Pregnant Women. MMWR Morbidity and Mortality Weekly Report Nr. 50.

**The following prevention messages** are conveyed at all levels of communication in prevention work (Chapter 3.1). They can be viewed as basic knowledge but have to be adapted and contextualized in terms of the communication level and target public. Contextualizing the messages means, for instance, combining them with prevention

3.6

# Prevention messages

message on STIs or – in the context of sex education – treating them as an aspect of sexual health.

- Everyone must assume, as far they are able, responsibility for protecting themselves against HIV infection.
- Sexually active individuals not living in a mutually monogamous and HIV-free relationship must observe the rules of safer sex:
  - always use a good-quality condom in penetrative sex;
  - never take semen into the mouth, never swallow semen;
  - never take menstrual blood into the mouth, never swallow menstrual blood;
- Sexually active individuals not living in a mutually monogamous and HIV-free relationship must inform themselves on the risks and protection options and practise using a condom.
- Partners in a mutually monogamous relationship must not dispense with the use of condoms until they have both had counselling (jointly) and a negative HIV test result after at least three months.
- An HIV test does not protect against AIDS. But anyone who feels that he or she has engaged in risk behaviour can obtain clarity with an HIV test and, depending on the outcome, can have an HIV infection treated at an early stage.
- Injecting drug users must always use a new syringe and clean paraphernalia of their own (spoon, filter, cotton-wool, water) and not share them with other users (safer use).
- HIV and AIDS can be treated but not cured. Treatment is complicated, demanding and expensive and there is no guarantee of success. The condom offers the best protection against HIV/AIDS.

- HIV/AIDS is still a social problem. Support for and solidarity with those affected or at risk is essential.
- HIV prevention work has its limits. Understanding and an open mind for people with HIV/AIDS are constituents of a society in which solidarity exists, will strengthen HIV prevention efforts.
- HIV is not transmitted by social contacts such as shaking hands, embracing, caressing, sneezing, coughing, having a meal or a drink together, using the same plate, glass or cutlery, working or living with people with HIV/AIDS, using the same bath, toilet or sauna, nor is it transmitted by insect bites.



# Current situation



4.1

# Epidemiology of Switzerland

As in the majority of the industrialized countries, HIV probably began to spread in Switzerland in the 1970s. The first case of AIDS (diagnosed retrospectively) in Switzerland was known in 1981. The number of cases then rose rapidly. Initially the disease affected primarily men with same-sex partners and injecting drug users, while heterosexual transmission only started increasing significantly in the mid-1980s.

The trend in the development of AIDS began to be reversed in 1995 with the introduction of highly active antiretroviral combination treatments that enabled the progression of the disease to be significantly slowed down in a growing number of people with HIV. The number of new cases of AIDS and of fatalities subsequently declined from year to year, though only slowly since the end of the 1990s.

Current situation

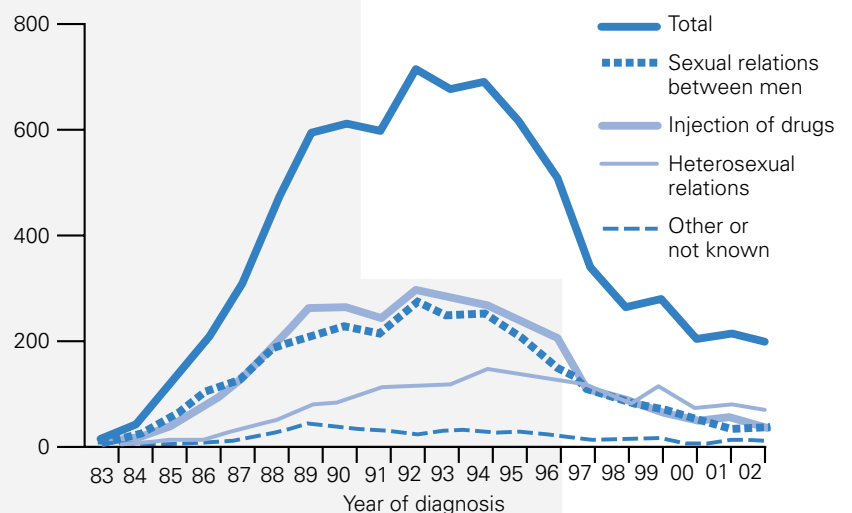


Figure 3: AIDS cases in Switzerland by transmission route and year of diagnosis (adjusted for delayed reporting)

Following the epidemic increase after 1985, when the HIV test was introduced on a wide scale, positive test results also showed a downward trend which persisted from 1991 until about 2000. Then the number began to rise again when as many as 25% more positive results were reported in 2002 than in the previous year. The increase is due primarily to men who have sex with men, most of them Swiss, and heterosexuals, mostly originating from countries with a high prevalence of HIV. The rate of positive HIV tests was still high compared with other Western European countries.

Among the positive HIV test results in 2002 the percentage of primary infections, i.e. of cases in the initial acute stage of HIV infection, showed a marked rise<sup>1</sup>. This indicates that risk behaviour has increased again in recent years, at least in some population groups.

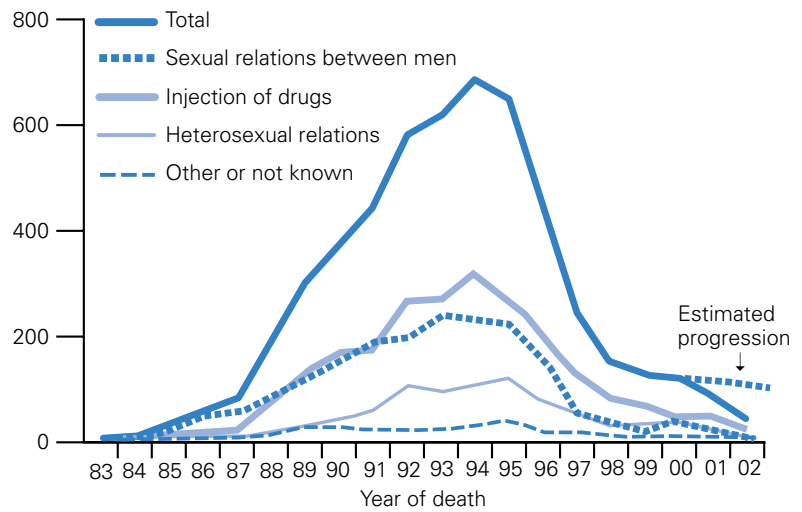


Figure 4: Reported fatalities among people with AIDS in Switzerland by transmission route and year of death

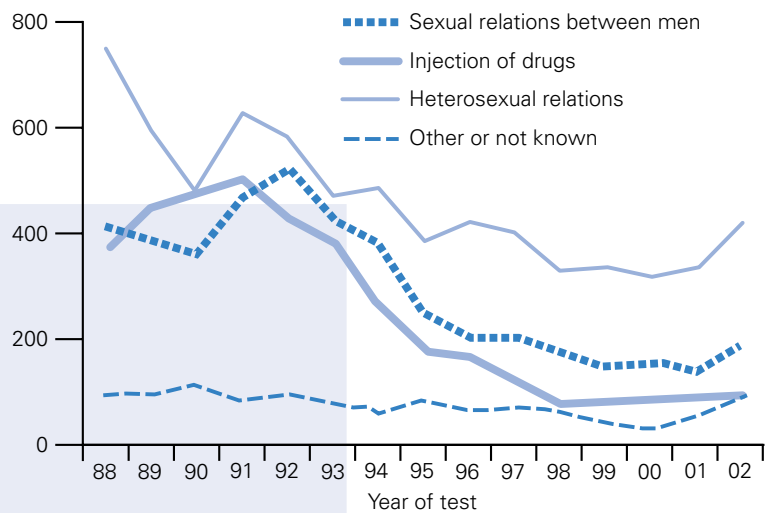


Figure 5: Estimate of the number of newly diagnosed HIV infections in Switzerland by transmission route and test year

<sup>1</sup> A detailed review of HIV/AIDS epidemiology is published annually by the SFOPH. The figures quoted for 2002 are taken from: Bundesamt für Gesundheit (2003) Aids und HIV in der Schweiz. Epidemiologische Situation Ende 2002.

4.2

# Changes in protective behaviour

According to the data obtained in the global evaluation of Switzerland's AIDS-prevention strategy regarding preventive behaviour, knowledge and conception of the disease in different population groups<sup>1</sup>, the population on the whole is well informed about HIV/AIDS and the protective measu-

res to be taken. This is due to the intensity, continuity and high level of coverage of media campaigns, activities in schools and quite generally to public awareness of the problem. Since 1987 there has been a far-reaching change in behaviour in the form of increased protection.

Although varying considerably according to age group and type of partner, rates of condom use are generally high. This is exemplified by the changes that have taken place in protective behaviour with casual sexual partners (Figure 6).

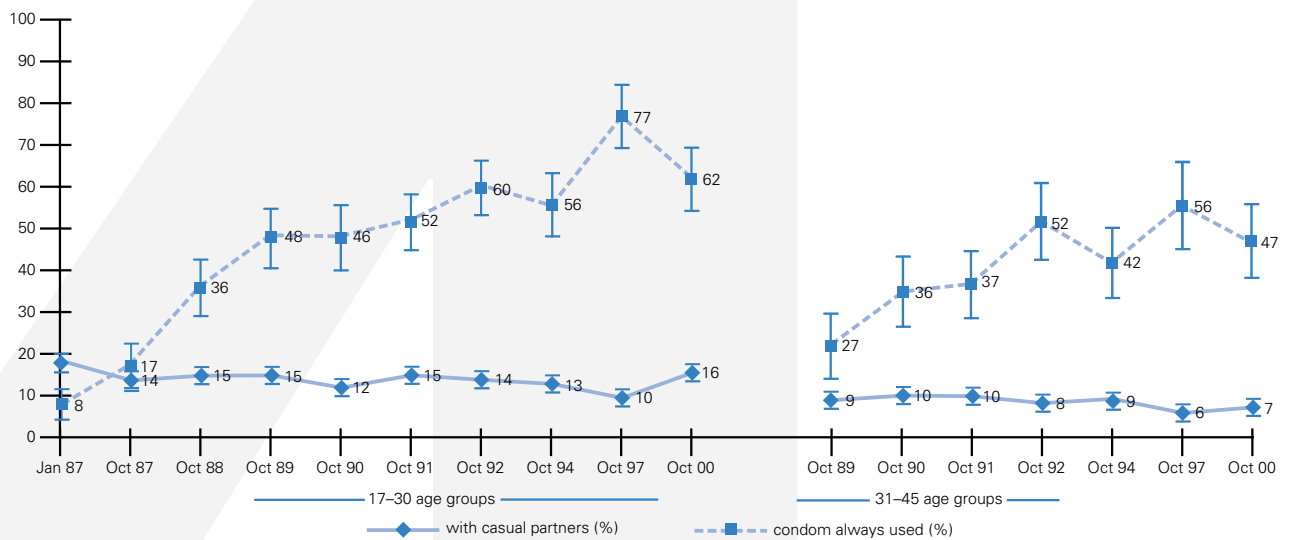


Figure 6: Percentage of persons with casual sexual partners in the six months before the survey, and use of condoms in the 17-30 (1987-2000) and 31-45 (1989-2000) age groups

<sup>1</sup> Dubois-Arber et al. (2003) Evaluation de la stratégie de prévention du sida en Suisse 1999-2002. Septième rapport de synthèse.

This increase in protective behaviour has shown signs of stability since 1992. The latest findings (2000) suggest that this stability is persisting, showing no evidence of decline. In view of the current epidemiological environment (recent increase in new HIV infections and STIs, resurgence of the epidemic internationally), however, caution is required. Besides changes in the overall situation, it has to be remembered that large differences exist at the individual level.

Neither the latest data on protective behaviour in young people (SMASH study<sup>1</sup>) nor changes in condom sales (Figure 7) indicate any decline in protection, in fact they confirm the trend to stabilization. These data, which were gathered in 2002, refer to a period marked by renewed interest in the topic of HIV/AIDS. From the end of 2001 on, the press, SFOPH media information and the prevention campaigns warned about a resurgence of the epidemic in the industrialized world and drew attention to the devastating conditions prevailing in developing countries.

However, the findings relating to the behaviour of specific population groups are inconsistent.

The following changes have been observed since 1997 in men who have sex with men: a decline in protective behaviour in contacts with casual partners<sup>2</sup>, stabilization of protective behaviour in contacts with steady partners at a still unsatisfactory level, and an increase in the number of sexual partners. Although the level of protection continues to be generally high, this decline in protective behaviour undoubtedly explains the recent rise in new cases of HIV in this particular group.

Among drug users, protection through not sharing injection material has recently shown a slight though not significant decline, while protection during sexual contacts has remained stable at an unsatisfactory level. This could indicate a renewed

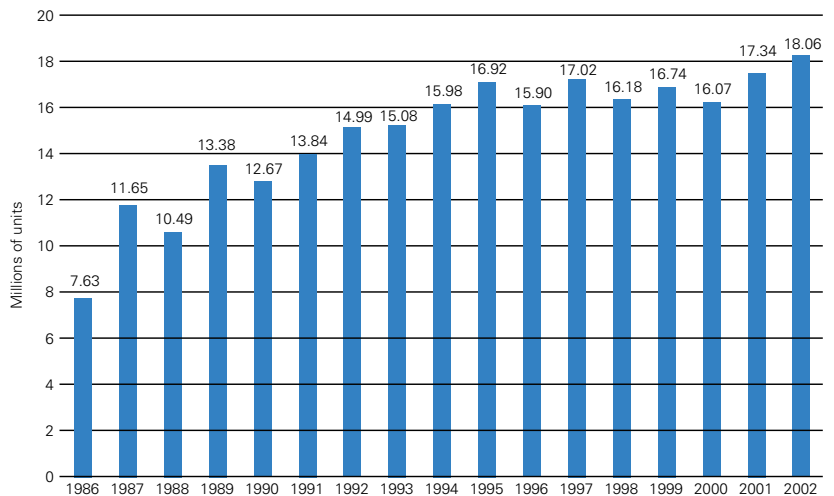


Figure 7: Sales of quality-mark condoms in Switzerland (estimate: over 80% of the market)

increase in infections (though this conclusion is not currently confirmed by the epidemiological findings), particularly in a number of towns in which sharing of injection material continues to be more widespread. Finally, new data is lacking in respect of migrants and sex workers. In particular, there is a great need for data describing the knowledge and behaviour of migrants, as epidemiological changes show that a large percentage of heterosexually transmitted new cases of HIV is observed in persons originating from sub-Saharan Africa<sup>3</sup> or in their partners. Among professional prostitutes, international data indicates a high level of condom use and a low prevalence of HIV. Among other sectors of prostitution, however, the situation is uncertain or even worrying.

<sup>1</sup> Swiss Multicenter Adolescent Study on Health, siehe Narring F. et al. (1997) Sexualité des adolescents et sida: processus et négociations autour des relations sexuelles et du choix de la contraception.

<sup>2</sup> This development was statistically significant in 2000.

<sup>3</sup> But it is not known whether these people contracted HIV in Switzerland or in their countries of origin.

**The United Nations HIV/AIDS** programme (UNAIDS) estimated that 42 million people were HIV-positive at the end of 2002. Some five million new infections occurred in 2002 alone, and 3.1 million people died as a result of AIDS. The developing countries were by far the most seriously affected, especially those located in sub-Saharan Africa, where about 70% of people with HIV or

and the trend is rising steeply. In China the million mark was probably passed in 2002, even according to official estimates, and the WHO does not rule out the possibility that over ten million people might become infected with HIV in the next decade. For India, there are fears that in the next few years AIDS could spread to such an extent that it could surpass even sub-Saharan Africa in severity.

collapse of the Soviet Union, resulting in a marked increase in illegal heroin trafficking and intravenous drug use. Almost 90% of positive HIV tests reported in 2001 were attributed to infections resulting from drug injections. But according to EuroHIV data there are also signs that the proportion of infections caused by heterosexual transmission is growing too.

## 4.3 International epidemiology

AIDS live. UNAIDS estimates that one in ten sexually active persons in these countries is infected with HIV. By way of comparison, only about 4% of HIV-positive persons live in the industrialized countries, and the prevalence in the sexually active population is calculated at less than 0.5%<sup>1</sup>.

The AIDS epidemic appears to have gained a foothold in East and South Asia at a later stage. But the number of people living there with HIV or AIDS is now evaluated at 7.2 million

HIV also began to spread relatively late in Eastern Europe and the countries of the former Soviet Union, probably in the early 1990s. The number of people with AIDS is therefore comparatively low, but the number of reported HIV infections is soaring. On the basis of the cases of HIV infection reported for Eastern Europe, the European Centre for Epidemiological Monitoring of AIDS (EuroHIV) calculated an average rate of close to 350 new HIV infections per million inhabitants in 2002. The comparable figure for Western Europe was 55<sup>2</sup>. The rapid spread of HIV in Eastern Europe is due almost entirely to the destabilization of political and social conditions in many of the countries affected after the

<sup>1</sup> UNAIDS et al. (2002) AIDS Epidemic Update: December 2002 (<http://www.who.int/hiv/pub/epidemiology/epi2002/en/>).

<sup>2</sup> EuroHIV (2002) HIV/Aids Surveillance in Europe. Mid-year report 2002. No. 67.

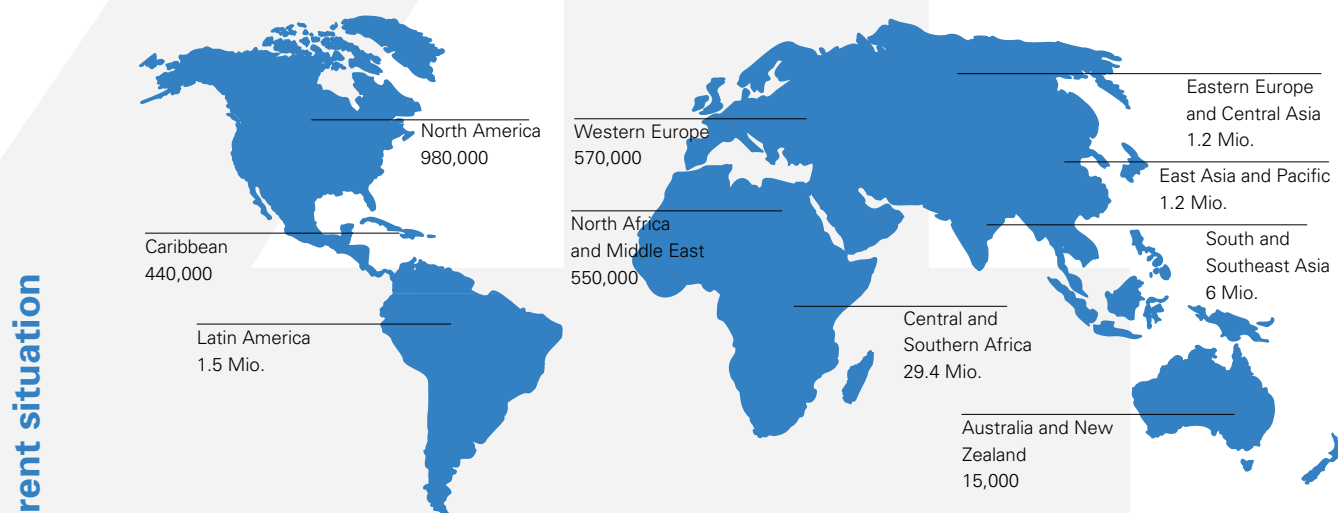


Figure 8: Estimated number of adults and children with HIV/AIDS, end of 2002

# Challenges



**"Normalization describes a process during which a phenomenon previously regarded as extraordinary – whether great or small, good or bad, threatening or enriching – loses this status and in terms of both perception and action, returns to the world of the known and the familiar. AIDS, too, has lost its exceptional**

# 5.1 End of the normalization of AIDS?

status. In Europe, AIDS is increasingly being perceived and handled – both rightly and wrongly – as just another chronic infectious disease – rather insignificant in epidemiological terms, fairly well controlled in terms of prevention and increasingly manageable in medical terms.

**This development not only has implications for the treatment of patients and the way they cope with the disease, but also affects all fields in which the exceptional status of AIDS in health policy terms ('exceptionalism') had given rise to unusual innovations."**

Rosenbrock et al. distinguish between four phases in the social and political process of managing AIDS:<sup>2</sup>

- Phase 1 (about 1981-1986): Emergence of exceptionalism: The emergence of AIDS triggers a marked readiness to undertake political action and financial expenditure and enables innovations in many fields.
- Phase 2 (approx. 1986-1991): Consolidation and performance of exceptionalism: AIDS retains its special status, and the processes, division of responsibilities and institutions are consolidated. Catastrophes in terms of incidence and prevalence do not occur.
- Phase 3 (approx. 1991-1996): Exceptionalism is crumbling and shifting towards normalization: The special status of AIDS is eroded by stable conditions in relation to prevention and discrimination and by the first treatment successes. AIDS management is consolidated and professionalized.

- Phase 4 (about 1996-?): Normalization, normality: Thanks to prevention efforts, there is a trend to endemic conditions, treatment dramatically prolongs survival time, innovations are threatened by pressure to save costs and by integration.

The question can be asked today whether AIDS work in Switzerland entered a new phase in 2001 (2001-?): Reported new cases of positive HIV tests increased again since the beginning of the nineties by just a few percentage points in 2001, 25% in 2002 and by as much as 37% in 2002 among men who have sex with men. At the same time, the pressure to cut costs had never been so great as in 2002 and 2003. It looks as if declining investment in prevention activities (see statements next to vertical bar) since the mid-1990s had led to a relaxation in the pressure to promote prevention and protective behaviour (cf. Chapter 4.2). In the media, AIDS features only as a catastrophe affecting the Third World (and therefore very far away) and/or as a medical success story (new antiretroviral drugs launched every few months, some of them at horrendous prices).

## Prevention is cheaper than treatment

An analysis of the social costs of HIV and AIDS based on 1998 figures revealed that for reasons of cost-effectiveness HIV prevention had to remain a key factor in the management of the AIDS epidemic<sup>3</sup>. The following figures provide impressive demonstration of this: HIV prevention activities in Switzerland in 1998 were estimated to have cost CHF 55 million. In contrast, the direct costs of HIV infection (outpatient and hospital treatment of HIV/AIDS patients) were estimated to be CHF 143 million. Antiretroviral drugs alone accounted for CHF 91 million, i.e. over 50% of the direct costs. Indirect costs as a consequence of illness and death were extrapolated at as much as CHF 275 million.

<sup>1</sup> Rosenbrock et al. (2002) Die Normalisierung von Aids: Erinnerungen für die Zukunft. Vorwort der Herausgeber.

<sup>2</sup> nach Rosenbrock et al. (1999) Die Normalisierung von Aids in Westeuropa. Der Politik-Zyklus am Beispiel einer Infektionskrankheit, S. 13ff.

<sup>3</sup> Zurn et al. (2001) Social cost of HIV infection in Switzerland ([http://www.hospvd.ch/iems/images/Rapport\\_sida.PDF](http://www.hospvd.ch/iems/images/Rapport_sida.PDF)).



If we accept that AIDS work has entered a new phase, i.e. the end of normalization, then it has to face up to two major challenges:

1. Saving the innovations of the last twenty years, provided they have not already fallen victim to normalization (as in Phase 4).
2. Creating new innovations – particularly in the field of prevention – to stop the rebound of new infections and lower their number (as at the beginning of the epidemic in Phases 1 and 2), despite the pressure to cut costs.

But these two major challenges cannot be met without ensuring that politicians and the public focus on the issues of HIV and AIDS. If the political world and the general public come to believe that HIV is not (or is no longer) a problem, then the resources, opportunities and structures that are needed to be able to continue with AIDS work will disappear. At the present time, for instance, it can be seen with frightening clarity how the subject of environmental protection has been slowly but surely vanishing from the political and public agenda. AIDS could well suffer the same fate.

The difficulty of the task is compounded by the trend to more conservative attitudes and values that can be observed in Western industrialized countries. In the USA in particular, the Bush Administration has brought about clear changes in AIDS policy. Since 2003 the "individually oriented search strategy" has been applied in the USA: The HIV antibody test is being propagated on a wide scale and can be performed in the medical system without first obtaining the subject's informed consent. There is also an increasing tendency to advocate sexual abstinence and fidelity rather than the use of condoms; this development also has its origins in the USA and is already institutionalized to some extent in international organizations. This change of direction in HIV prevention work is based on values rather than evidence. There is a risk that it will have a negative effect on protective behaviour.

# Prevention

**"There is no overlooking the signs: Sexuality, previously kept in check by AIDS and contained by prevention efforts, is back. What is more, it is increasingly abandoning the limits drawn up for it by the logic of prevention. This is particularly evident among homosexual men, the meticulously researched group which has been hit hardest by AIDS and which has a particularly high prevalence of HIV in comparison with other groups. Nowadays people dare to express their desires more openly and freely than a few years ago – liberating themselves from the ban imposed on sexuality since the emergence of AIDS. It is also evident that many individuals, regardless if HIV-positive or HIV-negative, have difficulty in adapting their sexual behaviour to the expectation of staying healthy that is expected of them."**<sup>1</sup>

The explanation for the decline in protective behaviour in the population as a whole and more particularly in specific groups<sup>2</sup>, and for people willing to run risks again in sexual encounters is readily found: People no longer die of AIDS! In Switzerland and other affluent countries, the removal of the death threat has eliminated a powerful motive to adopt protective behaviour. If Dannecker's theory is correct – and we have little reason to doubt this – then the success of prevention work was due essentially to fear of death from AIDS, this fear being redirected into productive channels by well-designed prevention campaigns. The current argument for protection against HIV infection is simply, to avoid the development of AIDS. HIV-positive individuals will, in several years' time, need tiresome, life-long and expensive antiretroviral treatment, associated with side effects and the long-term efficacy which has not yet been proven. On the other hand, it is argued that major advances have been made in the last few years and this will certainly continue to be the case.

Effective prevention of HIV infection requires new approaches to be developed without delay: motivating people to take care of their health without the threat of death in the background, making effective use of the limited (financial) resources available and attracting as much attention as possible with them, and taking people's sexual needs into account while still reducing the risk of infection.

"Risk management", as a further development of the prevention messages, could prove to be a possible concept for use in prevention work (cf. Chapter 3.6). New studies<sup>3</sup> show that many people before having sexual relations will try to manage the infection risk themselves by estimating the likelihood of the potential partner being HIV-positive. The studies unfortunately also show that unsuitable risk-assessment methods are often used, resulting in misjudgements. Discussion of the question "Prevention message as before, or to further develop the prevention message in the direction of risk management?" has not yet been started in Switzerland, but is urgently required.

<sup>1</sup> Dannecker (2000) Wider die Verleugnung der sexuellen Wünsche.

<sup>2</sup> Bochow (2002) Sozialwissenschaftliche Aspekte der XIV. Internationalen Aids-Konferenz in Barcelona, 7.-12. Juli 2002; Dubois-Arber et al. (2003) HIV/Aids: Zunehmendes Risikoverhalten? Das Prinzip der Vorsicht soll gelten.

<sup>3</sup> Bochow (2002) Sozialwissenschaftliche Aspekte der XIV. Internationalen Aids-Konferenz in Barcelona, 7.-12. Juli 2002.

### General population

Even though an actual epidemic has not taken place among Switzerland's heterosexual population, those who are sexually active must continue to observe a high level of protective behaviour in contacts outside HIV-free monogamous relationships to ensure that any future epidemic spread of HIV will also be prevented. Although the risk of HIV infection from an isolated unprotected heterosexual encounter is very low (cf. Chapter 3.3), the number of (unprotected) contacts is so high that HIV could still spread if the level of protection were to fall. If the success of previous prevention work is not to be jeopardized, it is essential that the STOP AIDS campaign be continued and that new concepts and effective messages that attract public attention be constantly devised.

### Target group

In Switzerland, the probability of encountering an HIV-positive (sexual) partner is estimated to be about 10% for a man seeking to have sex with another man (all age groups considered)<sup>1</sup>. Given this high prevalence and the much higher transmission efficiency of (unprotected) anal intercourse, even a slight reduction in protective behaviour would rapidly result in new HIV infections in this group. The fact that reported new cases of positive HIV tests in men who have sex with men (MSM) increased by 37% in 2002 should set alarm bells ringing. An urgent need for action is therefore required among sexually active gay men. In particular, prevention messages and condoms should be prominently displayed in all places where men can have sex with each other "on site" (men's saunas, bars and clubs with darkrooms). The distinct increase in positive HIV tests among migrants originating from countries with a high prevalence of HIV shows that a particular country's epidemiological situation cannot be viewed in isolation from developments elsewhere. Because migration can impact on the HIV/AIDS epidemic in Switzerland, it is important for HIV/AIDS prevention efforts to be carried out at an international as well as a national level. For one thing, efforts to prevent the

spread of the infection among migrants must be stepped up in Switzerland. For another, migrants' access to the health-care system has to be improved, for instance by developing transcultural skills in health-care professionals.

But sexual transmission of HIV is not the only cause for concern: HIV and hepatitis prevention are also at risk of being dropped as priority issues from the drug-policy agenda for injecting drug users. Appropriate efforts to sensitize the general public, politicians and also the people (potentially) directly affected as well as their support network should not only be continued but also increased. Prevention of hepatitis is still unsatisfactory. A basic requirement is comprehensive prophylaxis of infection and an efficient information policy targeting those concerned and their support network. The sexual behaviour of injecting drug users can also be described as high-risk, and therefore safer-sex behaviour has to be improved. This applies both to drug users who engage in prostitution and to the private sexual behaviour of drug users. In rural areas the social and medical services available for drug users have to be further improved and/or expanded; the situation is still unsatisfactory. In particular, action must be taken to counter the effects of decisions to cancel harm reduction services that have been taken at the cantonal or municipal level to save costs.

An HIV epidemic among male and female sex workers did not yet occur. Sex workers are not more HIV-prone than the average population. Activities focusing on sex workers as a target group must be continued as to maintain this situation. Since HIV-positive clients tend to be the main source of infection for sex workers, parallel efforts have to be made to motivate clients to "always use condoms".

Too little has been invested up to now in working with HIV-positive individuals. This restraint was due to fears that those concerned would suffer discrimination. Under "old public health" strategies (cf. Chapter 1.2) the entire burden of prevention is placed on the shoulders of those infected. Under "new public health" thinking, AIDS prevention calls on each individual to protect him or herself systematically. Personal responsibility for adopting protective behaviour should not be challenged, but the efforts of people with HIV to avoid passing on the infection should also be underpinned and supported. There is a need here for new approaches that do not undermine the successful strategy of self-protection but make an additional contribution to primary prevention without causing discrimination of those infected.

### Individual counselling

At the individual counselling level, too little advantage is taken of opportunities to advise both HIV-negative and HIV-positive persons on primary prevention. Prevention counselling must be systematically linked with the performance of an HIV test and must be an integral part of the management of people with HIV/AIDS. The professional skills required for prevention counselling are often underestimated and corresponding training courses underused. If better use is to be made of prevention opportunities at the individual counselling level, the further development of this approach must be a priority of the present programme.

### Vaccination

Vaccination against HIV is a further option of behavioural and structural prevention. The development of such a vaccine has been the object of years of intensive research. A breakthrough is not yet in sight. But given the variety of candidates in the early testing stages, it is not inconceivable that the first vaccines could be in use in the next ten years. However, even on optimistic assumptions it is highly unlikely that this will be enough to stop the HIV epidemic in its tracks. The first vaccines will very probably not afford protection against all existing HIV strains, and will only be partly effective against the strains for which they have been specifically developed. Complex questions arise in connection with the vaccine strategy application: vaccination of large groups could have a negative effect on prevention by reducing the risk of infection with HIV. It is also likely that epidemiological monitoring of HIV infection would become much more difficult because many of the vaccines used would make it impossible to distinguish between vaccinated and infected individuals.

<sup>1</sup> Häusermann et al. (2003) projet santé gaie. Les premiers résultats de l'enquête sur la santé des hommes gais de Genève.

tion with regard to therapy. Because successful antiretroviral combination therapy (often referred to as HAART, highly active antiretroviral therapy) can lower the number of viruses in the blood to the extent that they become undetectable (and thereby also lower the viral load of other body fluids), the role of treatment in primary prevention should not be underestimated. However, the problems should not be overlooked either: though infectivity in people

## 5.3 Treatment and counselling, laboratory and diagnostics

### Treatment and counselling

The aim of HIV infection treatment is to eradicate the virus, and this will not change. The antiretroviral drugs available since 1996 cannot achieve this aim. But what they can do – at least to some extent and for a limited period – is to keep the HIV infection under control and halt progression of HIV-induced immune deficiency. Current treatment is limited by side effects and the development of resistance.

New active substances and optimization of the use of the drugs will reduce the side effects in due course and result in simpler treatment regimens. A key factor in the treatment success and in preventing the development of drug resistance lies in the skill of the physician in selecting, monitoring and adapting the treatment in consultation with the patient (doctor-patient interaction) and the patient's adherence to therapy (compliance). Cooperation between primary care physicians (continuous doctor-patient interaction) and specialized HIV centres (state-of-the-art therapeutic skills) is a practical model for assuring the quality of medical care and treatment<sup>1</sup>. Simpler treatment schedules and administration modalities, plus fewer side effects, will do a great deal to improve patient motiva-

with HIV is reduced by successful treatment, it is greatly increased during treatment-free intervals, and in patients whose treatment is inadequate the risk of spreading resistant viral strains is very high. Any positive contribution to public health by HAART depends additionally on the therapy extent (comparable with the level of vaccination in a specific population). HAART is certainly not the solution to the problem of HIV. But responsible management of the potential preventive effect of successful therapy can make a significant contribution to primary prevention. Professional and meticulous counselling of people with HIV on primary prevention by the primary care physician and the specialized centres is as important as ever.

The decline in fatalities brought about by HAART means that the number of people living with HIV in Switzerland is increasing because the rate of new infections is much higher than the mortality rate. The range of psychosocial and legal counselling services had to be adapted in line with the

<sup>1</sup> Kopp (2002) The New Era of AIDS. HIV and Medicine in Times of Transition.

growing numbers of people with HIV and the change in their survival prospects. For people with HIV, questions concerning such issues as treatment decisions, relationships with partners or the desire to have children are important, while in the legal field issues such as working in a particular occupation or questions relating to social insurance are raised. Counselling services will have to continue being adapted to the changing needs of people with HIV/AIDS. It is an open question whether ongoing improvements and new developments in treatment will keep pace with the emergence of resistant strains of HIV. In treated patients, rates of over 70% for resistant variants are not unusual<sup>1</sup>. The stagnation in the decline in new infections is itself an indication that the number of people with HIV in Switzerland for whom there is no longer effective treatment is on the increase. It is therefore likely that the number of new AIDS cases and of AIDS-related deaths will also rise, as will the need for nursing care.

Resistant HIV variants are also being increasingly found in newly reported infections. The rate in Switzerland has been put at around 10%<sup>2</sup>, compared with up to 27% for other Western European countries<sup>3</sup>. Admittedly, this development may well be self-limiting because resistant HIV variants can gain the upper hand in the body only under the pressure of selecting treatment that limits the proliferation of non-resistant strains. In addition, most of the resistant variants are probably less infectious. But the level at which the percentage of HIV-positive persons with resistant HIV variants will settle is not yet known. It might be so high that this, too, could lead to a second wave of AIDS cases. Regardless of the level, however, treatment and counselling also have to be adapted to the situation of people with resistant HIV variants.

Observation of the global situation indicates that the number of people with HIV in developing countries who have access to antiretroviral combination treatment could increase substantially in the next few years as a result of the price reductions negotiated and the growing production of lower-cost generics. According to WHO estimates for the end of 2002, a total of 5.5 million people with HIV/AIDS in developing countries were in a stage of the disease that required treatment with antiretroviral drugs, but only 300,000 (5.5%) received them<sup>4</sup>.

With prices continuing to be too high and logistics problems still unresolved, these people are unlikely to come anywhere close to benefiting from the above-mentioned development. The need for action to create treatment access for people with HIV/AIDS in emergent, transition and developing countries therefore remains as great as ever. For various reasons (breaks in the supply chain, uncontrolled sharing of drug rations among several persons) there is a great danger that resistant HIV variants will spread very rapidly in these countries because they flourish under conditions in which treatment is inadequate.

<sup>1</sup> Yerly et al. (2003) Impaired Transmission of HIV-1 Drug-Resistant Variants. (Submitted Manuscript).

<sup>2</sup> Yerly et al. (2003) Impaired Transmission of HIV-1 Drug-Resistant Variants. (Submitted Manuscript).

<sup>3</sup> UK Collaborative Group on Monitoring the Transmission of HIV Drug Resistance (2001) Analysis of prevalence of HIV-1 drug resistance in primary infections in the United Kingdom. *BMJ* 2001; 322: 1087-8.

<sup>4</sup> WHO (2002) Coverage and Need for Antiretroviral Therapy in Developing Countries, December 2001 (<http://www.who.int/hiv/events/itac/en/>).

## Laboratory and diagnostics

Laboratory diagnostics play an important role in efforts to combat the AIDS epidemic by providing a basis for decision-making in the following key questions:

- Has an individual been infected with HIV (HIV test, confirmation)?
- Does an HIV-positive person require antiretroviral treatment? (CD4 T lymphocytes, viral load)?
- Is such treatment effective and will it remain effective? (viral load, CD4 T lymphocytes)?
- If not, why not and of what should effective treatment consist (resistance tests)?

New challenges will emerge for each of these questions in the next few years:

### Diagnosis of HIV infection

More efficient detection of the primary (acute) infection through extensive use of combined antibody/antigen tests. This will be associated with an increased incidence of non-specific reactions that will have to be investigated by means of more elaborate confirmation tests.

### Assessment of need for treatment

The increase in infections due to non-B subtype viruses entails a risk that the viral load of certain strains will be underestimated and therefore essential treatment will not be initiated. It is important that such cases can be identified with alternative, sequence-independent methods. Every HIV-positive person should receive appropriate treatment regardless of the virus with which he or she has been infected.

### Assessing the success of treatment

Here, too, it is thought that the viral load of certain strains of viruses cannot be measured and that sequence-independent tests will have to be used.

### Resistance tests

HIV resistance tests will be evaluated in a study called for by the Swiss Federal Social Insurance Office between 2003 and 2005. At low additional cost, this study can also yield information on the type of HIV subtype and the genetic identity of the virus involved, and the information can be archived in a central, anonymous register. Linking these sequence data with the SFOPH's anonymous epidemiological information (notifications by doctors) will provide invaluable insights into the origin and family tree of the HIV strains circulating in Switzerland today and thereby undermine decisions to be made on the most effective approach to prevention. Apart from these test-related challenges, the laboratories also make an

important contribution to epidemiological data gathering in the framework of the reporting system. The reporting process will have to be improved in the next few years and the information content increased by means of specific follow-up inquiries. In addition, the collection, processing and long-term storage of patient material in plasma and cell banks is a fundamental precondition for the clinical research conducted in the framework of the Swiss HIV Cohort Study (SHCS) and for basic research on HIV.

at people with HIV/AIDS; rather, they are manifestations of an increasingly less tolerant approach to marginal (social) groups. The groups having proved to be at risk of infection are therefore in particular danger of losing acceptance and support. Permanent efforts to win hearts and minds, including those of the general public, are of great importance in this context.

But the most urgent problem appears to be international solidarity with people with HIV/AIDS. The worrying situation in large parts of Africa and in other transition, emergent and developing countries is not a local but an international problem that is waiting for a political solution. Here, solidarity-based action is closely tied up with support for these countries in the area of trade. In line with the flexibility that characterizes the rules of the WTO (World Trade Organization), access to low-cost medicines in these countries should be promoted. In addition, prevention activities and the establishment of an infrastructure for treating and counselling people with HIV/AIDS should be supported.

## 5.4

# Solidarity

**The promotion** of solidarity with people affected by HIV/AIDS is a constant challenge in a society in which prevention of stigmatization and discrimination of minorities is a basic value. A ban on discrimination is an indispensable prerequisite for solidarity in the community with weaker population groups, and a democratic society is inconceivable without it. A community's ability to effectively reduce or prevent discrimination seems to be a milestone for the vitality of the solidarity it practises. As a core activity of AIDS work, the promotion of solidarity has to be understood in a broader sense: it involves not just eliminating the discrimination that people with HIV or AIDS experience in the social insurance system and the working world. This institutional level of solidarity, the guiding value of which is autonomy, requires personal, relationship-centred emphasis. Neither today nor in the future politics should close itself off to the individual level of solidarity because of – or in spite of – substantial improvements in institutional areas.

Solidarity contains an emotional component, implying acceptance and support. Solidarity with people who are at risk from or affected by HIV/AIDS can be created and strengthened by dispelling common fears and prejudices in society. Interpersonal solidarity can also be generated by strengthening the awareness that everybody is capable of feeling pain and humiliation and that anybody can become HIV-positive or suffer from a comparable disease.

There is, however, a latent conflict between the core fields of AIDS work, i.e. the self-protection strategy aimed primarily at preventing infection, and the solidarity strategy, which seeks to integrate people with HIV more effectively into society. Here it is important to avoid any decline in the acceptance of people with HIV/AIDS because, for instance, "people who don't protect themselves or others can't expect society to show solidarity with them". This latent conflict of goals in AIDS work should not be overlooked.

Although many are indifferent to the fate of people with HIV/AIDS, the situation in Switzerland can generally be described as "calm". HIV/AIDS has become a chronic disease and has lost its stigma. Credit for this is shared by the intensive prevention and information campaigns, the public commitment demonstrated by many people living with or affected by HIV/AIDS, and the treatment options that are now available. Set-backs in the promotion of solidarity – for instance, calls for compulsory treatment or other compulsory measures – are aimed not so much

**Cooperation and scientific rigour** appear to be key factors in the success of AIDS work in Switzerland to date. They essentially involve two areas:

- providing AIDS work with a scientific foundation, e.g. programme and project evaluations, reporting, monitoring and research
- broad consensus within the AIDS system in Switzerland<sup>1</sup>

The following measures will be the particular focus of these two areas in the 2004–2008 period:

- Strengthening nationwide cooperation between the Confederation and the cantons, continuing the cooperation between private organizations and improved networking of the state and private sectors
- Systematic inclusion of key individuals from politics and the public in deliberations
- Improved coordination of reporting, monitoring, evaluation and research in developing the scientific base will further improve quality and lead to additional benefits from synergies.
- Professional knowledge management will enable the store of knowledge associated with AIDS work in Switzerland - which has accumulated since the early days - to be safeguarded and to contribute to the efficient exchange of current knowledge among the many professionals and experts working in the field of HIV/AIDS. An important aspect of this knowledge management is the establishment of forums for information, knowledge transfer and discussion.
- In order to keep pace with professional standards, the latest developments in HIV and AIDS knowledge have to be systematically integrated into the basic and further training and the continuing education of a large number of professions.

These measures will help maintain and strengthen consensus, quality and professional skills in AIDS work.

5.5

# Cooperation and scientific rigour

<sup>1</sup> Kübler et al. (2002) Aidspolitik in der Schweiz: Welche Normalisierung? Normalisierungsszenarien und neue Partnerschaften in der HIV/Aidsprävention auf Bundesebene und in fünf Kantonen.



# The players in Switzerland's HIV/AIDS system

Prior to the description of strategy and goals regarding the above outlined challenges, the players active in the HIV/AIDS field in Switzerland need to be presented.

They play a key role in drawing up and implementing the programme. While specific responsibilities are outlined under the various national goals (Chapter 8), the roles of the key players in the field of HIV/AIDS are presented below. However, the HIV/AIDS field in Switzerland comprises many more players than can be presented in this context. For a full account of the players in the Swiss HIV/AIDS system, see the annex containing the list of stakeholders consulted.

6.1

# Key players and their responsibilities

## Responsibilities of the SFOPH

### Leadership in implementing the National HIV/AIDS Programme

The SFOPH has been assigned the leadership in directing and managing the National HIV/AIDS Programme.

### Information

The SFOPH ensures that both the general and the specialized public are provided with a broad range of coherent information through the STOP AIDS campaign and brochures and keeps the public regularly informed on current developments.

### Monitoring of the epidemic

Through its epidemiological monitoring activities the SFOPH provides the basic data required for drawing up the measures to be taken and initiates their implementation. It provides regular updates on HIV/AIDS statistics in the SFOPH Bulletin and supports epidemiological studies.

### Guidelines and recommendations

Taking the latest national and international data as a basis, the SFOPH, along with experts, is drawing up guidelines and recommendations on counselling, treatment, diagnostics that support treatment decisions, and nursing care of people with HIV/AIDS.

## Product safety

Together with the Swiss Agency for Therapeutic Products, Swissmedic, the SFOPH is responsible for authorizing laboratories to conduct HIV tests. Responsibility for the safety of blood products and for checking the quality of HIV tests and condoms lies with Swissmedic.

## Coordination and cooperation

The SFOPH works in close cooperation with other Swiss federal agencies, cantonal authorities and the umbrella organizations of NGOs and other non-profit organizations (NPOs). It coordinates activities with other federal agencies, prevents double-tracking and encourages the efficient use of resources. It is in regular contact with the cantonal authorities to ensure the exchange of information on the implementation of the National HIV/AIDS Programme. Together with private umbrella organizations, the SFOPH develops appropriate measures and offers help in implementing them. It coordinates the implementation of the National HIV/AIDS Programme and issues regular information on the progress.

## Promotion of political understanding

The SFOPH actively promotes political understanding of the problems associated with HIV/AIDS. It prepares the relevant topics for significant political decisions at the national level and ensures that the necessary scope for action is created and corresponding resources are made available.

## Knowledge management

The work of the SFOPH is evidence-based, using data gathered from the reporting system, monitoring, evaluation and research. It takes models of good practice as its yardstick. It is systematic in securing the relevant knowledge and regularly communicates important findings.

## International cooperation

The SFOPH promotes the implementation of UN directives on prevention, diagnostics, treatment, support and nursing care and on equality of people with HIV/AIDS.

## Responsibilities of the Federal Administration

### Implementation of the National HIV/AIDS Programme

The Federal Administration provides support for implementation of the National HIV/AIDS Programme. The tasks and responsibilities of the various federal offices are set out in the National Goals (cf. Chapter 8). Responsibilities of the EKAF  
Implementation of the National HIV/AIDS Programme  
The Swiss National AIDS Commission (EKAF) provides strategic and specialist support for the SFOPH in the implementation of the National HIV/AIDS Programme. It reviews and evaluates the planning and the

milestones of the HIV/AIDS system players and advises both the SFOPH (as previously) and the other players on specific HIV/AIDS-related questions. Together with the SFOPH, it is particularly active in assuring better access for those affected to counselling and social care, treatment and nursing care. In collaboration with the SFOPH it promotes equality of people with HIV/AIDS.

#### Guidelines and recommendations

In cooperation with its special commissions on "HIV/AIDS Clinical and Treatment" (FKT) and "HIV/AIDS Laboratory and Diagnostics" (FLD), the EKAF formulates and disseminates guidelines and recommendations on counselling, treatment, diagnostics that support treatment decisions, and care of people with HIV/AIDS.

#### Dialogue with experts

The EKAF is in constant contact with experts on HIV/AIDS, thereby ensuring its sensitivity to current topics and developments.

### Responsibilities of the AHS

#### Implementation of the National HIV/AIDS Programme

In accordance with its mission and service-level agreements with the SFOPH, the Swiss AIDS Federation (AHS) engages in a range of prevention-related activities that contribute to the implementation of the National HIV/AIDS Programme.

#### National umbrella organization

The AHS acts as an umbrella organization for its members. It represents their interests, engages in communication and public relations, supports and motivates the member organizations in the provision of their services, coordinates joint tasks, assures the flow of information and knowledge transfer within the federation and develops and assures the consistency of the prevention and counselling messages. It is responsible for joint fund-raising. It ensures uniformity of image presentation in national or cross-regional campaigns and provides and coordinates basic and further training and continuing education programmes for its members.

#### Information and advice

Through its public relations work and its involvement in the STOP AIDS campaign the AHS contributes to the provision of information to, and sensitization of, the general public. It dispenses practical information on psychosocial, legal and medical issues in a simple and understandable form. It advises people with HIV/AIDS on matters in which its members are unable to assist because

of lack of resources. It offers a service to members of the general public in search of advice when the medium or the counselling instrument does not allow regional or cantonal differentiation (e.g. electronic media such as the Internet).

#### Promotion of political understanding, lobbying

The AHS actively promotes political understanding of the problems associated with HIV/AIDS at the national level. It cultivates contacts with politicians who specialize in health-policy issues and collaborates to build up a lobby for HIV/AIDS questions.

#### Coordination and cooperation

Besides coordination and cooperation activities stemming from its role as umbrella organization, the AHS maintains contacts at the national and international levels with other NGOs with similar interests.

#### Contribution to monitoring

The AHS supports reporting, monitoring and evaluation in the HIV/AIDS field by contributing specialized suggestions.

### Responsibilities of the cantonal authorities

#### Implementation of the National HIV/AIDS Programme

The cantonal authorities are responsible for implementing and coordinating measures within the territory of the respective canton. They assure the provision of HIV-related services of appropriate quality in the fields of prevention, counselling and treatment by financing and auditing local institutions (e.g. regional HIV treatment centres or prevention and counselling facilities).

#### Thematic integration of HIV/AIDS

The cantonal authorities seek to ensure that the subject of HIV/AIDS is integrated into non-HIV-specific counselling services, e.g. cantonal family planning centres.

#### HIV prevention in schools

The cantonal authorities ensure that HIV prevention is implemented in schools. They seek to ensure that the subject matter is included in the teaching syllabus in a form appropriate to age level and they define – ideally in collaboration with experts – quality criteria for HIV prevention in schools.

#### Contribution to monitoring

The cantonal authorities are responsible for reporting cases of AIDS in accordance with the Ordinance on Notification.

#### Basic and further professional training and continuing education

The cantonal authorities seek to ensure that defined national standards of training in the HIV/AIDS field are applied in cantonal institutions. Inter- and supracantonal coordination and cooperation  
The cantonal authorities promote inter- and supracantonal coordination and cooperation in the HIV/AIDS field.

#### Responsibilities of the regional HIV treatment centres

##### Implementation of the National HIV/AIDS Programme

The regional HIV treatment centres ensure that the clinical and diagnostic aspects of the National HIV/AIDS Programme are observed and implemented in their respective geographic regions. They function as a sensor on behalf of the SFOPH, support the reporting system and provide advice to the SFOPH (e.g. through the FKT and FLD special commissions).

#### Counselling and solidarity

The regional HIV treatment centres advise and assist people living with or affected by HIV in their region. They promote respect for solidarity at the individual level. As part of the medical counselling provided for people with HIV/AIDS and their partners, all centres regularly conduct discussions on individual HIV prevention.

#### Individual counselling and anonymous HIV testing

The regional HIV counselling centres maintain an official, free-of-charge range of information and counselling services for people with questions, fears or problems relating to HIV/AIDS and advise them on individual HIV prevention. They advise people who wish to undergo a serological HIV test on preventive behaviour and carry out anonymous HIV antibody tests.

#### Cooperation with the Swiss HIV Cohort Study (SHCS)

In connection with the Swiss HIV Cohort Study and with the consent of the patients concerned, the regional HIV treatment and diagnostic centres gather clinical-epidemiological data which are then passed on for centralized evaluation. These analyses supplement the SFOPH's epidemiological surveys. In conjunction with the SHCS, the centres constitute the platform for clinical HIV-related research in Switzerland.

#### Monitoring of the epidemic/reporting system

The regional HIV treatment centres support the cantons and the SFOPH in ensuring compliance with the Ordinance on Notification. In the context of their clinical activities and on behalf of the SHCS they act as sensors for new scientific findings and for the study of new epidemiological aspects/behavioural changes (e.g. primary infections, molecular epidemiology).

#### Basic and further training

The regional HIV treatment centres are responsible for the basic and further training of physicians. In addition, they participate in the basic and further training of other professional groups in the health-care sector.

#### Guidelines and recommendations

The representatives of regional HIV treatment centres are mandated by the SFOPH to draw up guidelines and recommendations on diagnosis, counselling and treatment. They seek to ensure that these guidelines are distributed and observed in their regions.

#### Responsibilities of the regional and local prevention and counselling centres

##### Implementation of the National HIV/AIDS Programme

In accordance with their missions and service-level agreements the regional and local prevention and counselling centres provide a range of professional information, prevention and counselling services. Within the limits of their possibilities, they participate in tasks which, under national leadership, are realized regionally or locally. Within the scope available they seek to inform and sensitize the public.

#### Inter- and supracantonal coordination and cooperation

The regional and local prevention and counselling centres coordinate their activities at inter- and supracantonal level. Within the limits of their possibilities they make knowledge and know-how available for projects and tasks of the umbrella organization and ensure that experience and information are exchanged.

#### Contribution to monitoring

The regional and local prevention and counselling centres support reporting, monitoring and evaluation in the HIV/AIDS field by contributing professional suggestions.

#### Promotion of political understanding, lobbying

The regional and local prevention and counselling centres represent their interests at the regional and local levels and carry out the required public relations work.

# Swiss commitment international level

**Internationally, Swiss efforts** in the field of HIV/AIDS prevention are borne primarily by federal agencies, particularly the Swiss Agency for Development and Cooperation (SDC), in accordance with their remit and by various non-profit organizations in concurrence with their missions. The Swiss Confederation's commitment is based on the "Declaration of Commitment on HIV/AIDS" (2001)<sup>1</sup> and the "Millennium Development Goals" (2000)<sup>2</sup> of the United Nations General Assembly (cf. "Goal 1 International cooperation" in Chapter 8). The following chapter outlines the activities of the Confederation.

The Confederation already intensified cooperation between the SFOPH and SDC as part of the National HIV/AIDS Programme 1999–2003. Under the leadership of SDC, the two agencies are active in the Joint United Nations Programme on HIV/AIDS, UNAIDS<sup>3</sup>, of which Switzerland is now a full member for 2003 and 2004. In 2003 Switzerland was co-president of a working group that drew up proposals for UNAIDS governance.

## Activities of SDC

SDC's commitment is defined in its "SDC AIDS Policy 2002–2007"<sup>4</sup>, which aims to slow down the spread of the epidemic and reduce its harmful effects by raising awareness and creating an institutional commitment. The following strategies have priority: strengthening skills and capacities in the field of HIV/AIDS, promoting programme synergies, adopting a multisectoral and systemic approach, integrating HIV/AIDS prevention in SDC projects and programmes and promoting operational research. Along with the "SDC guidelines for dealing with HIV/AIDS in bilateral development cooperation"<sup>5</sup>, this policy serves SDC staff as the basis for their HIV/AIDS work and it demonstrates to partner organizations and other interested groups the importance that SDC attaches to HIV/AIDS work.

In Switzerland, SDC also supports the "Swiss Platform HIV/AIDS and International Cooperation", a network set up under the aegis of "Medicus Mundi Switzerland"<sup>6</sup> with the aim of promoting coordination, exchange of experience and exploitation of synergies among the various players.

<sup>1</sup> UNAIDS (2002) Keeping the Promise. Summary of the Declaration of Commitment on HIV/AIDS United Nations General Assembly Special Session on HIV/AIDS (UNGASS) 25-27 June 2001, New York.

<sup>2</sup> United Nations General Assembly (2000) United Nations Millennium Declaration.

<sup>3</sup> <http://www.unaids.org>

<sup>4</sup> [http://www.deza.ch/ressources/deza\\_product\\_d\\_224.pdf](http://www.deza.ch/ressources/deza_product_d_224.pdf)

<sup>5</sup> [http://www.deza.ch/ressources/deza\\_product\\_d\\_232.pdf](http://www.deza.ch/ressources/deza_product_d_232.pdf)

<sup>6</sup> <http://www.medicusmundi.ch/aidsfocus.htm>

# at the

## Multilateral cooperation

Besides bilateral cooperation on HIV/AIDS in emergent and transition countries, primarily by SDC, and backing for the NGOs and NPOs involved, the Confederation also supports efforts to combat HIV/AIDS through its membership of multilateral institutions and organizations and the financial assistance it provides. Along with many other donor countries, Switzerland is a founding member of the "Global Fund to Fight AIDS, Tuberculosis and Malaria", GFATM<sup>1</sup>, and makes a financial contribution to this fund. Besides its membership of UNAIDS, it also belongs to the United Nations Population Fund, UNFPA, which operates an HIV prevention programme<sup>2</sup>, and the World Health Organization, WHO. The WHO is active in various HIV/AIDS fields. It has, for instance, drawn up the "Global Health Sector Strategy for HIV/AIDS 2003–2007"<sup>3</sup>, manages the list of essential medicines<sup>4</sup>, which also contains a number of antiretroviral drugs, and issues guidelines<sup>5</sup> on antiretroviral treatment in resource-limited countries. Switzerland is also a member of the World Bank<sup>6</sup>, the biggest source of funding for HIV/AIDS programmes, and the World Trade Organization, WTO<sup>7</sup>. In connection with the implementation of the "Doha declaration on the TRIPS agreement and public health"<sup>8</sup>, the WTO is currently negotiating on exceptions to intellectual property rights with a view to giving

poorer countries access to patented medicines. Finally, in the framework of the United Nations Commission on Human Rights, Switzerland also takes part in the negotiations on resolutions related to HIV/AIDS ("Protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS)", "Access to medication in the context of pandemics such as HIV/AIDS, tuberculosis and malaria").<sup>9</sup>

<sup>1</sup> <http://www.globalfundatm.org/>

<sup>2</sup> <http://www.unfpa.org/hiv/index.htm>

<sup>3</sup> [http://www.who.int/hiv/pub/advocacy/hiv2002\\_25en.pdf](http://www.who.int/hiv/pub/advocacy/hiv2002_25en.pdf)

<sup>4</sup> <http://www.who.int/medicines/organization/par/edl/access-hivdrugs.shtml>

<sup>5</sup> [http://www.who.int/hiv/pub/prev\\_care/ScalingUp\\_E.pdf](http://www.who.int/hiv/pub/prev_care/ScalingUp_E.pdf)

<sup>6</sup> <http://www.worldbank.org>

<sup>7</sup> <http://www.wto.org>

<sup>8</sup> [http://www.wto.org/english/thewto\\_e/minist\\_e/min01\\_e/mindecl\\_trips\\_e.htm](http://www.wto.org/english/thewto_e/minist_e/min01_e/mindecl_trips_e.htm)

<sup>9</sup> <http://www.unhcr.ch/html/menu2/2/59chr/document.htm>

# Basis of the strategy



# Vision

**The National HIV/AIDS Programme 2004–2008 plays a decisive part in preventing the further spread of HIV in Switzerland and in ensuring that people with HIV enjoy the same quality of life as non-infected persons.**

**The measures undertaken to achieve this vision are planned and implemented on a basis of partnership and participation. They are contingent upon on solidarity, acceptance and equality of opportunities.**

## **Partnership**

means transparency, mutual respect and interdisciplinary thinking and working.

## **Participation**

means that measures are drawn up and implemented with the target groups concerned on a basis of cooperation between equals.

## **Solidarity**

implies a reciprocal awareness of responsibility within and among communities that benefits the quality of life of all concerned. Solidarity in practice means mutual acceptance and support.

## **Acceptance**

means that people with HIV/AIDS and groups at particular risk of HIV infection must be accepted for their quite specific individuality, as those who are not infected with HIV or not exposed to a particular risk of infection. Diversity of lifestyles and values is part and parcel of a pluralistic society. Any conflicts that ensue must be addressed openly.

## **Equality of opportunities**

means that all people enjoy the same right of access to the resources they need to develop and maintain their physical and psychological well-being.



# Mission

The players in the HIV/AIDS field in Switzerland share the goals of the National HIV/AIDS Programme and make a decisive contribution to achieving them. They direct their activities towards ensuring that

- the number of new infections declines,
- all people with HIV/AIDS enjoy access to state-of-the-art treatment, diagnostics, counselling, information and nursing care in accordance with their needs, and that
- people with HIV/AIDS are given the same opportunities as non-infected persons in all areas of life and feel well integrated and well treated in society.

The Epidemics Act assigns responsibility for combating transmissible diseases in humans to the Confederation and cantons (cf. Chapter 1.6)<sup>1</sup>. In the core field of prevention (cf. Chapter 2), the Swiss Federal Office of Public Health, together with the cantons, is therefore responsible for ensuring that the number of reported new infections decreases. It pursues this goal in close collaboration with the private-sector non-profit partner organizations working in the field. In the core fields of treatment and solidarity the Swiss Federal Office of Public Health plays a coordinating role to ensure that these goals can also be achieved.

<sup>1</sup> Art. 1 of the Federal Law of 18 December 1970 on the Combatting of Transmissible Diseases in Humans.

**The National HIV/AIDS Programme (NHAP)** pursues goals both in terms of substance and at the formal level:

At the **formal level**, the programme seeks to create a common basis for HIV/AIDS work in Switzerland over the next five years by laying down the cornerstones of HIV/AIDS work, identifying the challenges that lie ahead in the next few years and

effective deployment of one during the term of the new programme. Behaviour that protects the individual and his or her sexual partner(s) against HIV must continue to be supported by suitable prevention and health-promotion measures, while vulnerability to infection must be reduced by the creation of favourable general conditions.

treatment or the development of resistance. In the field of legal counselling, advice on questions to do with working in a particular occupation or social insurance is important.

**The NHAP is committed to ensure that people with HIV/AIDS – whether in Switzerland or abroad – receive state-of-the-art counselling, support, treatment and nursing care in accordance with their needs.**

7.3

# General goals

defining the goals, including tasks and responsibilities, on which the different players have reached agreement. It will secure existing achievements in HIV/AIDS work and rise to new challenges by means of networking and the systematic exchange of knowledge, know-how and experience within the HIV/AIDS field as well as with related areas of public health. In addition, the NHAP will make a contribution to maintain and increase public awareness of the problem of HIV/AIDS. This is an essential precondition of effective prevention (problem awareness, availability of resources) and of solidarity with those with HIV/AIDS.

Both internationally and nationally, the NHAP will make a contribution – in accordance with the responsibilities assigned to the different federal agencies – to implement the United Nations "Declaration of Commitment on HIV/AIDS"<sup>1</sup> and "Millennium Development Goals"<sup>2</sup>.

In **terms of substance**, the NHAP will vigorously pursue the three general goals (corresponding to the three core fields of activity; Chapter 2) which determined Switzerland's previous strategy on HIV/AIDS<sup>3</sup>.

## 1. Preventing the spread of HIV

In Switzerland, HIV is a health risk for the sexually active population, injecting drug users and the children of HIV-positive mothers. To a much lesser extent it is also a risk to medical personnel and the recipients of blood transfusions. The actual risk of infection very much depends on situational, personal and environmental factors (cf. Chapter 3.3). Because the number of HIV-positive persons is steadily growing (there are more new infections than AIDS-related deaths) the general risk is growing too.

The spread of HIV can be stopped only by behavioural and structural prevention measures, which are also much more cost-effective than treatment (cf. Chapter 5.1). Work on developing a vaccine is in progress, but there is unlikely to be wide and

**Both nationally and internationally, the NHAP is committed to reduce the number of new cases of HIV infection.**

## 2. Reducing the negative effects in people with HIV/AIDS

AIDS continues to be a severe, incurable disease. Under complicated and demanding drug treatment, HIV infection can, up to a certain point and for an as yet undetermined time, be transformed into a chronic, usually asymptomatic disease. The success of treatment depends on the accessibility, tolerability and efficacy of the drugs, adherence to the drug regimen and monitoring of the course of the disease. Findings from empirical research on long-term efficacy are lacking, and symptoms and side effects can make life very difficult under such therapy. The development of drug resistance is frequently observed, and its consequences for prevention and treatment are subjects of controversy.

Steps must therefore be taken to ensure that both people receiving antiretroviral treatment and those who are not being treated or in whom treatment is not (or is no longer) effective receive appropriate information, counselling, support and nursing care.

The range of psychosocial and legal counselling services provided has to be constantly adapted to the changing survival prospects of people with HIV/AIDS. In the psychosocial field, for instance, this may mean addressing such issues as stable relationships and the wish to have children, or choice of therapy or the best way to handle the failure of

## 3. Promoting solidarity and acceptance

Nowadays HIV/AIDS is scarcely viewed by the general public as a social problem. This change of heart is a result of the stabilization of the infection rates achieved in the 1990s, the treatability of HIV/AIDS, the generation change<sup>4</sup> and also the emergence of other issues. HIV/AIDS has therefore lost out in terms of both attention and resources, which not only undermines preventive behaviour but also entails a risk that solidarity with people with HIV/AIDS will decline.

In view of the worldwide development of the epidemic, the resurgence (for various reasons) in the numbers of positive test results in Switzerland and the problems associated with treatment (resistance, continuing absence of vaccines), vigorous efforts must be made to combat any decline in solidarity. Marginalization and discrimination of people with HIV/AIDS and of groups at increased risk of HIV infection must be prevented.

**The NHAP is committed to ensure that people with HIV/AIDS, whether in Switzerland or abroad, are given the same opportunities as non-infected persons in all areas of life and feel accepted as an integral part of society.**

<sup>1</sup> UNAIDS (2002) Keeping the Promise. Summary of the Declaration of Commitment on HIV/AIDS. United Nations General Assembly Special Session on HIV/AIDS (UNGASS) 25-27 June 2001, New York. Cf. also "Goal 1 International cooperation" in Chapter 8.

<sup>2</sup> United Nations General Assembly (2000) United Nations Millennium Declaration. Cf. also "Goal 1 International cooperation" in Chapter 8.

<sup>3</sup> Bundesamt für Gesundheit (1999) HIV und Aids. Nationales Programm 1999 - 2003

<sup>4</sup> Today's young people no longer encounter AIDS as a fatal disease. And people at increased risk of HIV infection may no longer personally know anyone with HIV/AIDS.

**The fundamental values** underlying the National HIV/AIDS Programme are based on the Swiss Federal Constitution, specifically on equality under the law and respect for and protection of human dignity and the right to privacy, on the European Human Rights Convention and the United Nations Human Rights Pact. At the health-policy level these values are specified in the "Ottawa Charter for Health Promotion"<sup>1</sup>, the

7.4

# Basic values and the conception of the individual

WHO framework policy "Health for all"<sup>2</sup> and the framework policies derived from it, "Health 21" for Europe<sup>3</sup> and the "Gesundheitsziele für die Schweiz" [Health policy goals for Switzerland]<sup>4</sup>.

In accordance with the Ottawa Charter for Health Promotion and the SFOPH's global strategy<sup>5</sup>, the National HIV/AIDS Programme takes a global approach to health. As a positive concept, health underscores both social and personal resources and physical abilities. Health is an essential prerequisite of social, economic and personal development and crucial for quality of life.

It has to be assumed that not everybody possesses the same ability to understand and learn nor the same freedom of self-determination.

Besides a readiness to learn and motivation to stay healthy that varies from individual to individual, every person and every group also exhibit impulses and motives that are harmful to their health and to the well-being of the community. General conditions and the social and economic situation have a decisive influence on the freedom of self-determination.

It is also evident that motives and acts conducive or harmful to health can vary in individuals and groups in the course of a lifetime or over time, depending on the prevailing internal and external circumstances.

<sup>1</sup> WHO (1998) Ottawa Charter for Health Promotion (1986).

<sup>2</sup> WHO (1998) Health for All in the 21st Century. World Health Declaration. Approved by the World Health Community at the 51st World Health Assembly in May 1998 (<http://www.who.int/archives/hfa/>).

<sup>3</sup> WHO Europe (1998) Health 21: An introduction to the health for all policy framework for the WHO European Region.

<sup>4</sup> SGPG (Hg.) (2002) Gesundheitsziele der Schweiz. Gesundheit für alle im 21. Jahrhundert (WHO Europa).

<sup>5</sup> Bundesamt für Gesundheit (2002) Gesamtstrategie BAG.

**In the context of HIV/AIDS**, personal responsibility implies the responsibility of individuals to protect themselves; responsibility for others refers to protect sexual partners and, indirectly, any sexual partners these may have.

The main thrust of the previous prevention strategy was to promote personal responsibility, i.e. self-protection, in situations relevant to HIV.

HIV/AIDS are particularly vulnerable in many respects and therefore cannot be burdened with additional responsibility. On the other hand, it is also evident that, because people with HIV/AIDS have to be taken seriously and accorded the same rights and the same responsibilities as people without HIV/AIDS (cf. Goal 8 in Chapter 8) and because they can help influence the further spread of

others involved into account. This obligation includes frank communication by the participants of blood status and of any previous risk situations they have experienced, and taking the necessary precautions regarding protection against HIV. The commitment underlying the sexual encounter therefore determines the ratio of personal responsibility to responsibility for others.

7.5

# Personal responsibility, responsibility for others

More recently, insurance jurisprudence specialists<sup>1</sup> and epidemiologists<sup>2</sup> have been asking whether people with HIV do not bear a particular responsibility for the spread, or for preventing the spread, of HIV.

As indicated in Chapter 7.4, however, because of the unequal distribution of resources, not everybody can be expected to share the same level of personal responsibility. It is particularly difficult for vulnerable individuals or people in vulnerable situations to take on responsibility either for themselves or others. As a further dilemma facing prevention, it has been pointed out that the difficulty of reaching vulnerable people increases in proportion to the repressiveness with which they are called upon to assume responsibility.

It is obvious that people with

HIV through their behaviour, they should not be freed completely from responsibility.

The following proposal stems from the HIV prevention field and is based on ethical and moral considerations<sup>3</sup>: In any HIV-relevant sexual situation, the sexual partners involved bear a responsibility to themselves and to others. However, the ratio of the two forms of responsibility varies according to the nature of the sexual encounter: the more casual the encounter and the more unknown the sexual partners are to each other, the greater is the element of personal responsibility, i.e. the obligation to protect oneself. In a darkroom or during a one-night stand for instance, the principle of personal responsibility applies unconditionally, quite regardless of the participants' blood status. It is not a question of attributing particular responsibility in this situation to people with (diagnosed) HIV/AIDS, nor of releasing from responsibility people who, for whatever reason, do not know (or do not want to know) what their blood status is. It should be noted that this approach applies to voluntary sexual encounters, but not to those involving a dependence relationship or compulsion. It should be borne in mind though that, in practice, sexual encounters take place in a continuum between the poles of free will and compulsion or dependence. However, the greater the role played by elements of familiarity or even trust and love in a sexual encounter, the greater the level of responsibility for others, i.e. the obligation to take the well-being and protection of the

<sup>1</sup> Riemer-Kafka (2002) Das Spannungsverhältnis von Selbstverantwortung und gesellschaftlicher bzw. kollektiver Verantwortung bei HIV-positiv/AIDS. Paper presented at the EKAF-Symposium 2002.

<sup>2</sup> Francis (2001) Have we learned anything after 20 years of AIDS? Call for a Nation Health Board.

<sup>3</sup> Staub (2003) HIV-positiv: Fertig mit Sex? Oder: Erwächst HIV-positiven Menschen eine andere oder besondere moralische Verantwortung? Thesis for Master of Advanced Studies in Applied Ethics (MAE) 2001-2003.

# Quality of AIDS work

**In the present National HIV/AIDS Programme** a specific goal for promoting and assuring quality in HIV/AIDS work has been dispensed with because the pursuit of quality is regarded as being inherent in every occupation (professional ethics) and is thus taken for granted by all players in the HIV/AIDS field. In other words, quality assurance and development is a professional obligation that extends well beyond the individual goals of the NHAP.

Quality in HIV/AIDS work implies a commitment to

- Professionalism (services satisfy current professional and ethical standards; the necessary individual skills are acquired particularly by means of appropriate basic and further training and continuing education and by exchanges with other professionals),
- Adaptation to needs (services are designed to take account of client needs; this is reflected particularly in the range of services offered, access to them, tailoring of the services to individual needs while taking gender, age and origin into account, and in client satisfaction with the services), and
- Cost effectiveness (professional services appropriate to needs should also be as cost-effective as possible, i.e. the cost/benefit ratio should be optimum).

Generally speaking, authorities and institutions are themselves responsible for quality assurance within their organizations. When service-level agreements have to be concluded with external partners, the mandating

and mandated parties first agree on the requirements to be met by the quality of the services provided and by quality assurance.

The following measures will make an important contribution to global supra-institutional quality development :

- Gathering of evidence as a basis for professional, needs-oriented and cost-effective HIV/AIDS work (reporting, monitoring, evaluation, research; cf. Goals 9 and 10 in Chapter 8)
- Supra-institutional knowledge management, including exchanges among professionals (cf. Goal 11 in Chapter 8)
- Basic and further training and continuing education of professionals (cf. Goal 12 in Chapter 8)

The SFOPH's commitment in this area goes without saying and will have to be strengthened. In addition, cooperation among different players is particularly useful and important in the quality assurance field.

# Gender-specific AIDS work

**A gender-specific approach** to draw up projects, counselling services and other measures is an essential prerequisite for sustainable needs-oriented AIDS work. As was shown in the previous chapter, services can be lastingly effective only if they are geared to the specific needs and interests of the target groups; the principle of adaptation to needs applies particularly to differences in the requirements and circumstances of women and men.

HIV/AIDS prevention recognized the need for gender-specific measures at an early stage and implemented them in its programmes: services specifically for women and for homosexual and heterosexual men have always featured in the programmes.

The new programme will consolidate what has already been achieved in the gender area. Target group-specific projects for both women and men will continue to be realized. Over and above these, a systematic effort will be made in the general programmes and campaigns to ensure that women and men are addressed appropriately and their respective needs taken into account. For instance, measures targeting the general population are planned with a view to maintaining public awareness of HIV/AIDS. Such campaigns have been shown to be effective only when they take account of the different needs and interests of women and men: this gender-specific approach to HIV/AIDS work will be systematically included and institutionalized in the implementation of the new programme.

The SFOPH's Gender Health Unit will draw up a checklist ("10 Golden Rules"), based on existing international tools, for the gender-specific design of policies, programmes and projects. This practical tool is also intended for use by professionals who have little knowledge of gender-specific work. It is geared to the work steps involved in planning a programme or policy and should be deployed, as required, for stocktaking and corrective purposes at several points in the process, ranging from general planning of a project all the way through to its evaluation. It will structure and simplify the gender-specific approach to work, and thereby become a tool for promoting the quality (adapted to gender needs) of preventive measures.

# National goals



**The national goals** reflect the strategic orientation of the National HIV/AIDS Programme and set the priorities for the programme period. The goals provide the basis and the legitimacy for maintaining, developing or improving services designed to meet regionally diverse needs. The national goals are binding for the Federal Administration. The other players may use them as criterion to which their HIV/AIDS prevention activities are directed. Like the programme as a whole, the goals have been developed in the course of a consultation exercise involving players in the HIV/AIDS field in Switzerland to ensure that the programme is implemented coherently and enjoys wide support (cf. annex: Consultation partners).

The twelve national goals are subdivided into five target areas. The two general goals of international and national cooperation are followed by the three core fields of activity "Prevention", "Treatment and counselling" and "Solidarity". While the two core fields "Treatment and counselling" and "Solidarity" are covered by one goal each, the core field "Prevention" has been spread over four goals. These are based on the model of the three levels of communication in prevention (cf. Chapter 3.1) in that they feature prevention measures that addressing the general public, specific target groups and the individual. The support-level goals refer to measures that enable and foster implementation of the preceding goals. Thus the order in which the national goals are listed is logical in terms of substance, but says nothing about the value attached to the individual goals.

## Target areas

Target areas	National goals
General goals	Goal 1: International cooperation Goal 2: National cooperation
Core field "Prevention"	Goal 3: Prevention in the general population Goal 4: Prevention in schools Goal 5: Prevention in specific target groups Goal 6: Individual prevention counselling
Core field "Treatment and counselling"	Goal 7: Counselling and social care, treatment and nursing care
Core field "Solidarity"	Goal 8: Equality
Support-level goals	Goal 9: Reporting, monitoring, evaluation Goal 10: Research Goal 11: Knowledge management Goal 12: Basic and further professional training and continuing education

## Structure of the national goals

<b>Title:</b>	designates the area of activity
<b>Lead:</b>	designates the desired outcome
<b>Background:</b>	designates the current situation and the need for action
<b>Tasks and responsibilities:</b>	designates the players mandated to help realize the goal and their tasks and responsibilities
<b>Milestones:</b>	verify the extent to which goals have been realized. The present milestones are confined in most cases to the tasks of the SFOPH and, if appropriate, to its partners. They are also incomplete and cannot take regional differences into account. As described in Goal 2 "National cooperation", the responsible players will define additional milestones for their own organizations in a separate process



# Goal 1

**The aim of international cooperation is to encourage implementation of the United Nations resolutions, particularly access to prevention, diagnostics, therapy, counselling and nursing, and treating people with HIV/AIDS on an equal footing with non-infected individuals.**

## **International cooperation**

### **Background**

As of end 2002, UNAIDS estimated that 42 million people were infected with HIV. Some five million new infections occurred in 2002 alone, and 3.1 million died as a result of AIDS. Over 95% of people with HIV/AIDS live in transition, emergent or developing countries. These countries are therefore by far the most seriously affected, above all those located in sub-Saharan Africa, where about 70% of people with HIV/AIDS live. HIV/AIDS is destroying or threatening to destroy the development of the countries affected.

The epidemic is a global challenge that does not stop at national boundaries. Given today's international networking, mobility and migration, global measures are essential as a sign of solidarity and because they are in the interests of all countries.

## Tasks and responsibilities

### SFOPH and SDC

In the framework of the "Swiss International Health Policy" project, the SFOPH and SDC define the roles taken in international cooperation and its optimization within the scope of the federal agencies' existing responsibilities.

### Milestone 1:

**The coordination mechanisms laid down in the "Swiss International Health Policy" project will be implemented as from 2004.**

### SDC

In the field of development cooperation and humanitarian aid, the SDC is committed – in accordance with its mandate – to implement Goal 6 of the United Nations "Millennium Development Goals" in developing countries (South) and transition countries (East) at a multilateral as well as a bilateral level.

### SFOPH

The SFOPH is committed to implement in Switzerland the goals set by the United Nations in the "Declaration of Commitment on HIV/AIDS" to halt the spread of HIV/AIDS and reduce its negative consequences.

### IGE

In issues relating to the protection of intellectual property, the Federal Institute for Intellectual Property (IGE) acts at the national and international level to guarantee favourable conditions in which research and development in the HIV/AIDS field can be conducted.

### Pharmaceutical and diagnostics manufacturers

The pharmaceutical and diagnostic industry promotes access to diagnostics and treatment in the developing countries, to which it also promotes the transfer of knowledge and technology.

### SNSF

In the framework of its regular activities to promote research and on the basis of its service-level agreement with the Confederation (cf. Goal 10), the Swiss National Science Foundation (SNSF) promotes research, knowledge transfer and networking in the HIV/AIDS field with transition, emergent and developing countries and supports research topics that are of particular importance for these countries.

### NGOs

Non-governmental organizations work towards implementation of the goal in accordance with their respective missions.

The points of reference for HIV/AIDS work at the international level are the "Declaration of Commitment on HIV/AIDS" (2001)<sup>1</sup> and Goal 6 of the "Millennium Development Goals" (2000)<sup>2</sup> of the General Assembly of the United Nations. The "Declaration of Commitment on HIV/AIDS" was approved in 2001 at the United Nations General Assembly Special Session on HIV/AIDS (UNGASS), at which Switzerland was represented. It describes the global situation in the various areas of HIV/AIDS work and specifies the commitments undertaken by the signatory states. The "Millennium Development Goals", which are to be implemented by 2015, are part of the "Millennium Declaration" endorsed by the United Nations General Assembly in 2000. Goal 6 is worded as follows: "Combat HIV/AIDS, malaria and other diseases; halt and begin to reverse the spread of HIV/AIDS; halt and begin to reverse the incidence of malaria and other major diseases."

Switzerland is committed to sharing the responsibility for combating HIV/AIDS at the global level. By contributing ideas and funding to bilateral and multilateral (e.g. UNAIDS, WHO, GFATM, UNFPA, WTO and World Bank) international cooperation and by participating in knowledge and technology transfer, Switzerland is implementing the "Declaration of Commitment on HIV/AIDS" and Goal 6 of the "Millennium Development Goals" in a coordinated, coherent and proactive fashion.

<sup>1</sup> UNAIDS (2002) Keeping the Promise. Summary of the Declaration of Commitment on HIV/AIDS. United Nations General Assembly Special Session on HIV/AIDS (UNGASS) 25-27 June 2001, New York.

<sup>2</sup> United Nations General Assembly (2000) United Nations Millennium Declaration.

# Goal 2

In terms of content, structures and funding, cooperation between the Confederation and the cantons, the public and private-sector players and with key individuals is defined at both the strategic and operational level. Leadership in AIDS work rests with the SFOPH. The Swiss National AIDS Commission (EKAF) advises and supports the SFOPH in this respect. The instruments, channels and networks of national cooperation have been selected and communicated and are regularly used.

## National cooperation

### Background

In accordance with its responsibilities in the event of an epidemic<sup>1</sup>, the SFOPH is active in the field of AIDS work, particularly in HIV prevention. The Federal Council has instructed the extraparlimentary EKAF to act as advisory body to the SFOPH. As a government organization, the SFOPH works closely at the national level with an NGO, the Swiss AIDS Federation (AHS), and with other national NGOs/NPOs<sup>2</sup> active in the HIV/AIDS

or related fields. The goals of the cooperation have been coordinated. Likewise, the corresponding cooperation between government and non-governmental organizations has been established in a large number of cantons. Cooperation between the national and cantonal levels and private organizations takes place in the network of the Swiss AIDS Federation (AHS) and its members. Though networks have been available to the national authorities and administrations for cooperation with their counterparts at the cantonal level, i.e. for cooperation between the Confederation and the cantons, they have not to date been used on a regular basis. The SFOPH ensures that regular exchanges with the cantons will also be established. Key individuals such as politicians, media representatives and other important figures have so far not been systematically included in HIV/AIDS prevention work, and this aspect will have to be strengthened. It is not possible to map out precise milestones in the operational implementation of a programme over five years in advance. The goals set out in this NHAP contain milestones that make no claim to completeness. From time to time, the SFOPH will invite all players to draw up a specific plan, including milestones, for their respective organizations. The EKAF advises the SFOPH and the players on planning and takes note of the players' annual reports.

## Tasks and responsibilities

### SFOPH

The SFOPH directs and coordinates the implementation of NHAP 04 – 08 and sets thematic priorities. It invites stakeholders to proceed with planning the implementation of the programme and to submit their plans to the SFOPH and EKAF for information.

### EKAF

The EKAF advises the SFOPH and the players on planning, milestones and special questions. It comments on the players' annual reports and the evaluation of the NHAP.

### Confederation/cantons

They cooperate in terms of contents, structures and funding in the field of HIV/AIDS and institute the necessary coordination measures.

### National NGOs/cantonal NGOs

They cooperate in terms of contents, structures and funding in the field of HIV/AIDS.

### Confederation/national NGOs

They cooperate in terms of contents, structures and funding in the field of HIV/AIDS.

### Cantons/cantonal NGOs

They cooperate in terms of contents, structures and funding in the field of HIV/AIDS.

### All players

They periodically plan the implementation of the programme and set milestones.

<sup>1</sup> Federal Law on the Combating of Human Transmissible Diseases (Epidemics Act) of 18 December 1970 [818.101] (cf. Chapter 1.6).

<sup>2</sup> For simplicity's sake only NGOs are specified in the goals. However, NPOs that are not NGOs are not excluded.

# Goal 3

All people living in Switzerland are informed about HIV transmission modes in a form appropriate to their needs. They are aware of the risk situations and take suitable protective measures. The prevention messages aimed at the general public take account of social diversity.

## Prevention in the general population

### Background

All people living in Switzerland are informed on a regular, nationwide basis about HIV/AIDS and know how to protect themselves against infection. In view of our society's diversity



## Tasks and responsibilities

### SFOPH, AHS

The SFOPH, in cooperation with the AHS, runs the STOP AIDS campaign to keep the general public regularly informed on a nationwide basis.

### SFOPH

The SFOPH makes information material available in all relevant languages.

### AHS and its members

The Swiss AIDS Federation (AHS) and its members provide a professional range of information, prevention and counselling services and take part in the STOP AIDS campaign.

### Cantons

The cantonal authorities integrate HIV prevention into professional counselling services in the fields of sexual and reproductive health, lifestyle counselling and drug-dependence assistance.

(e.g. lifestyle, language, age, gender, origin, education, religion, etc.), steps must be taken to ensure that the entire population enjoys the same access to information, prevention and counselling. Account must be taken of the fact that there are circumstances which make it more difficult for protective measures to be taken. Special measures are called for in such cases, whether for vulnerable groups (cf. Goal 5) or for the type of vulnerable situation in which anyone may find themselves in the course of a lifetime (e.g. influence of alcohol or other drugs, emotional stress). If the epidemic is to be halted, it is important to maintain a high level of adherence to the rules of safer sex and to institutionalize them as a social norm. Regular discussion of the rules of safer sex helps promote solidarity by keeping the subject of AIDS alive and drawing attention to the potential risk it represents to the individual.

# Goal 4

**HIV prevention is incorporated into the curricula of primary, secondary and vocational schools on a mandatory basis and in a form appropriate to educational level.**

## **Prevention in schools**

### **Background**

Before achieving adulthood, children and adolescents should acquire at school the knowledge and ability to protect themselves against infection with HIV. However, HIV prevention is still poorly covered in a large number of schools. The teaching models used (teaching done by a teacher or external specialist), the incorporation



## Tasks and responsibilities

Responsibility for implementing Goal 4 in schools is shared by the cantonal departments of education and economics, the cantonal and municipal school authorities, the Swiss conference of cantonal education directors (EDK), the Federal Office for Professional Education and Technology (OPET) and the SFOPH. The role of the SFOPH in this constellation is predominantly one of coordination and support. "Education & Health – Swiss Network", a joint programme of the EDK and SFOPH, runs "Amorix – Nationales Kompetenzzentrum für Bildung und sexuelle Gesundheit" [Amorix – national centre of excellence for education and public health], which provides the cantons and municipalities with professional support and coordination.

### SFOPH, EDK

The SFOPH and EDK coordinate and support prevention activities in schools in the framework of the "Education & Health – Swiss Network" programme.

### SFOPH, OPET, EDK

#### Milestone 1:

**In 2008 these organizations will review the quality of implementation of this goal in schools and, depending on the outcome, define measures for the further development of prevention work in schools and by Amorix.**

### Teacher training colleges

#### Milestone 2:

**From 2007 teacher training colleges will assure the basic and further training of teachers on the subject of HIV/AIDS, taking collaboration between teaching staff and external specialists into account.**

### Cantonal departments of education and economics, cantonal and municipal school authorities

#### Milestone 3:

**From 2007 the cantons will be responsible for introducing and distributing appropriate teaching material for HIV prevention in schools.**

### AHS and PLANeS

The Swiss AIDS Federation (AHS) and PLANeS (Swiss Foundation for Sexual and Reproductive Health) create a blueprint for the "Amorix – national centre of excellence for education and sexual health" project on behalf of the SFOPH and EDK, set up the organization and implement the agreed goals (including methods of communicating prevention messages in the school setting, publishing and promoting examples of good practice).

#### Milestone 4:

**The organization will be set up by the end of 2005.**

#### Milestone 5:

**From 2006 all teachers and external specialists will have access to an overview of the relevant teaching material available throughout Switzerland. The availability of this material will be guaranteed and gaps in it identified.**

### Youth-work institutions outside the school system

These organizations incorporate HIV prevention into their activities, network with schools and health-promotion institutions and cooperate with specialists who are qualified in the field of sexual health and HIV prevention. They attend specific further training programmes and are familiar with the corresponding information material.

### NGOs in the field of HIV/AIDS and sexual health at the national and cantonal levels

Their knowledge and experience is put at the disposal of HIV prevention activities aimed at young people within and outside the school system networking with the school institutions and youth workers outside the school system.

of HIV prevention as a subject, the basic and further training of teachers and external specialists and access to appropriate teaching material are very heterogeneous. HIV prevention therefore needs to be incorporated into the mandatory curricula and its quality reviewed and assured. It will have to be integrated into the broad context of sexual health and prevention of addiction and should be gender based and take due account of the age and specific background of the students. The cantons must provide sufficient resources to implement teaching of HIV prevention in schools.

However, some young people are either not reached or only poorly reached in the school setting. Since they are particularly vulnerable, they will require additional awareness and information activities on HIV/AIDS prevention from the public-sector juvenile assistance schemes and outreach workers outside the school setting.



# Goal 5

People at increased risk of HIV infection or with an increased need for prevention activities are addressed by means of prevention messages specific to their situation and they adopt appropriate protective behaviour. Behavioural prevention activities are supported by structural prevention measures. A monitoring system is in place to identify new subgroups at increased risk of HIV infection.

## Prevention in specific target groups

### Background

People at increased risk of HIV infection or with an increased need for prevention activities offer the greatest potential for effective prevention and therefore require special measures. Various personal, social and situational factors may influence the risk of infection with HIV and these factors may accumulate (for definitions of "risk" and "vulnerability" see Chapter 3.3). At the time of publication of this programme, the need for prevention is greatest among:

- gay and other men (and young people) who engage in unprotected anal intercourse
- migrants from countries with a high prevalence of HIV, and their sexual partners
- injecting drug users
- sex workers
- sex workers' clients, and travellers to endemic regions who do not practise protection.



## Tasks and responsibilities

### SFOPH

The SFOPH allocates resources to the implementing organizations and agencies. It mandates and coordinates risk monitoring and evaluation of the measures. It publicizes examples of good practice, makes suitable information material available and networks the NHAP with the Confederation's national programme of measures to combat addiction for the 2005–2008 period ("MaPa-Su").

### Milestone 1:

**In 2004, the SFOPH working groups on "MSM", "Migration", "Drugs", "Sex Work/Clients/Sex Tourism" and "People with HIV/AIDS" will each present an action plan for the 2004–2008 period on specific HIV prevention in the corresponding target groups.**

### OPET, imes, SFOPH

OPET, imes (Federal Office of Immigration, Integration and Emigration) and the SFOPH allocate resources to the implementing organizations and agencies in the migration field.

### NGOs

They implement prevention in target groups at increased risk of infection, produce information material and take part in monitoring activities.

### Cantons

They are responsible for cantonal prevention activities in target groups and for promoting empowerment, for instance by supporting organizations of vulnerable groups.

On account of the prevention potential, there is also an increased need for action among people living with HIV/AIDS.

Prevention efforts aimed at target groups require particular sensitivity as there is always a risk of stigmatization. Behavioural and structural interventions (see Chapter 3.3) have to be developed and carried out in collaboration with the groups concerned.

Target groups are neither stable nor homogeneous. A particular group may comprise various subgroups with different levels of risk and vulnerability. If people at increased risk are to be reached, appropriate resources must be employed to observe which subgroups exhibit an accumulation of risk factors or increased vulnerability (monitoring).

There are also settings in which people at increased risk of HIV infection are represented in high numbers, for instance prisons, juvenile residential facilities and drug-dependence treatment centres.

# Goal 6

**Individual prevention counselling is carried out by trained specialists and systematically reaches people who have questions about prevention or wish to be tested, and people with HIV/AIDS. It encourages them to adopt preventive behaviour and explains that the HIV test does not prevent infection. After counselling, the clients are empowered to take appropriate action to protect themselves and their partner(s) against infection.**

## **Individual prevention counselling**

### **Background**

As the third level of prevention (cf. Chapter 3.1), individual counselling is in itself uncontroversial, but it is also the least developed of the levels. The preventive potential of individual counselling, for instance before and after an HIV test or in people with HIV/AIDS, is not systematically exploited in all settings or situations. Targeted counselling on prevention by specialists is a demanding task and the requisite skills are often lacking. In addition, the specialists have to be able to clarify the need for, or conduct, post-exposure prophylaxis (PEP) following a risk situation or be able to refer their patients to an appropriate service.



Several hundred thousand HIV tests are performed outside the blood donation sector in Switzerland each year. To ensure that the people being tested are able to adapt their behaviour to their situation, they need individual counselling in accordance with the rules of VCT (voluntary counselling and testing) before and after the HIV test, with due regard for data protection (see Chapter 3.5). For this reason "home tests" are not permitted. People with HIV/AIDS should receive prevention-oriented counselling tailored to their specific situation.

There are indications that migrants from countries with a high prevalence of HIV are more likely to have no knowledge of their HIV status than Swiss subjects. It is therefore important that the provision of HIV counselling and testing for this target group should accord with its specific needs and that the group should be made aware of it.

It should also be ensured that asylum seekers from countries with a high prevalence of HIV are systematically offered counselling while their applications are being processed.

To ensure that the prevention opportunities offered by individual counselling and the HIV test can be exploited, the further development of this third level of prevention has to be a priority task of the present programme. The SFOPH must perform the necessary groundwork and cooperate with the professional health-care system and the branches of the Swiss AIDS Federation to ensure that a concept for individual prevention work is drawn up and put into practice.

## Tasks and responsibilities

### SFOPH

The SFOPH cooperates with the professional health-care system and the members of the Swiss AIDS Federation to develop an appropriate concept and coordinates and promotes its implementation.

In cooperation with the EKAF and FLD, the SFOPH regularly reviews the recommendations on VCT and PEP and adapts them to new developments.

### Milestone 1:

**By the end of 2005, the discussion with all the players concerned will have determined to which extent innovative risk-management approaches to prevention such as "negotiated safety"<sup>1</sup> have been incorporated into prevention work.**

### SFOPH, OPET, imes, EKA

They develop a concept for counselling migrants, especially those from countries with a high prevalence of HIV, and initiate its implementation.

### Cantons

They fund a suitable counselling infrastructure in their respective territory.

### Private and public-sector HIV counselling and test centres

They provide pre- and post-test counselling for persons wishing to take the HIV test, in accordance with VCT and PEP recommendations.

### Physicians

They provide pre- and post-test counselling for persons wishing to take the HIV test, in accordance with VCT and PEP recommendations, and give appropriate counselling to people with HIV/AIDS on prevention.

### Professional medical bodies

They encourage and monitor adherence to VCT and PEP recommendations among physicians.

<sup>1</sup> Negotiated risk of HIV infection from unprotected sex (see Chapter 5.2).

# Goal 7

All people with HIV/AIDS in Switzerland and those close to them have access to a range of professional services tailored to actual needs in the fields of medical and psychosocial counselling and care, treatment and nursing care. People with HIV/AIDS play an active role in shaping such services and use them in accordance with their specific needs.

Core field: "Treatment and counselling"

## Counselling and social care, treatment and nursing care

### Background

Regardless of residence or health insurance status and domicile, all people living in Switzerland with HIV/AIDS must have appropriate access to medical and non-medical services in the field of HIV/AIDS. Medical and care services for HIV/AIDS-related medical problems include counselling, social care, treatment, diagnostics that support treatment decisions, and nursing care.

Psychosocial services include counselling and social care, with due regard for the client's social environment, plus low entry-threshold access to current psychosocial, legal and medical information, and services promoting empowerment. Relatives and close friends who nurse and care for AIDS patients are also entitled to counselling and support.

"Professional" means that the services satisfy current professional standards and guidelines in the areas of counselling and social care, treatment and nursing care. This presup-



poses suitable basic and further training and continuing education of medical, nursing and psychosocial professionals and appropriate quality assurance measures. These requirements apply as much to facilities specializing in HIV/AIDS as to the institutions normally responsible for counselling, care and further referral of people with HIV/AIDS (e.g. family doctors, home-care ["Spitex"] organizations, social services, addiction counselling centres). Cooperation and networking among these organizations has to be assured. "Tailored to actual needs" means that the range of services must be transparent and readily accessible. Counselling and social care, treatment and nursing care must be geared to the needs of the individual, taking into account language skills, cultural origin, residence status, religious affiliation and gender. There is a need for action to improve access to such services, particularly in the field of trafficking in people, particularly women, as well as for migrants, particularly those with uncertain residence status. The beneficiaries must have access to good information and advice empowering them to make their own decisions independently. As a matter of principle, people with HIV/AIDS must have the possibility to take part in the development of the services to further their success. Their participation is encouraged and promoted.

## Tasks and responsibilities

### SFOPH, EKAF

In cooperation with the FKT and FLD special commissions, the SFOPH and the EKAF promote the formulation and dissemination of professional standards of counselling and social care, treatment, diagnostics that support treatment decisions, and care of people with HIV/AIDS.

They take action to improve access to counselling and social care, treatment and nursing care for people with HIV/AIDS, particularly those with uncertain residence status and other socially disadvantaged groups.

### SFOPH

The SFOPH conducts periodical surveys of the needs of people with HIV/AIDS and their families and of access to counselling and social care, treatment and nursing care, broken down by target group and region of Switzerland (cf. Goal 9).

### Cantons

They ensure the operational implementation of the goal by public institutions and through the funding of NGOs.

### Physicians, HIV treatment centres

They maintain professional standards of counselling and social care, treatment, diagnostics that support treatment decisions, and care of people with HIV/AIDS.

### Professional medical bodies

They promote adherence to professional standards among their members and network primary care physicians, HIV treatment centres and psychosocial services.

### Regional and local counselling centres

They inform, advise and assist people with HIV/AIDS, their families and also specialists who look after and assist people with HIV/AIDS.

They regularly review the services provided with regard to transparency, accessibility for different target groups and adaptation to needs.

They ensure coordination between providers of similar services at the national level.

### Umbrella organizations

They ensure coordination between providers of similar services at the national level.

For the benefit of people affected and for professionals as well, they compile an overview of the counselling and social care, treatment and nursing care services provided for people with HIV/AIDS in Switzerland.

They coordinate and support counselling centres in the development of quality assurance measures.

They promote participation and empowerment of people with HIV/AIDS in a targeted fashion.

# Goal 8

People with HIV/AIDS have the same rights and the same responsibility as non-infected individuals in all aspects of life and feel accepted as an integral part of society.

## Equality

### Background

A society in which discrimination is minimized generally fosters a culture of mutual respect and solidarity. Though people with HIV/AIDS are not discriminated on a systematic basis, they repeatedly experience discrimination in their everyday lives, primarily in relation to their occupation and the insurance business (life insurance, insurance of salary payment during illness-related absences, loss of earnings, company pension fund, etc.).



## Tasks and responsibilities

### SFOPH, EKAF

The SFOPH and the EKAF commission regular assessments of the extent to which equality has been achieved for people with HIV/AIDS. In cooperation with other federal agencies, they contact any bodies that infringe the principle of equality and recommend that they take appropriate corrective action.

### SFOPH

The SFOPH exercises quality assurance by requiring mandated organizations in the HIV/AIDS field to ensure that their products and services promote equality for people with HIV/AIDS.

At regular intervals (at least once a year) the SFOPH informs the key players in the HIV/AIDS field of the extent to which equality has been achieved, the need for action and the measures taken.

The SFOPH sensitizes the public to the need to avoid discrimination of people with HIV/AIDS.

### Milestone 1:

**On the basis of situation reviews already conducted<sup>2</sup> the SFOPH and the EKAF will submit, no later than by the end of 2004, proposals for appropriate action to any bodies that infringe the principle of equality.**

### Milestone 2:

**At the end of 2006 the SFOPH and the EKAF will have the situation reviewed in the bodies concerned.**

### Milestone 3:

**At the end of 2007 the SFOPH will be in possession of a new review of the situation regarding equality for people with HIV/AIDS.**

According HIV/AIDS an equal footing with other chronic diseases in the relevant legislation and in the application of the relevant laws should be examined, though without neglecting the particular characteristics of HIV/AIDS. Cooperation with the advocacy groups representing other chronic diseases should be sought. Primary prevention should also be designed so as to ensure that people with HIV/AIDS do not suffer discrimination.

At the operational level, efforts should be focused as much as possible on the resources of people living with or affected by HIV/AIDS so that they are encouraged to assert their rights and needs.

The goal of equality is based particularly on Goal 2, "Ensuring equity in health" of WHO Europe's "Health 21". If this goal is to be achieved, the public, employers, insurers, etc., will have to be sensitized to the issue. Adherence to the principle of equality must be established and regularly monitored.

### AHS

The AHS serves as a notification centre for cases of discrimination for all organizations that counsel people with HIV/AIDS. It passes on this information to the EKAF and keeps the SFOPH informed on a regular basis (at least once a year).

It is available to assist, where necessary, the above-mentioned bodies in developing and implementing suitable measures to prevent discrimination.

The AHS cooperates with players and those affected to combat discrimination of people with HIV/AIDS.

It participates in campaigns to raise awareness among the general public.

### Other NGOs

Counselling centres for people with HIV/AIDS assist their clients in asserting their rights and notify the AHS about cases of discrimination. They participate in campaigns to raise awareness among the general public.

### All players

They conduct, on their own initiative, checks to ensure that their products (projects, services, measures, etc.) promote, or do not threaten, equality for people with HIV/AIDS.

<sup>1</sup> WHO Europa (1998) Health 21: An introduction to the health for all policy framework for the WHO European Region.

<sup>2</sup> Aids-Hilfe Schweiz (2001) Wo kranke und behinderte Menschen überall benachteiligt werden; Dubois-Arber et al. (1998) Identification des discriminations institutionnelles à l'encontre des personnes vivant avec le VIH en Suisse; Pärli et al. (2003) Aids, Recht und Geld. Eine Untersuchung der rechtlichen und wirtschaftlichen Probleme von Menschen mit HIV/Aids



# Goal 9

**Reporting, monitoring and evaluation in the HIV/AIDS field are coordinated and mutually complementary. In conjunction with research, they form the basis for effective, evidence-based AIDS work. Due account is taken of data protection requirements.**

## **Reporting, monitoring, evaluation**

### **Background**

An exact knowledge of the scale of the HIV epidemic and an understanding of the behaviour of the population as a whole and of the various target groups provide an important basis for planning prevention measures. The system set up for reporting HIV infections, AIDS cases, and sexually transmitted infections (STIs) delivers important information for planning further action. Trends in the incidence of STIs can indicate changes in sexual risk behaviour that are also of relevance to the transmission of HIV.

## Tasks and responsibilities

### SFOPH

The SFOPH ensures that the data systematically gathered through the intermediary of the internal services (reporting, monitoring, controlling and programme management) are regularly analysed and incorporated into evaluation activities. The SFOPH draws up and commissions an external evaluation of the programme. The aim of this evaluation is to assess the programme's intentional and unintentional effects and its relevance and cost effectiveness and to formulate recommendations appropriate to the needs of the organizations being addressed.

The SFOPH gathers, analyses and communicates relevant data on HIV/AIDS (positive HIV tests, cases of AIDS, AIDS-related deaths) and on STIs and hepatitis in accordance with the Ordinance on Notification.

### Milestone 1:

**The obligation to report cases of syphilis will have been introduced by the end of 2005.**

### Milestone 2:

**Notifications of positive HIV tests by doctors will be systematically followed up in 2004 and 2005, linked to the sequential data from the FLD's evaluation register and evaluated for the purpose of acquiring more information on the time, place and mode of infection.**

"Monitoring" refers to the routine gathering of data that goes beyond the requirements of the reporting system. The focus here is on HIV-relevant data: for instance, the attitudes and sexual behaviour of the population as a whole and of specific groups, sales of condoms, the extent to which services are used, the needs of people with HIV/AIDS, the attention paid to advertising media, etc. Molecular epidemiology methods can be used as a special monitoring instrument for identifying, for instance, current hotspots of the epidemic and for tracing the origin of the viruses and spread of resistant strains (resistant viruses in primary infections).

Evaluation studies serve as a means of assessing programmes, projects and other measures for their relevance, efficacy and cost effectiveness. The coordinated interaction of reporting, monitoring and evaluation – always also coordinated with HIV/AIDS research (cf. Goal 10) – delivers the information and knowledge necessary for the best possible deployment of resources.

### FLD/SNCR

On behalf of the Federal Social Insurance Office (FSIO), the FLD (coordinated by the Swiss National Centre for Retroviruses/SNCR) maintains a central register of HIV-1 resistance tests in which the HIV subtype and virus sequences are also archived.

### FMH

The Swiss Medical Association (FMH) seeks to optimize reporting of positive HIV test results by doctors.

### NGOs

They make suggestions and offer support with regard to reporting, monitoring and evaluation.

# Goal 10

**Integrated HIV/AIDS research focuses on both health and disease. It is tailored to the needs, of high quality, and coordinated and networked with reporting, monitoring, evaluation and practice.**

Support-level goal

## Research

### **Background**

Research findings, together with data from reporting, monitoring and evaluation and supplemented by insights from practice, deliver the basis for effective and efficient all-round AIDS work. The promotion of HIV/AIDS research in the three areas of basic research, clinical and therapeutic research and research oriented to the social sciences and public health has proved its value as an innovative, inter-disciplinary approach. Networking and coordination of the three areas of research allows a global approach to HIV/AIDS, the exploitation of synergies and the promotion of relevant high-quality research.

## Tasks and responsibilities

### SNSF

The Swiss National Science Foundation promotes HIV/AIDS research in accordance with the service-level agreement for the 2004–2007 period concluded between the Confederation and the SNSF.

### OFES/GWF

The Swiss Federal Office for Education and Science (OFES) and the Swiss Science Agency (GWF) draw up the 2004-2007 service-level agreement with the SNSF and audit the specific targets required of the SNSF in the field of HIV/AIDS research.

### SFOPH

The SFOPH coordinates research, monitoring, evaluation and practice and clarifies the main focuses of research.

### Milestone 1:

**By the end of 2005 a structure will be in place which beneficially links up research, monitoring, evaluation and practice, and the respective players.**

The SFOPH investigates ways in which departmental service research<sup>2</sup> in the HIV/AIDS field could be financed and conducted.

### SHCS

The SHCS engages in integrated HIV/AIDS research that focuses on both health and disease, including an emphasis on questions relating to epidemiology, public health and genetic predisposition to infection and disease progression.

### IGE

The Federal Institute for Intellectual Property (IGE) acts at the national and international level in questions relating to the protection of intellectual property in order to ensure conditions conducive to HIV/AIDS research and development.

Through the establishment of a large cohort of HIV/AIDS patients, the Swiss HIV Cohort Study (SHCS) has enabled the creation of a representative pool of data that is accessible to all interested researchers. As an interdisciplinary, cooperative network, the SHCS encompasses aspects of disease- and patient-oriented research.

Based on the multi-year plan of the Swiss National Science Foundation (SNSF)<sup>1</sup> and on the Federal Council's "Message relating to the promotion of education, research and technology in the 2004–2007 period", integrated HIV/AIDS research that focuses on both health and disease will be continued in accordance with the service-level agreement concluded between the Confederation and the SNSF. Coordination of research, evaluation and monitoring while taking due account of the needs of professionals promotes the quality and application of the results.

<sup>1</sup> Schweizerischer Nationalfonds SNF (2002) Mehrjahresprogramm 2004–2007.

<sup>2</sup> Departmental service research comprises all research activities which the State requires for the performance of its tasks and which it normally conducts or finances itself. Such research aims to provide the individual federal agencies (Ressorts) with a basis for decision-making that will enable them to properly fulfil their special tasks." (Translation). Bundesamt für Gesundheit (2002) Forschungskonzept Gesundheit 2004 - 2007, p.5.

# Goal 11

**Knowledge, experience and results in the HIV/AIDS field are managed systematically. Important findings from HIV/AIDS work (research, reporting, monitoring, evaluation and practice) are communicated on a regular basis. They are made available to the players in the HIV/AIDS field and are used by them.**

## **Knowledge management**

### **Background**

A great deal of knowledge and experience has now been accumulated on the subject of HIV/AIDS. To preserve this and make it available to as wide a range of specialists as possible, information flows and channels have to be coordinated and networked. This requires a knowledge management system that processes and updates the available knowledge as required and makes it

## Tasks and responsibilities

### SFOPH

The SFOPH, together with suitable partners, develops and runs a national knowledge management system.

#### Milestone 1:

**By the end of 2004, a review of previous approaches to knowledge management in the HIV/AIDS field will have been completed and a concept for a national knowledge management system (including an Internet platform and decentralized information events organized by the SFOPH) will be in place.**

#### Milestone 2:

**The concept will be implemented from 2005 on.**

### AHS

The AHS maintains an information network specializing in HIV/AIDS and ensures the exchange of knowledge and experience with other fields.

### All players

They make their information and specific knowledge available and take an active part in exchanges.

accessible to interested parties. The system must also be capable of ensuring regular exchanges among the players and encouraging active communication. Incentives must be created to make such exchanges between institutions and organizations more systematic and to improve accessibility both for players in the AIDS field and for people living with or affected by HIV/AIDS as well as for the broader public. Particular attention must be given to secure the experience gained in HIV/AIDS work and the insights acquired during the development of HIV and AIDS and to ensure their usability. The SFOPH, in conjunction with its most important partners, will be concerned with a system for effective knowledge management and for documentation in the AIDS field.

# Goal 12

**Solutions are in place for providing appropriate and systematic basic and further professional training and continuing education for occupations that are concerned with HIV and AIDS.**

## **Basic and further professional training and continuing education**

### **Background**

A large number of occupations are involved professionally in aspects of HIV and AIDS, though to a varying extent. Besides social workers and medical staff (including, for instance, pharmacists), they comprise teachers, psychologists, police personnel, lawyers, and other professionals. If effective prevention, high-quality support and treatment of people with HIV/AIDS are to be achieved or

maintained, these professional groups need to possess the necessary knowledge and specific skills. Under EpG, Art. 4, it is the responsibility of the SFOPH to ensure that the required professional training is in place. The SFOPH's goal is to define a basic level of knowledge and skills that are recognized by the corresponding professional associations and form part of their respective diploma programmes. This ensures that a uniform approach is achieved in Switzerland which also takes multidisciplinary into account. The SFOPH issued recommendations for training on HIV/AIDS issues<sup>1</sup> in 1998 and provided financial support for basic and further training over a period of several years. The SFOPH's policy on basic and further training in the HIV/AIDS field was evaluated in 2001<sup>2</sup>. As preparation for Goal 12, in 2003 the SFOPH commissioned a review of the situation and proposals for appropriate measures. The findings will be used as a basis for identifying suitable players, tasks and milestones.

## Tasks and responsibilities

### SFOPH, OPET

The SFOPH, in conjunction with the OPET<sup>3</sup>, the professional bodies and specialist organizations of the occupations concerned and experts on HIV/AIDS, defines the standards of training to be observed in the areas of HIV/AIDS prevention, support and treatment.

### Milestone 1:

**On the basis of the situation review and proposed measures (see "Background"), the SFOPH will, by the end of 2004 and with the participation of the bodies responsible for basic and further professional training, have put together the structures required for achieving the goal in place<sup>4</sup>.**

### SFOPH

The SFOPH ensures that new content from knowledge management is fed into basic and further professional training and continuing education.

### Professional bodies and specialist organizations of the occupations concerned

They promote incorporation of the training standards in basic and further professional training and continuing education.

### Educational institutions

They implement the above-mentioned standards in basic and further professional training and continuing education.

### AHS

The AHS covers basic and further training needs of professionals active in the fields of HIV/AIDS prevention and counselling, and thereby underpins the basic activities of regional and municipal AHS branches and other organizations operating in the HIV/AIDS field. The further training programmes of the AHS deliver current knowledge and help ensure the best possible exploitation of synergies.

<sup>1</sup> Bundesamt für Gesundheit (1998) Ausbildungsempfehlungen zum Thema HIV und Aids für 14 verschiedene Berufe.

<sup>2</sup> Interface Institut für Politikstudien (2001) Evaluation der Aus- und Weiterbildungspolitik des BAG im Bereich HIV/Aids.

<sup>3</sup> As from 2004 or 2005, the OPET will be responsible for defining the contents of training for non-medical health-care occupations. Until then, this will be carried out by the SDK and SHRK at the cantonal level.

<sup>4</sup> OPET, cantonal departments of vocational training, SIBP, WBZ, etc.



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# Abbreviations

<b>AHS</b>	Aids-Hilfe Schweiz
<b>Aids</b>	Erworbenes Immunschwächesyndrom (Acquired Immune Deficiency Syndrome)
<b>AMBV</b>	Arzneimittel Bewilligungsverordnung
<b>BAG</b>	Bundesamt für Gesundheit
<b>BBT</b>	Bundesamt für Berufsbildung und Technologie
<b>BBW/GWF</b>	Bundesamt für Bildung und Wissenschaft/Gruppe für Wissenschaft und Forschung
<b>BFF</b>	Bundesamt für Flüchtlinge
<b>BRB</b>	Bundesratsbeschluss
<b>BSV</b>	Bundesamt für Sozialversicherung
<b>DEZA</b>	Direktion für Entwicklung und Zusammenarbeit
<b>EDI</b>	Eidgenössisches Departement des Innern
<b>EDK</b>	Schweizerische Konferenz der kantonalen Erziehungsdirektoren
<b>EKAF</b>	Eidgenössische Kommission für Aids-Fragen
<b>EpG</b>	Eidgenössisches Epidemienengesetz
<b>EuroHIV</b>	Europäisches Programm für die epidemiologische Überwachung von Aids
<b>FKT</b>	Fachkommission Klinik und Therapie HIV/Aids
<b>FLD</b>	Fachkommission Labor und Diagnostik HIV/Aids
<b>FMH</b>	Verbindung der Schweizer Ärztinnen und Ärzte
<b>GFATM</b>	Globaler Fonds zur Bekämpfung von Aids, Tuberkulose und Malaria (Global Fund to Fight AIDS, Tuberculosis and Malaria)
<b>GRID</b>	mit Homosexualität assoziierte Immunschwäche (Gay Related Immunodeficiency)
<b>HAART</b>	Hochaktive antiretrovirale Therapien (Highly Active Anti-Retroviral Therapy)
<b>HIV</b>	Immunschwächevirus beim Menschen (Human Immunodeficiency Virus)
<b>IGE</b>	Eidgenössisches Institut für Geistiges Eigentum
<b>imes</b>	Bundesamt für Zuwanderung, Integration und Auswanderung
<b>KKAF</b>	Kommission zur Kontrolle der Aids-Forschung
<b>MaPaSu</b>	Massnahmenpaket Sucht
<b>NGO</b>	Nicht-Regierungsorganisation (Non-Governmental Organisation)
<b>NHAP</b>	Nationales HIV/Aids-Programm
<b>NPO</b>	Non-Profit Organisation
<b>NZR</b>	Nationales Zentrum für Retroviren

<b>PEP</b>	Post-Expositions-Prophylaxe
<b>PLANeS</b>	Schweizerische Stiftung für sexuelle und reproduktive Gesundheit (Fondation Suisse pour la santé sexuelle et reproductive)
<b>SDK-CDS</b>	Schweizerische Sanitätsdirektorenkonferenz
<b>SHCS</b>	Schweizerische HIV-Kohortenstudie (Swiss HIV Cohort Study)
<b>SHRK</b>	Schweizerische Hochschulrektorenkonferenz
<b>SIBP</b>	Schweizerisches Institut für Berufspädagogik
<b>SNF</b>	Schweizerischer Nationalfonds
<b>SR</b>	Ständerat
<b>STIs</b>	Sexuell übertragbare Infektionen (Sexually Transmitted Infections)
<b>UEPP/IUMSP</b>	Unité d'évaluation de programmes de prévention/Institut universitaire de médecine sociale et préventive, Lausanne
<b>UNAIDS</b>	HIV/Aids-Programm der Vereinten Nationen (The Joint United Nations Programme on HIV/AIDS)
<b>UNFPA</b>	Bevölkerungsfonds der Vereinten Nationen (United Nations Population Fund)
<b>UNGASS</b>	Sondersession der Vereinten Nationen zu HIV/Aids 2001 (United Nations General Assembly Special Session on HIV/AIDS)
<b>VCT</b>	Beratung und Test auf freiwilliger Basis (Voluntary Counseling and Testing)
<b>VPM</b>	Verein zur Förderung der Psychologischen Menschenkenntnis
<b>WBZ</b>	Weiterbildungszentrale Luzern
<b>WHO</b>	Weltgesundheitsorganisation (World Health Organisation)
<b>WTO</b>	Welthandelsorganisation (World Trade Organisation)

# Consultation partn

**The following stakeholders were consulted in the process of drawing up the present programme:**

**Swiss Confederation (including para-state agencies)**

AIDS special commission of the Swiss National Science Foundation  
Directorate of Political Affairs  
Federal Chancellery  
Federal Institute for Intellectual Property  
Federal Office for Education and Science/Swiss Science Agency  
Federal Office for Professional Education and Technology  
Federal Office for Refugees  
Federal Office for the Equality of Women and Men  
Federal Office of Immigration, Integration and Emigration  
Federal Office of Justice  
Federal Office of Police  
Federal Office of Private Insurance  
Federal Social Insurance Office  
General Secretariat, Federal Department of Defence, Civil Protection and Sports (DDPS)  
General Secretariat, Federal Department of Economic Affairs (DEA)  
General Secretariat, Federal Department of Foreign Affairs (DFA)  
General Secretariat, Federal Department of Home Affairs (DHA)  
General Secretariat, Federal Department of Justice and Police (DJP)  
Special commission on "HIV/AIDS Clinical and Treatment"  
Special commission on "HIV/AIDS Laboratory and Diagnostics"  
State Secretariat for Economic Affairs  
Swiss Agency for Development and Cooperation  
Swiss Health Observatory  
Swiss National AIDS Commission  
Swiss National Health Policy Project  
Swissmedic

**Cantons**

Cantonal economic affairs departments  
Cantonal education departments  
Cantonal health departments  
Cantonal health officers  
Cantonal health promotion officers  
Cantonal integration officers  
Cantonal pharmacists  
Cantonal social affairs departments  
Universities of applied sciences specializing in social work  
University and cantonal hospitals/HIV clinics

**Intercantonal organizations**

Association of cantonal health promotion officers (VBGF)  
Commissione di Formazione HIV/aids della Svizzera Italiana (HIV/AIDS training commission of the Italian-speaking region of Switzerland)  
Conference of cantonal education directors  
Conference of cantonal justice and police directors  
Conference of cantonal social affairs directors  
Conference of health directors

**Non-governmental organizations/  
non-profit organizations**

Addiction counselling centres  
AHS member organizations  
AIDS & Child  
AIDS chaplaincies  
Aids Info Docu Schweiz  
Association for the Condom Quality Seal  
Association romande et tessinoise animatrices et animateurs en éducation sexuelle (association of sex education specialists in French and Italian-speaking regions of Switzerland)  
Berne Declaration  
Caritas Switzerland  
Coordination Suisse des Ministères Sida et Aidsparfarr-ämter (Swiss AIDS chaplaincies coordination)  
Counselling centres for migrants  
Dialogai  
FASD/BRR (Office for harm reduction/coordination in the substance-dependence and AIDS fields)  
Fantasy Projects  
Groupement romand d'Etudes sur l'Alcoolisme et les Toxicomanies (study group for alcoholism and drug abuse in the French-speaking part of Switzerland)  
IG Sauna  
Institutes specializing in sex education  
International Association for Maternal and Neonatal Health  
Maria Magdalena  
Médecins sans frontières  
Medicus Mundi Switzerland  
Pink Cross

# ers

ProCoRe (Prostitution Collective Reflection)  
Radix Health Promotion Foundation  
Swiss AIDS Federation  
Swiss Association of Family Planning Counsellors  
Swiss Association of Pharmacists  
Swiss Centre for International Health  
Swiss Foundation for Health Promotion  
Swiss Foundation for Sexual and Reproductive Health  
Swiss Institute for the Prevention of Alcohol and Drug Problems  
Swiss Medical Association (FMH)  
Swiss Nurses' Association  
Swiss Red Cross  
Swiss Red Cross blood donation service  
Swiss Society of Public Health SGPG/SSSP  
Swiss Tropical Institute  
VSD (association of professionals in the drug-dependence field)  
VSSB (association of counsellors in pregnancy and sexual matters)  
Xenia (counselling centre for sex workers)  
Youth and family counselling services

## **For-profit organizations**

cR DDB  
Interpharma  
Manufacturers of HAART

## **Organizations of people with or affected by HIV/AIDS**

actHIV Aids-Beratung und Betroffenenorganisation  
Aktion Positiv Schweiz  
Fédération suisse des personnes vivantes avec le VIH/Sida

## **Research organizations**

Addiction Research Institute, University of Zurich  
Fondation Charlotte Olivier  
Institute of Political and International Studies, University of Lausanne  
Institute of Political Science, University of Zurich  
Institutes of Social and Preventive Medicine in Basel, Berne, Geneva Lausanne and Zurich  
Psychological Institute, University of Zurich  
Research units of university hospital infectious disease departments  
Swiss HIV Cohort Study  
Swiss National Centre for Retroviruses  
Swiss National Science Foundation  
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