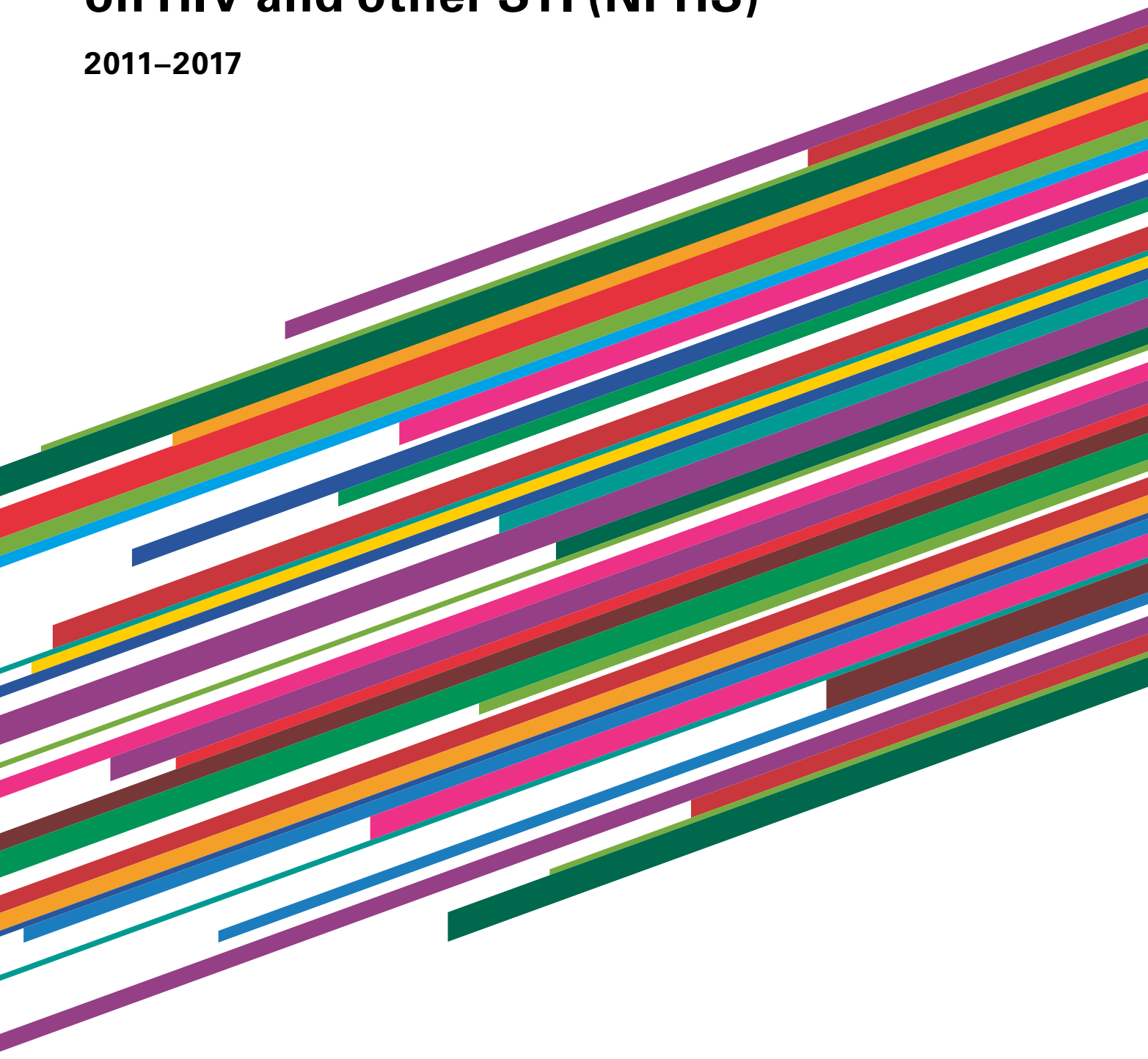
National Programme

on HIV and other STI (NPHS)

2011–2017



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1 SUMMARY

The Swiss National Programme on HIV and Other Sexually Transmitted Infections 2011–2017 (known as NPHS for short) sets out to improve the sexual health of the Swiss population. Its legal basis is the Swiss Epidemics Act, and the programme is pitched at efforts against disease. The NPHS is a national strategy for the prevention and also the diagnosis and treatment of HIV and other STI (sexually transmitted infections), including chlamydia, syphilis, gonorrhoea, hepatitis, human papilloma virus, lymphogranuloma venerum and herpes.

The programme is rooted in scientific evidence and is based essentially on the findings of four external studies[1] by internationally renowned specialists. It was drawn up in a participatory process with the key stakeholders. The programme lays down the substantive guidelines for HIV and STI work in Switzerland for the next seven years and thus represents the common core for all the organisations active in the field of HIV and STI.

There are four main reasons for developing a new programme in the field of HIV and STI:

1. HIV is a severe, complex, chronic disease, whose eradication appears unlikely as things stand at present. HIV and AIDS can be treated, but not cured. No medicine has yet been developed that would be able to cure those affected, and there is no hope that an effective vaccine could come into use within a matter of years.
2. Some 600–800 new sufferers have become infected with HIV each year in Switzerland over the past ten years. At present, these individuals need medical treatment – and will continue to do so for the rest of their lives. The treatment of one infected person costs up to a million Swiss francs (lifetime costs of the treatment: 25,000 Swiss francs per year for a mean life expectancy of forty years). Untreated, HIV results in death.
3. Untreated STI can have severe consequences: chronic diseases, infertility, cancer and pregnancy complications, as well as serious deformities and problems in new-born babies. In Europe, infections with Chlamydia trachomatis are the principal cause of the inability to have children despite wanting them.
4. HIV and STI continue to have epidemic potential (precisely on account of the globalisation of travel) and might constitute a threat to public health in Switzerland.

This is the starting situation from which the *NPHS vision* has been derived:

The conditions in Switzerland are such that people can fully live undisturbed, low-risk sexuality in a self-determined manner and with mutual respect. The National HIV and other STI Programme 2011–2017 makes a decisive contribution to this by empowering inhabitants to exercise their sexual rights and maintain or improve their sexual health.

The programme has *four* main goals:

1. People living in Switzerland are empowered, through suitable means of sensitisation and education, to insist on their rights in the realm of sexuality (these rights being derived from human rights in general).
2. Effective and innovative measures of behavioural and contextual prevention reduce the transmission risk of HIV and other STI that are relevant for public health.
3. Infected individuals are diagnosed early, treated correctly and in good time and given comprehensive accompaniment to enable them to continue with as high a quality of life as possible. Early diagnosis and correct treatment reduce the consequential harm and longer-term health impairment.
4. HIV and STI work has a lasting effect, because it is accepted by the population, is focused on participation of the target groups and is based on scientific evidence while, at the same time, allowing scope for innovations. What it has to offer is attuned to the needs of the target groups, and these are coordinated amongst one another.

Model of three axes of intervention:

In order to structure HIV and STI work, the NPHS channels all the interventions into three axes. Each intervention axis addresses particular population groups. The subdivision into axes is in accordance with criteria of prevalence and vulnerability (risk):

- **Intervention axis 1:** everyone living in Switzerland.
  The objective is to maintain the protective behaviour of the population at large at a high level. Everyone living in Switzerland must be aware that HIV and STI still constitute a problem and that all ought to adopt protective measures when necessary.
- **Intervention axis 2:** Sexually active individuals with a heightened exposure risk for HIV and/or STI (men who have sex with men, migrants from high-prevalence countries, injecting drug users and prison inmates) as well as their partners.
  The objective is to slow decrease further spread of HIV and STI as far as possible. Individuals belonging to a group with a high STI and/or HIV prevalence or those who are in sexual contact with individuals from those groups ought to be kept HIV-negative and free from other STI despite the heightened risk for infection.

[1] Kessler et al. (2009) National HIV/Aids Programme: 2009 Web-based Survey of Stakeholders, Basel, June 2009
Rosenbrock et al. (2009) Review of the Swiss HIV Policy by a Panel of International Experts
Kessler (2009) International Context Analysis of HIV and STI Strategies and Programmes: The European and International Reference
Jeannin et al. (2010) Monitoring the Swiss Prevention Strategy against HIV/AIDS. Summary Report for 2004–2008

- **Intervention axis 3:** Individuals with HIV and/or an STI as well as their (non-infected) partners.
  The objective is to eliminate the infectiousness as quickly as possible, to reduce it to the lowest possible level, to avoid infections within partnerships and also to prevent HIV-positive individuals or those affected with STI from becoming infected with further STI.

The next step is to take the main goals stated above and to break them down into the individual intervention axes, which results in the aims for each of the axes.

Innovation

One the one hand, the new strategy is further developing proven work in the field of HIV/AIDS and, on the other hand, it includes a number of important *innovations:*

1. **Inclusion of the other Sexually Transmitted Infections (STI) in the programme:** various different reasons provide strong arguments for this extension:
   - Epidemiology: the number of diagnoses of syphilis, gonorrhoea and chlamydia infections has been increasing since 2000.
   - STI are a driving force behind the HIV epidemic: STI increase the infectiousness of HIV carriers and susceptibility for HIV, and the interaction between HIV and other STI may make the particular treatments more difficult.
   - Creating synergies: prevention messages concerning HIV are in part the same as or similar to those concerning STI. For the work of preventing other STI, it is possible to make use of the structures that already exist for HIV work.
   - The inclusion of STI is in line with the international trend. Several countries (such as the United Kingdom) have combined strategies.

2. **Information about rights in relation to sexuality:** The rights that people have in relation to sexuality are derived from human rights in general and include the freedom, equality, privacy, self-determination, integrity and dignity of all human beings. In Switzerland, these rights are guaranteed, but not everyone succeeds in making them reality. By providing the corresponding information, the programme empowers those living in Switzerland to experience their sexuality in a self-determined manner and to look after their sexual health by calling on prevention and care available if and when the need arises.

3. **Prevention in particularly affected population groups:** The NPHS is focusing prevention on the target groups in question to a greater extent than was previously the case. Measures of situational and behavioural prevention are envisaged, and these will include the contexts in which the target groups are found as well as specific test concepts.

4. **Normalisation of voluntary partner information:** For every diagnosis, the infected person is encouraged to support the provision of information to his or her sexual partner(s) (anonymously, if necessary). Partner(s) will then be tested and, if appropriate, treated quickly in order to avoid recurrent and repeated infections.

5. **Diagnosis and treatment as important elements in prevention:** The faster an STI or HIV can be treated, the lower the risk of spreading the infection further. Infected persons are thus encouraged to seek treatment in time, and incentives motivate them to adhere to it. In the case of individuals infected with an STI, treatment providers are generally to verify their success once treatment has been completed.

6. **Comprehensive treatment of HIV patients:** Given the significance of adherence for both public health and for patients, those diagnosed as HIV-positive must be given comprehensive treatment and provided with support where this may be necessary (in legal, social and other ways). A pilot project for this disease-management model in the field of HIV and STI is to be launched which may lead to further improvements in the quality of the treatment.

7. **Third-generation surveillance furnishes necessary evidence:** Decisions on resource allocation have been rendered more difficult since the various preventive measures are not comparable with one another in terms of effectiveness and costs. The NPHS envisages the development of a model for third-generation surveillance. This extends biological surveillance in the field of STI and closes gaps in behavioural surveillance. It combines the findings of HIV and STI surveillance and extends monitoring, including cost/benefit analysis, to the prevention and care measures on offer.

8. **Encouragement for innovative projects:** An innovation pool is to make it possible to grant start-up financing for promising new projects (or pilot projects) in the fields of prevention, diagnosis and treatment. This measure is intended to ensure that innovative ideas (even if they originate from small organisations) have a chance of being tried out and monitored. When successful, ideas that have been put to the test lead to new evidence.

2 THE PREVENTION OF HIV AND OTHER SEXUALLY TRANSMITTED INFECTIONS WILL CONTINUE BASED ON PROVED SUCCESSFUL ACTIVITIES AND SETS NEW PRIORITIES

Switzerland can look back over nearly three decades of experience in HIV work. It was in 1981 that the first ↘diagnosis of ↘AIDS was made in Switzerland (terms preceded by a sloping arrow (↘) are explained in the glossary in Chapter 16). Since then the Swiss Confederation and its key partners have implemented four national HIV programmes and achieved a great deal. Practically all the sexually active inhabitants of Switzerland are familiar with the danger of an HIV infection and know how to protect themselves against it. There is a fundamental guarantee of access to the professional advice on offer and to high-grade medical care. Despite this, between 600 and 800 individuals become newly infected with ↘HIV every year. Currently more than 20,000 people are living with HIV in Switzerland. Although an HIV infection no longer automatically leads to AIDS, since drugs are available for treating it (although not for curing it), 200 cases of AIDS have nonetheless been diagnosed annually in recent years, and in Switzerland too several dozen people die of AIDS each year.

In order to prevent HIV from developing into AIDS, those infected with it must take drugs for the rest of their lives. It is estimated that the total costs of anti-retroviral treatment can run up to a figure approaching a million Swiss francs in the course of a lifetime (25,000 Swiss francs per year multiplied by a mean life expectancy of 40 years). The annual expenditure on ↘anti-retroviral drugs (ART) to be borne by the compulsory health-insurance sector amounted to more than 200 million Swiss francs in 2008 according to extrapolations[2] (approximately 8000 patients costing 25,000 Swiss francs each), and these costs are going up by 10% every year. So, the cost of treating HIV amounts to nearly 1% of the annual premium volume. In other words: every new infection that we manage to avoid currently saves the compulsory health-insurance sector more than twenty thousand Swiss francs per year on drugs. Additionally, those who are saved from infection are also spared the uninterrupted treatment lasting decades that they would have to undergo, adhering to a rigid, predetermined schedule.

To date, it has remained an unfulfilled hope that medical progress would be able to eradicate the infection in the medium term (for instance, through new drugs that would bring about complete cure or through a new vaccine that would make ↘eradication of HIV appear realistic). Even if a medical breakthrough were to succeed in the near future, experience has shown that it would take several years or even decades until it would be possible to apply a remedy or measure on a large scale, thereby achieving a broad effect. That is why Switzerland needs a fifth national programme employing ↘prevention, early detection and correct treatment in order to prevent the further spread of HIV and ↘STI and to improve the quality of life of those affected by HIV and/or STI.

Integration of the other Sexually Transmitted Infections

The National Programme on HIV and other Sexually Transmitted Infections 2011–2017 is building on the experiences and achievements of previous strategies. It is further developing the tried-and-tested HIV work in the fields of prevention, diagnosis and treatment – namely: the exceedingly successful ↘*"LOVE LIFE STOP AIDS"* campaign to heighten the awareness of the population at large, the specific prevention measures for given ↘target groups, the professional counselling and testing services on offer, the high-grade medical care and the integrated ↘research into HIV and AIDS (for example in the context of the Swiss HIV Cohort Study (SHCS).

At the same time, it is undergoing a decisive innovation, in that it is to integrate the other sexually transmitted infections (STI), which is reflected in the name of the programme. This expansion of the programme makes sense for a number of reasons.

First of all, the epidemiological development provides a case for including the other STI, given that the ↘incidence of various STI has increased in recent years. One example of this is the number of reported chlamydia infections, which has tripled since 2000. The number of diagnosed cases of syphilis has also risen over this same period, where it is predominantly men who are affected by this increase. Infections with gonococci (gonorrhoea) remain at a constant high level. Syphilis and gonorrhoea are more widespread in Switzerland than the mean for Western Europe. STI often follow an asymptomatic course, which makes it more difficult to detect them. Untreated STI can lead to severe consequences later on, namely chronic diseases, cancer, infertility, pregnancy complications and harm to foetuses or infirmities in new-born babies. STI may thus cause severe individual suffering and threaten ↘public health (since many of them are relatively easily transmitted and/or widespread).

[2] The extrapolation by the Swiss Federal Office of Public Health is based on surveys amongst the health-insurance underwriters and data from the Swiss HIV Cohort Study.

Secondly, it is medical facts that are decisive for the coordinated prevention of HIV and STI. There are interactions between HIV and other STI. Most STI increase the susceptibility for an HIV infection, and, in the case of those who are HIV-positive, the simultaneous occurrence of an STI may increase the infectiousness of HIV.[3] STI are in part more difficult to detect in people affected by HIV, and treating an STI is sometimes more complicated with them. Other STI, in other words, have implications for the spread of HIV and, according to current knowledge they are a significant driving force in the HIV ↘epidemic.

This leads, thirdly, to the recognition that efforts against HIV and other STI together makes sense and creates synergies, since STI prevention can be advanced on the basis of the HIV prevention already established and essentially using its structures too. This is all the more so, since the rules of ↘safer sex formulated in the context of engaging with HIV also help overcome or mitigate the risk of infection with most of the other STI (even if they cannot entirely eliminate that risk). The prevention messages are thus in part the same or similar. There is also a need for targeted, additional prevention measures and for messages in the field of the other STI as a large section of the population (including groups at risk) so far has been only poorly informed about STI and is hardly aware of the interactions between STI and HIV.

Fourthly, Switzerland, by including the STI in the national strategy, is accepting the need expressed by many ↘stakeholders, who are already practising the combined prevention of HIV and other STI in their daily lives, and it is also joining the international trend. Several countries, such as the United Kingdom, France, Sweden, and Norway, have developed strategies for engaging with HIV and STI jointly. In some of these countries (such as the United Kingdom) these are sexual-health programmes in the true sense of the term, which set out to promote ↘sexual health.

The preceding paragraphs explain the reasons why the NPHS positions HIV and the other STI at the same strategic level and mentions them together in much of its activity. It must, however, be borne in mind that HIV is a much more severe, chronic disease than most of the other STI. The lives of those infected by HIV and the treatment of it are changed for ever, and, on account of its complexity, HIV creates completely different requirements for the healthcare providers than most other STI.

[3] Basically, the following reasons are decisive for increased sensitivity and infectiousness: Mucosal ulcers form important ports of entry and exit for HIV, large quantities of specialised immune cells present in wounds and inflammations create a receptive environment for HIV, messenger substances produced by defence cells, triggered by components of pathogens, stimulate the propagation of HIV.

Not a sexual-health programme

The NPHS is not a strategy for the holistic promotion of sexual health. It is true that the planned interventions ought to aim at improving the sexual health of the population, but the programme's primary aim is to address communicable diseases, i.e. HIV and other STI. In contrast to the British strategy, the Swiss one (still) cannot be advanced into a sexual-health programme proper, for tackling sexual abuse, for example, or in providing fertility treatments. It must also be stated that, although a number of cantons have enacted prevention laws, Switzerland as a whole still does not have a national statutory basis for prevention[4]. For that reason, Switzerland's strategy is based on the Swiss Epidemics Act[5], which merely assigns the Confederation and the cantons the task of engaging with communicable diseases and protecting people against the pathogens that cause them. What Switzerland does have is a national system of reimbursements with its Health Insurance Act (statute number 832.10).

The latest programme continues the close cooperation between the Confederation, the cantons, the local authorities and the non-governmental organisations, given that this was the decisive element for the success of earlier strategies. The current programme was therefore developed in a participatory process with the various partners[6]. The latter had several opportunities through workshops and written submissions of making known their requirements for the new programme and of discussing the proposals from the Federal Office of Public Health. The document drawn up jointly constitutes a form of roadmap for the work of all who are active in HIV and STI. The strategy and objectives are binding for Switzerland.[7] Individual responsible bodies decide on how to implement these in their specific situations and on how to use the resources available to them. The Confederation has the task of coordinating the activities.

[4] Switzerland's Prevention Act (statute number SR 818.31) was going through the parliamentary procedure at the time of publication of the programme.

[5] The Swiss Confederation's Federal Authorities (1970) Federal Act of 18 December 1970 on combating communicable diseases in humans (Epidemics Act) SR 818.101.

[6] Those not mentioned by name here are listed in Annex 15.1 (Stakeholders who have contributed to drawing up the programme).

[7] Under the terms of Article 118, Para. 2, b of the Swiss Constitution, the Confederation issues instructions on the combating of communicable, widespread or particularly dangerous diseases in humans and animals. HIV and other STI come under this category. The Confederation is thus competent to lay down guidelines for the cantons and communes on how to implement the HIV&STI programme. Under the terms of the Epidemics Act, the Confederation is also in overall control and is responsible for coordinating the cantonal measures (Art. 9 Epidemics Act). The Confederation is therefore in charge of strategy development and monitors the implementation of the strategy. Its instructions are thus binding in this respect.

Structure and duration of the programme

The programme document is intended to be used as a work of reference by both specialists and interested lay persons. Its opening section offers an overview of the most important findings in relation to HIV and STI. This provides explanations of the public health relevance of the individual STI and HIV, the characteristics of their transmission, the results of ↘biological ↘surveillance and ↘behavioural surveillance and an analysis of the most important developments and new challenges in HIV and STI work as well as the structuring of interventions. It also contains statements about the resources needed. In this way, it is the function of the first section to explain the Swiss context at the time when the NPHS was adopted. The second part then presents and explains the programme's targets (which are subdivided into the vision, the main goals and the individual aims). The programme finally contains tangible proposals for implementing the targets. These proposals at the operative level may also be subject to modifications depending on changes in the situation and make no claim to be complete. The NPHS also offers a clarification of roles, stating responsibility for tasks. This is found in the annex (15.2) to the current document and gives an overview of how the programme is to be rendered operational. Given the Confederation's only limited powers to issue instructions (in Switzerland's federal system, the powers for implementing public health measures lie predominantly with the cantons), it is thus to be understood as an interpretative document in the nature of a collection of recommendations.

The programme will run for a period of seven years. This might appear unusual, but considering that successes in the field of prevention are generally only manifest in the medium term, this duration seems appropriate. It makes it possible to align the activities for reaching the objectives to a period of five years. After that, the activities and their contribution to reaching the objectives will be subjected to a comprehensive ↘evaluation. With this schedule, sufficient time will be allotted to draw up a future programme to follow the current one. If modifications become urgent within these seven years because of new ↘evidence, these will be carried out in accordance with the processes defined in the programme itself. In developing the current programmes, the value of having sufficient time available to be able to work out well-founded objectives in cooperation with the key partners and stakeholders was recognized. It is only by such a procedure that the objectives will be supported by them in the final analysis. The key to the success of the current programmes will assemble all the forces involved behind the objective described. If the further spread of HIV and other STI will be decreased, it is necessary to have a coordinated procedure and a coordinated implementation of the strategy decided on throughout Switzerland.

We thank all the stakeholders who played a part in drawing up the programme. Without their committed and valuable work, the current programme would not be what it is. We are looking forward to implementing the programme together with them.

3 HIV AND OTHER STI: PUBLIC HEALTH RELEVANCE AND MEDICAL FINDINGS

There are more than twenty infectious diseases that can be transmitted sexually. They are mainly caused by bacteria and viruses, but there are also those that are caused by fungi or parasites, and there are big differences among them in terms of ↘symptoms, the course of the disease and the possibilities for treatment. Not all of these diseases are of the same relevance for public health, and there is an urgent need to establish priorities on account of the limited financial and personnel resources available for monitoring and engaging with the pathogens (even if there were to be no other reason for doing so).

In order to proceed to establishing priorities in public health surveillance, the Swiss Federal Office of Public Health developed a priority setting tool in 2008. It makes the criteria for decisions in the realm of public health objective, transparent, evidence-based, explicit and measurable, so that the limited resources can be optimally deployed. The tool weights the infectious diseases in accordance with various models, for instance on the basis of epidemiological criteria[8], non-epidemiological criteria[9] and the perception of the population – or on the combination of various criteria. The tool thus facilitates simple access to standardised, evidence-based information on a large number of pathogens and also permits comparisons between the pathogens. The tool's database was compiled in 2005/2006. Applying the criteria mentioned, HIV was found to rank in second place in terms of public-health relevance, and it seems unlikely that there will have been any major change since (refer to the graphic in Annex 15.3 dealing with the relative importance of the pathogens on the basis of epidemiological and non-epidemiological criteria). The data concerning the other Sexually Transmitted Infections does not result in such a clear picture (cf. chapter 4.2 on STI: Epidemiology). On the basis of the notification data available and the epidemiological criteria, the following sexually transmitted infections are regarded as relevant for public health at the time of the programme's adoption, in addition to HIV:

- gonorrhoea
- syphilis
- chlamydia
- hepatitis B
- hepatitis C
- human papilloma virus (HPV)
- herpes (HSV 1 and 2)
- lymphogranuloma venerum (LGV)

[8] Epidemiological criteria include, inter alia, the severity of the disease, its incidence, higher severity risk groups, initial occurrence or re-occurrence of a pathogen, need for immediate public health measures, spread potential, changes in incidence and public health interventions already in existence.

[9] Non-epidemiological criteria include, inter alia, the national interest of other sectors, the international interest of other sectors, the potential for bio-terrorism and the interest of the media.

Transmission of HIV and other STI

What HIV and other STI have in common is that they are transmitted during unprotected sexual intercourse. The pathogens differ from one another, however, as regards their infectiousness and other transmission routes. This chapter offers an overview of the various transmission risks of HIV and other STI. In addition, Annex 15.4 contains a table of the most important STI, explaining the detailed symptoms, complications, ↘prevalence and possible treatment methods.

HIV is most frequently transmitted during unprotected sexual intercourse, and the risk of infection is very markedly reduced by applying the rules of safer sex. According to the notification system (cf. chapter on HIV epidemiology), 646 individuals tested HIV-positive for the first time in Switzerland in 2009. Around 90% of these infections (or 578 cases) were ascribed to unprotected sexual intercourse.[10]

Not all sexual practices, however, harbour the same risk of HIV transmission. Unprotected anal intercourse is the highest-risk practice of all as regards HIV infection – for both individuals involved. Unprotected vaginal intercourse is regarded as a practice of lesser risk. Contrary to a frequent assumption, HIV-negative men with an HIV-positive female partner face only a marginally lower risk of infection than HIV-negative women with an HIV-positive male partner. In the practice of oral-genital sexual contacts it is impossible to rule out a risk if seminal fluid makes its way into the mouth or is swallowed or if menstrual blood makes its way into the mouth of the partner (male or female) during cunnilingus. Oral intercourse without ejaculation in the mouth and apart from the menstruation period is regarded as safe, provided no other STI is present. The risk of becoming infected with HIV or of infecting others with HIV in such situations is, depending on circumstances, very considerably higher if one of the individuals involved suffers from another active STI, but is still very significantly lower than with anal or vaginal penetration.

[10] cf. FOPH Bulletin No. 18, 3 May 2010, pp. 480–483. The remaining percentage is accounted for by transmissions through sharing syringes and needles when consuming drugs, vertical transmissions from mother to child and blood transfusions. The risk of transmission and/or infections also depends on the nature and duration of the exposure to HIV (with a higher risk of infection in the event of a massive exposure, such as through blood transfusion) and the quantity of viruses (individuals with a higher viral load, for example during the initial phase of infection, appear to be more infectious) as well as cofactors (such as inadequate nutrition and infection of the uro-genital tract existing at the same time); see also http://www.aidsfinder.org.

Other STI are also transmitted through contact with genital or anal mucus and are often more readily transmitted than HIV. Examples include chlamydia infections, gonorrhoea, syphilis, hepatitis B, herpes genitalis (HSV), human papilloma virus (HPV) and lymphogranuloma venerum (LGV) as well as others. STI can also be transmitted orogenitally, and in these instances it is generally enough to have mucosal contact, it not being necessary to have contact with genital secretions (seminal fluid or menstrual blood), as is usually the case with HIV. This is generally the case, for instance, with chlamydia, gonorrhoea, syphilis, hepatitis B, herpes genitalis (HSV), human papilloma virus (HPV) and lymphogranuloma venerum (LGV). All STI, including HIV, can also be transmitted (even if only rarely) as so-called contact infections through contaminated objects, such as dildos (or hands) if inserted.[11] As is the case with HIV, it is also possible for various STI to be transmitted vertically from mother to child during birth; this can happen with gonorrhoea, chlamydia, syphilis, herpes, hepatitis B, hepatitis C and HPV.

Measures providing protection against an infection through sex

Full protection against HIV and all STI is offered solely by abstinence or strict monogamy in a relation free of HIV and STI. Promoting this is not, however, a realistic public-health measure. Rather, everyone should have the possibility to take informed decisions so that they can handle the risk of an infection with HIV or any other STI responsibly and can protect themselves against the longer-term health risks of an infection.

Condoms do not provide the same quality of protection against all STI as they do against HIV, since certain pathogens can infect through intact skin, and, what is more, a condom only covers the glans and the shaft of the penis. Thus contact with skin that has suffered changes due to, for example, syphilis can also lead to transmission of syphilis outside of the genital area.[12]

Circumcision (excising the foreskin away from the glans of the penis) also reduces the risk of infection with HIV and STI. According to scientific studies, it can reduce the risk of HIV transmission by up to 60% for ↘heterosexual contacts.[13] For that reason, the World Health Organisation recommends also considering circumcision as a means for engaging in HIV-related issues and other STI. At the same time, however, it must be clearly stated that circumcision does not represent dependable protection against an infection.

Early diagnosis and treatment have a preventive character. In cases of STI that are relatively easily transmitted (such as gonorrhoea, syphilis or Chlamydia trachomatis), primarily at stake is not necessarily to avoid every potential infection but to detect a possible infection early on, to cure it entirely through the correct treatment and to stop the further spread of the pathogen (those affected ought to be encouraged to apply protective measures during their infectious phase). Bacterial STI are often easy to cure. Antibiotics are helpful with gonorrhoea – and with chlamydia infections too (where spontaneous healing often occurs). Syphilis can also be cured with an antibiotic treatment, at least in the early stages of the infection. Viral STI are generally more difficult to treat. It is possible, for instance, to treat a hepatitis-B infection at its chronic stage with antiviral drugs. The effect of this treatment is to keep the multiplication of the viruses under control, and a complete cure is achieved in approximately 20–30% of cases for particular forms of treatment. For HSV sufferers, antiviral drugs can be used to shorten the duration of herpes episodes, and where such episodes are frequent, continuous treatment may serve to reduce their frequency.

Anti-retroviral drugs as a preventive measure are now coming in for more and more consideration (for instance as a form of pre-exposure prophylaxis (PrEP)). A large-scale study of PrEP was announced at the World AIDS Conference in Vienna (July 2010). Even if this study were to confirm the effectiveness of this method, however, there would still be numerous questions needing to be sorted out before propagating PrEP. It is possible, for instance, for a preventive treatment applied to a person whose positive status is not known to lead to resistances to the medicines. The widespread use of anti-retroviral drugs might furthermore lead to them becoming ineffective faster.

[11] In the case of herpes genitalis (HSV), for example, direct contact infections can happen relatively easily. See also Swiss Aids Federation, FOPH, Sexually transmitted infections, information for advisers; Flepp et al. (1999), Präventionsempfehlungen zur Reduktion des HIV-Übertragungsrisikos bei orogenitalen Sexualpraktiken behalten ihre Gültigkeit.

[12] See also Swiss Aids Federation et al. (2008) Sexually transmitted infections, information for advisors

[13] WHO et al. (2007) New Data on Male Circumcision and HIV Prevention: Policy and Programme Implications

↘**Microbicides** are medicines that are applied locally and are intended to form a barrier against HIV and other STI. In the field of microbicides, scientists at the World AIDS Conference in Vienna (Juli 2010) presented one study in which a microbicide (a gel applied to the mucus of the vagina, penis or anus) was effective in reducing HIV infections and the transmission of herpes. The transmission risk fell by a mean of around 40% for HIV in a broadly based study in South Africa[14]. By contrast with early microbicides that were based on the principle of chemical barriers (and whose effects were weak), experiments are now taking place with microbicides containing the active anti-retroviral substances that are also used for HIV treatment. For vulnerable women (for example sex workers) effective microbicides might one day come to represent an important means of protection, since these can be used before sexual contact and independently of the sexual partner. However, further research and development studies are still needed before a medicine for widespread use becomes available. Moreover, microbicides are only effective if the instructions for using them are followed meticulously, which constituted a difficulty for many of the female participants in the study.

HIV vaccine still a long way off

Vaccines are only available against hepatitis B, HPV and faecal-oral hepatitis A (which is only very rarely transmitted sexually). In the case of HIV, efforts to develop vaccines have not so far produced any tangible result. At the AIDS Vaccine Conference in Paris in October 2009, there was, however, one report of a modest success with vaccination against HIV. This involved a randomised, placebo-controlled study of more than 16,000 men and women in Thailand over a period of three years. Only half the test subjects received a vaccination with the active ingredient, while the other half received a placebo. Of the 8200 individuals who were given the active vaccine, 51 contracted an HIV infection during the observation period, whereas 74 individuals in the placebo group contracted HIV. The effectiveness of the vaccination was around 30%. Mathematical models show that a vaccine capable of preventing 60% of HIV transmissions would already represent a major breakthrough and would decisively reduce the spread of HIV within a population, but would not provide dependable protection for individuals. So it is too early for euphoria. No effective and dependable vaccine exists as yet for use in the population at large. In this context, a significant statement was made by UNAIDS Executive Director Michel Sidibé at the media conference concerning the Conference mentioned above: "A ready-to-use vaccine against HIV could be more than a decade away […] Meanwhile we have to redouble our combination HIV prevention efforts to stop the continuing tide of new HIV infections."[15] Despite initial partial successes in the field of vaccinations, it is clear that, in the second decade of the 21st century, effective prevention, early detection and efficient treatment are going to remain the sole promising approach to keeping down the number of new infections.

For all these reasons, the issues of HIV vaccination, microbicides and pre-exposure prophylaxis do not form an integral part of the current programme. According to its remit, the Swiss National AIDS Commission (EKAF) has the mandate of monitoring new findings in the field of HIV and other STI. If such findings require adaptations to the strategy, the EKAF would advise the Federal Office of Public Health to that effect and urge it to make appropriate modifications.

[14] CAPRISA – Centre for the AIDS Programme of Research in South Africa (2010) The CAPRISA 004 tenofovir gel trial results

[15] UNAIDS (2009) Scientists come together for the AIDS Vaccine Conference 2009

4 BIOLOGICAL SURVEILLANCE: AN OVERVIEW OF HIV AND OTHER STI WHOSE NOTIFICATION IS COMPULSORY

4.1 HIV: EPIDEMIOLOGY IN SWITZERLAND AND IN EUROPE

HIV infects cells belonging to the immune system that would normally repel pathogens and eliminate pathologically modified cells from the body (CD-4 cells, so-called helper cells). When their correct functioning is disrupted as a result of an HIV infection, it is only possible to compensate for this to a limited extent. Distinctions are made between the following phases of an **untreated HIV infection:**

1. Acute HIV infection ↘(primary infection): For a period of time lasting from several days to a few weeks following infection, it is possible for temporary symptoms to occur, such as fever, swollen lymph nodes, painful joints and unspecified complaints. Considerably more than half of those infected go through a phase of symptomatic primary infection.

2. Asymptomatic phase: During the following phase, lasting a mean of 8–10 years, no clinical complaints due to HIV occur in most cases. However, the viruses continue to multiply and further immune cells become affected. The person affected remains more or less strongly infectious depending on their ↘viral load.

3. Onset of immunodeficiency: The term "AIDS" ("acquired immune deficiency syndrome") is used to designate that stage in which the immune system is severely impaired and the life-threatening diseases brought about by AIDS occur, such as opportunistic infections (like pneumocystis pneumonia and cerebral toxoplasmosis), or tumour diseases (like Kaposi's sarcoma and non-Hodgkin lymphoma). Severe general symptoms (such as fever from an uncertain cause and neurological diseases) can also occur. With the introduction of the combined anti-retroviral treatments, the number of AIDS cases has gone down in all countries in which there is a properly functioning health-care system and anti-retroviral drugs are accessible in sufficient quantities.

4.1.1 HIV IN SWITZERLAND

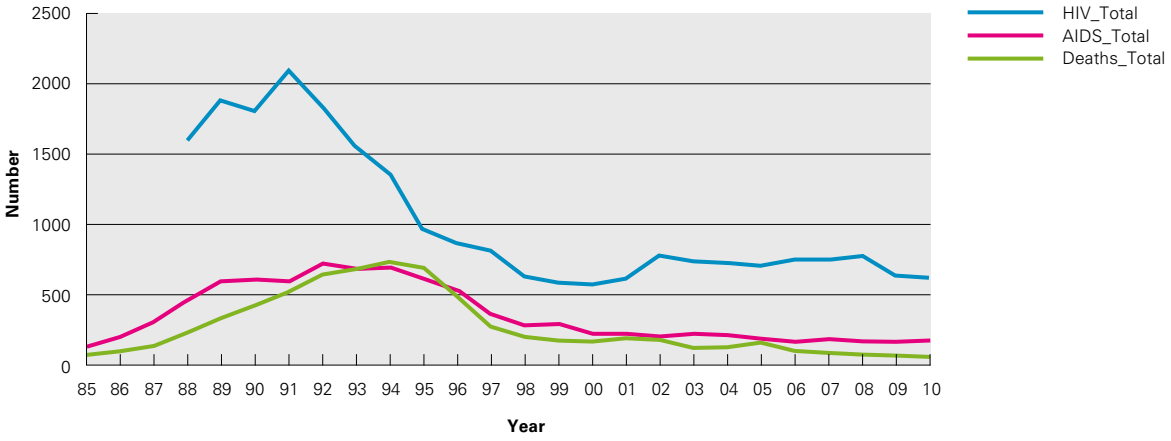
HIV has probably been present in Switzerland since the 1970s, when the first AIDS diagnosis was established (retrospectively) in 1981. From 1985 onwards, individual laboratories in Switzerland were able to show the presence of antibodies to HIV and notified cases of positive findings to the Federal Office for Public Health (FOPH). In December 1987, a ↘obligation of notification was imposed for HIV and AIDS.

In the first two years after the introduction of the HIV antibody test (1985 and 1986), most of the HIV cases diagnosed and notified to begin with were those that were already prevalent, i.e. those infections that had accumulated in the population since the beginning of the epidemic on an unknown date (2800 notifications for 1985). The figures fell somewhat in 1987 and 1988. Of the total of 1604 HIV tests that produced positive results in 1988 more than half were IDU (injecting drug users), more than a quarter were ↘MSM (men who have sex with men) and approximately 20% were individuals who had become infected via a heterosexual route. Whereas the number of HIV diagnoses in IDU started to decline steeply as early as 1988 and the number of MSM infections increased only slightly, the trend amongst the heterosexuals still continued to increase sharply, a change in this tendency did not occur until 1992 (Fig. 1). It is presumably as a consequence of the prevention efforts and the impact of the highly visible AIDS epidemic that the trend fell markedly from then until the year 2000 in all groups.

It was not until 2001 that the trend in the number of positive HIV tests increased again (from 578 to 631). In 2002, the figure grew again to 794 – a jump of more than 25% compared with the previous year. Breaking these figures down by gender, infection route and nationality shows that the positive HIV tests increased especially amongst MSM and women from countries with a generalised epidemic[16]. This was followed by a period of several years during which the total number of new HIV diagnoses remained fairly constant within the range of 740 to 780 cases, before falling again by 17% in 2009.

[16] In the case of Switzerland, the countries primarily concerned are those of the sub-Saharan region (96.6%), along with a number of Caribbean countries (2.4%) and some in Central or South America (1%) (percentages based on the notifications from doctors between 2000 and 2009).

HIV cases, AIDS cases, and HIV/AIDS deaths in Switzerland



HIV cases, AIDS cases, and HIV/AIDS deaths among heterosexuals

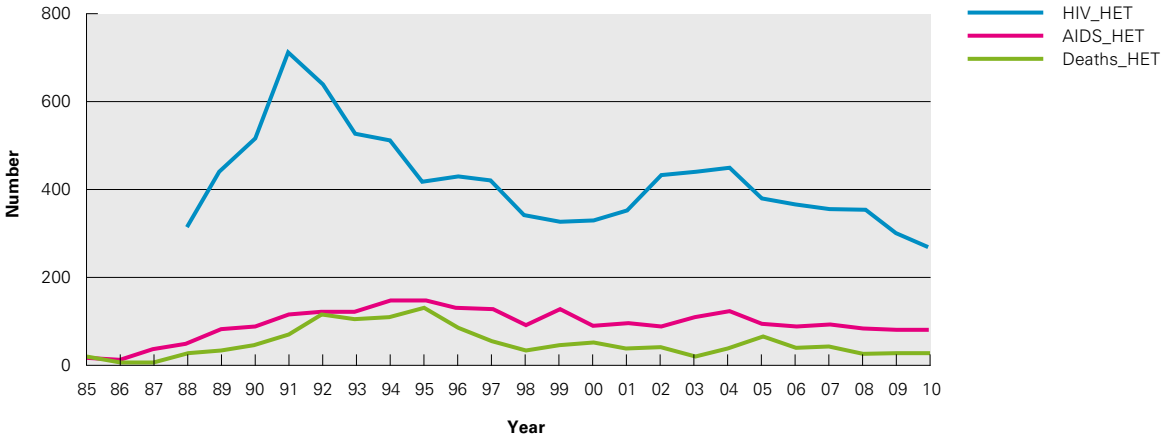
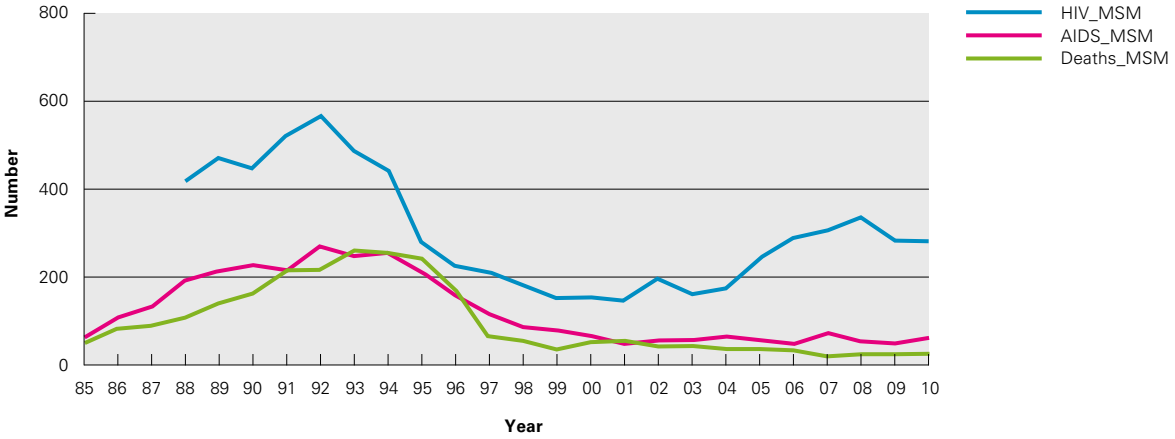


Figure 1: Newly diagnosed HIV infections, new AIDS cases and deaths per year amongst individuals with HIV or AIDS in Switzerland as a whole and broken down by infection route. The most striking feature is the reduction in the number of AIDS cases and deaths from the mid-1990s onwards, which was achieved through the widespread use of anti-retroviral treatments.

HIV cases, AIDS cases, and HIV/AIDS deaths among MSM



HIV cases, AIDS cases, and HIV/AIDS deaths among IDU

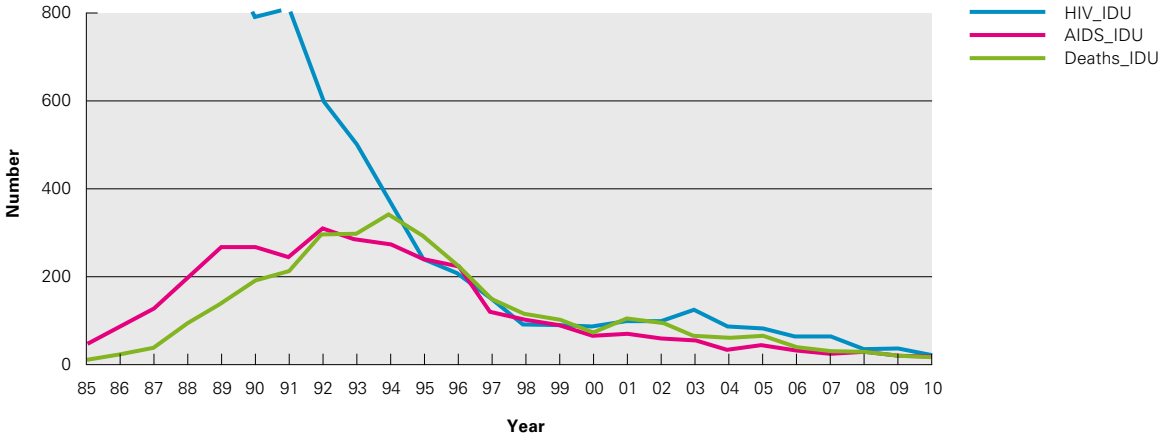


Figure 1: Newly diagnosed HIV infections, new AIDS cases and deaths per year amongst individuals with HIV or AIDS in Switzerland as a whole and broken down by infection route (MSM: men who have sex with men, IDU: injecting drug users). The most striking feature is the reduction in the number of AIDS cases and deaths from the mid-1990s onwards, which was achieved through the widespread use of anti-retroviral treatments.

Number of Persons with HIV-diagnosis or AIDS still alive (extrapolated for 2010)

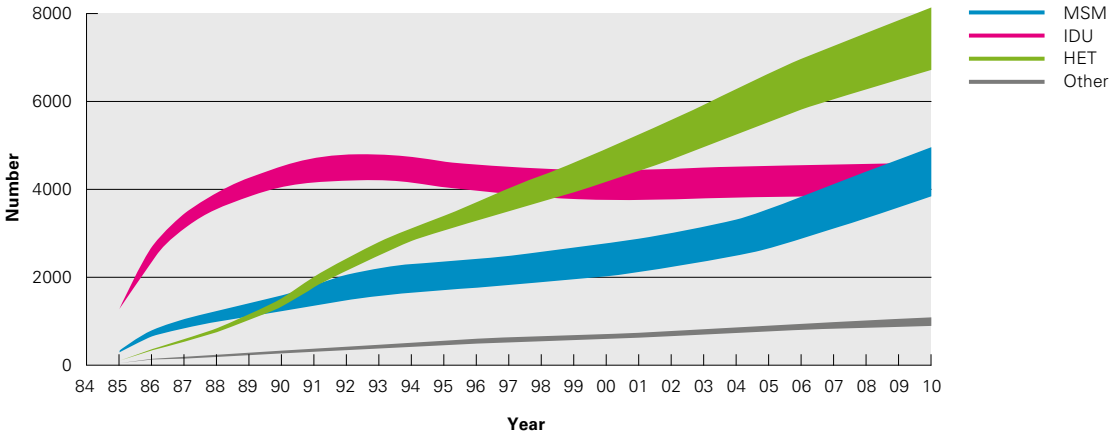


Figure 2: Statistical estimate of the number of persons in Switzerland with HIV broken down by infection route. The curve along the top of each range indicates the total number of persons with HIV, whereas the curve along the bottom of each range indicates the number of persons not diagnosed as having AIDS. By subtraction, this leaves the coloured band between them showing the number of persons diagnosed as having AIDS.

Total number of HIV-positive individuals in Switzerland

The number of persons living in Switzerland with an HIV or AIDS diagnosis has been increasing steadily (Fig. 2), given that, right from the beginning of the epidemic, there have nearly always been more new diagnoses than deaths in all the groups affected. The computation for 2009 arrives at a total of between 14,000 and 21,000 individuals with an HIV diagnosis, of whom roughly 43% (between 6200 and 9200 individuals) were infected heterosexually and one quarter each (between 3600 and 5500 individuals) through the MSM and IDU routes[17]. To these must be added those who are infected but do not know it. On the basis of studies in comparable industrialised countries (United Kingdom and Canada) it is possible to produce an estimate for Switzerland. According to that, it seems likely that at least 20,000 persons with HIV must be living in the country.

From the beginning of the epidemic through the end of 2009, a total of 31,579 HIV tests were confirmed in Switzerland. The doctors had notified a total of 8977 AIDS cases. Considering the delays in filing notifications, that leads to an estimated total of approximately 9100 cumulated AIDS diagnoses in Switzerland. The mortality statistics indicate that there have been around 7000 deaths amongst individuals with an HIV infection, including around 5900 cases in which AIDS had been diagnosed and was the most probable cause of death[18].

[17] Given that there are various sources, the computation takes into account an unknown rate of repeat tests and notification delays for new AIDS cases and deaths. Since these sources of errors accumulate over the years, the computation is not very precise. It should also not be forgotten that HIV infections in individuals who have not yet undergone an HIV test are not included in these figures.

[18] State of notifications as at 31 March 2010. This considers the notifications filed by the laboratories confirming HIV since 1985, the supplementary notifications for HIV from doctors (a total of 14,736 since their introduction in 1988) and the supplementary notifications for AIDS since 1983 as well as those death certificates that were available by 31 March 2010. Laboratory reports that were recognisable as repeat tests were excluded.

Number of HIV diagnoses, broken down by infection route

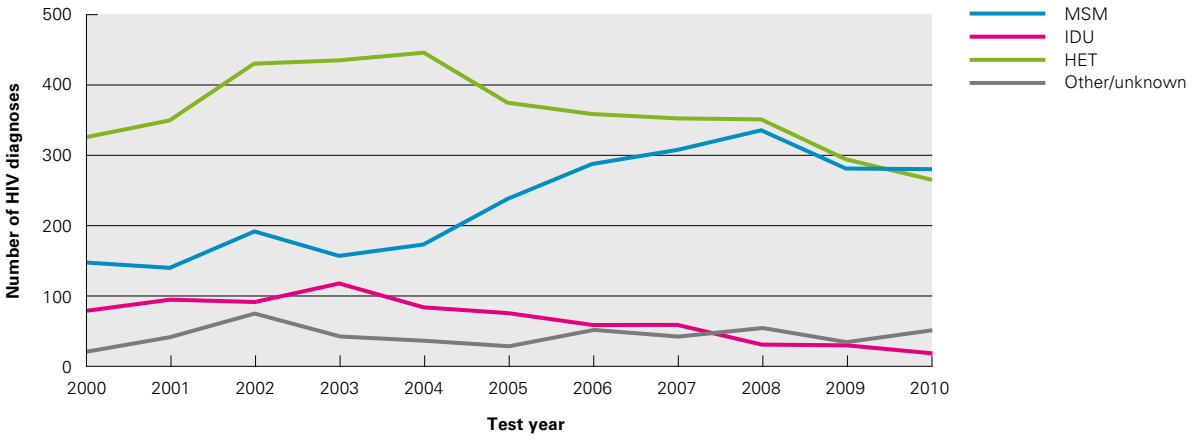


Figure 3: Newly diagnosed HIV infections in Switzerland for the principal infection routes, broken down by year of test (estimate based on notifications by medical doctors).

Developments between 2000 and 2009

In 2001, there was once again an increase in the number of positive HIV tests, following a rather long period over which they had declined, this increase continued on into 2002 (Fig. 3). It was observed that this increase affected primarily Swiss MSM and women from the sub-Saharan region.
In the years that followed it is true that the aggregate number of positive HIV tests remained relatively stable, but this concealed two opposing trends. The number of HIV diagnoses amongst MSM increased from 175 to 335 between 2004 and 2008, whereas it decreased amongst heterosexuals from 445 to 355. The proportion of women amongst those with positive HIV tests hovered around 40% between 2000 and 2003 and then declined steadily thereafter (to 27% in 2009).

In 2009, fewer diagnoses were once again recorded for MSM, which, in combination with the continuing falling trends in the other groups, resulted in a relative fall in the total of 17% compared with the previous year.

The proportion of diagnoses that are not caused by sexual contacts or drug injections but by the transfusion of infected blood or from mother to baby, fluctuates between 1.5% and 2.8%. A large portion of the HIV infections in new-born babies in Switzerland are followed by the Swiss National Centre for Retroviruses. According to this centre's statistics, the proportion of babies infected at birth fell to less than 5% of infections after the mid-1990s, and in the years 2004–2006 none of the children examined by the centre had been infected by an HIV-positive mother. This was probably an outcome of more frequent HIV testing of pregnant women and thus the possibility of applying medical measures to prevent mother-to-child transmission (such as anti-retroviral treatments and Caesarean sections).

Whereas there are many Swiss amongst the MSM with a new HIV diagnosis (their proportion was 60% in the years 2008 and 2009), only 35% of the heterosexuals (male and female) with a new HIV diagnosis are Swiss. According to UNAIDS data, more than a third of those individuals diagnosed with HIV who were infected via the heterosexual route originating from a country with a generalised HIV epidemic[19].

[19] In the case of Switzerland, the countries primarily concerned are a number of those to the south of the Sahara. Small numbers of HIV infections are diagnosed in Switzerland, but regularly so, amongst individuals from Caribbean countries, which are also regarded as high-prevalence countries according to the UNAIDS data. Since 2000, there has been a total of 47 such cases, including 18 individuals from the Dominican Republic, 14 from Cuba and ten from Haiti. (UNAIDS et al. [2009] 2009 AIDS epidemic update)

HIV diagnoses classified as recent or older per half year and group (projected up to 2010.2, latest notification data from 30.9.2010)

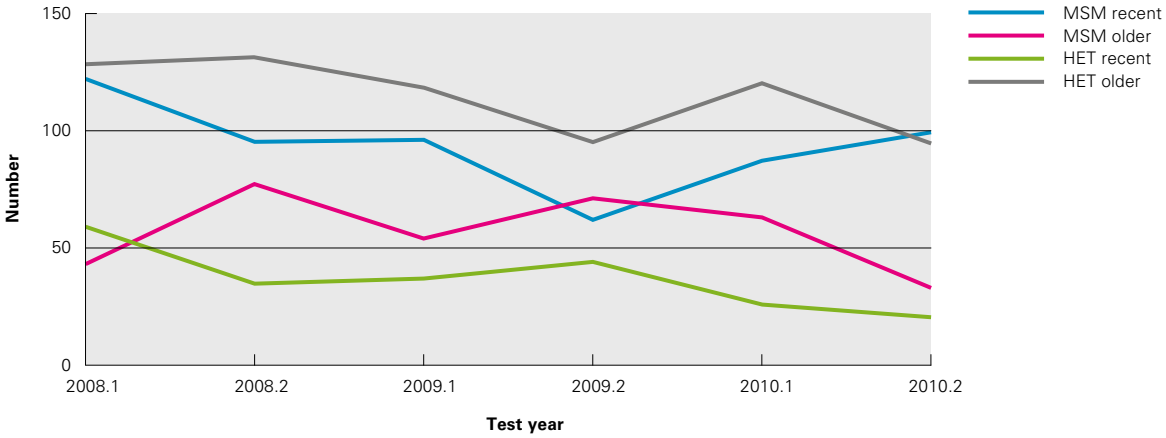


Figure 4: HIV diagnoses classified as recent or older in MSM and those infected by the heterosexual route, for 2008 and 2009, broken down into half-years (cf. Tab 4).

Timing of the diagnosis

Throughout the period from 2000 to 2009, only 18% of the HIV diagnoses were made in the first few months following infection, i.e. during or shortly after the primary infection, and 28% were only diagnosed at a late stage (13% already at the AIDS stage). Primary infections were diagnosed most frequently in MSM (27%) and least frequently in those infected through the heterosexual route (13%). The corollary of this was that diagnosis only in a late stage was significantly more frequent in the heterosexual group than in the MSM.

In addition to the breakdown into stages, a laboratory method developed by the Swiss National Centre for Retroviruses has also made it possible, since 2008, to distinguish between recent infections and those that have been established for longer[20]. Positioning these results more precisely over time shows that in the case of MSM the number of recent infections declined from 2008 to 2009, but that was not the case with those who had been infected via the heterosexual route. The fall in the number of HIV diagnoses in 2009 thus had different causes in the two groups: amongst the MSM, they were the infections classified as "recent", and in the heterosexual cases they were the "older" ones (Fig. 4). This supports the interpretation that there really were fewer infections amongst MSM in 2009, whereas the decline in the number in the heterosexual group is more likely to be explained by the immigration of individuals from countries with a generalised epidemic.

Late testers

The term "late tester" has been coined for a person whose HIV diagnosis is only established a very considerable time after their infection. This term is used in the following section of this report for those affected by HIV who only learn about their infection after they have reached an advanced stage of immunodeficiency (with CD-4 values of less than 200/µl). As mentioned, the mean proportion of HIV infections diagnosed late (compared with the total number of diagnoses) was nearly 28% over the period from 2000 to 2009, although this proportion declined in the course of that period. In 2009, it still stood at around 20%. This proportion did, however, vary depending on the infection route and the origin of the persons affected (Fig. 5).

The proportion of late testers amongst the MSM declined considerably (especially in the first half of the ten-year period) and was 12% in 2009. The proportion of late testers also fell amongst the heterosexuals, but less markedly so. It is significant that this proportion was higher amongst Swiss and European men and women (28%) than amongst persons from a country with a generalised epidemic (20%).

[20] In the InnoLia assay (a procedure similar to the western blot for determining HIV-specific antibodies) the intensity of the ranges becomes greater, the older the infection is. The procedure was introduced in the course of 2007 by the laboratories confirming HIV infections, and since 2008 virtually all new HIV diagnoses have contained the information as to whether or not the infection is probably a recent one (i.e. less than a year or so old). The method's sensitivity is 50%. See also Fachkommission Labor und Diagnostik von HIV/Aids des BAG FLD [2006] Das schweizerische HIV-Testkonzept – aktualisierte Übersicht über Technisches Konzept und Laborkonzept; Bundesamt für Gesundheit [2010] Neuerungen im HIV-Laborkonzept)

Late stages by the time of the HIV diagnosis

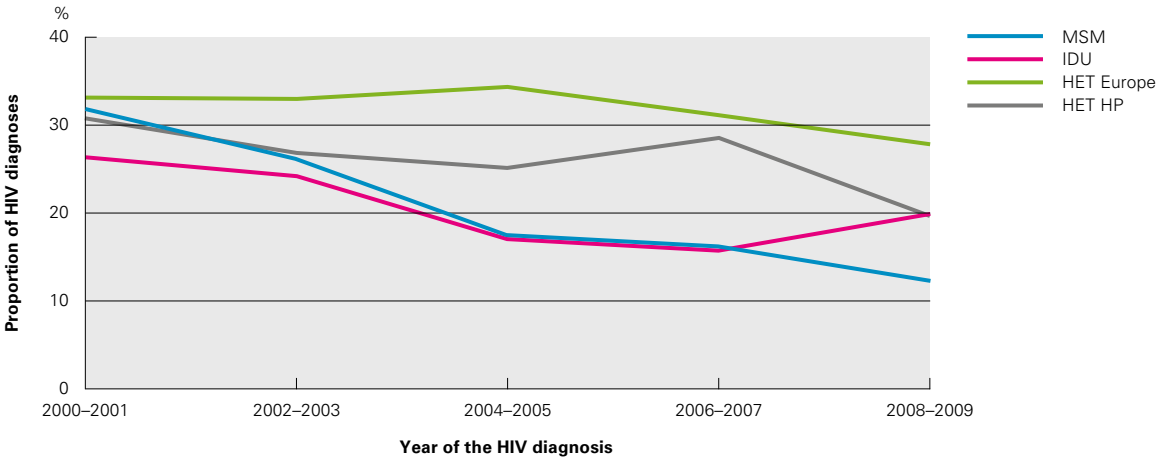


Figure 5: Proportion of late testers amongst the HIV diagnoses made in 2000–2009, broken down by course over time, infection route and region of origin. (HET Europe: heterosexuals originally from a country that does not have a generalised epidemic, primarily Europeans. HET HP: Heterosexuals from a country with a generalised epidemic).

The proportion of late testers can also be appraised on the basis of the number of new diagnoses of AIDS. This shows that the proportion of individuals whose HIV infection was only diagnosed shortly before the diagnosis of AIDS (a maximum of two months before it[21]) lies between 30% and 35%. This explains why around a third of all AIDS cases occur when it was not possible to prevent the progression of disease through anti-retroviral treatment, since the HIV infection was not known in good time.

Geographic location of the infection

In 2007, a new form was introduced for the ↘supplementary notification of HIV diagnoses, including questions regarding the presumed geographic location at which the infection occurred. This has been used in the majority of cases since 2008. Out of the total of 1149 supplementary notifications filed in 2008 and 2009, 878 (76%) included data on the place where the infection presumably occurred. According to the data, infection in 40% of the cases occurred outside of Switzerland (in both 2008 and 2009). That the HIV infection presumably occurred outside of Switzerland was reported significantly more frequently for individuals infected heterosexually (57% of cases) than for MSM (23%) and IDU (20%). Additional data was also supplied in 70% of those cases in which the infection was presumed to have occurred in Switzerland. According to this, nearly 97% of the MSM became infected in an urban location, while the figure was 81% for heterosexuals.

Sexually transmitted infections (STI), predating an HIV diagnosis

When performing the HIV diagnosis, the treating doctors carry out an ↘anamnesis for STI diagnosed earlier[22]. Between 2000 and 2009, 14% of the supplementary notifications mentioned at least one of the three STI considered (a total of 5870 notifications). In 7% of cases, the STI diagnosis had been established within the two years preceding the HIV diagnosis. Different frequencies were found for syphilis, gonorrhoea and chlamydia infections depending on the infection route (Fig. 6). Amongst the MSM, syphilis was diagnosed more frequently than gonorrhoea.

[21] The arbitrarily chosen number of months (cut-off) has no impact on the results, since in nearly all cases the HIV diagnosis occurs either very shortly before the AIDS diagnosis (two months or less) or very much longer before it (more than a year). It should be noted that the percentage of late testers, which is based on the AIDS diagnoses, is not directly comparable with that based on the HIV notifications, since the data refers to different report populations.

[22] Specific questions were asked about syphilis, gonorrhoea and chlamydia infections. Up until the questionnaire was revised in 2007, it also asked about "other STI". Between 2000 and 2007, there were between 20 und 30 supplementary HIV notifications per year mentioning "other" STI. Those mentioned most frequently were hepatitis B or C, herpes genitalis and HPV.

STI two years before the HIV diagnosis

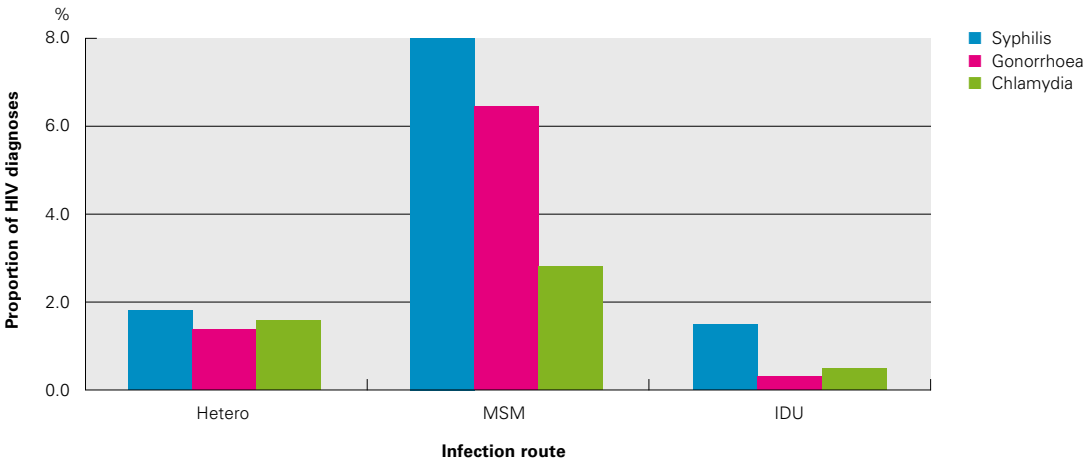


Figure 6: Proportion of the HIV diagnoses between 2000 and 2009 with a positive anamnesis for syphilis, gonorrhoea or chlamydia within a maximum of two years prior to the positive HIV test, broken down by infection route.

4.1.2 HIV IN EUROPE

The HIV epidemic has spread in all the countries of Europe[23] and is also concentrated, as in Switzerland, in particular groups of people with a higher risk of infection (MSM and IDU). Which groups are affected most by HIV varies from country to country. There are also big differences in the overall rate of HIV diagnoses per million inhabitants and year (Table 1). In nearly all the countries of the region the number of HIV notifications has increased steadily from 2000 onwards[24].

The highest rates of new HIV diagnoses were reported for the countries of Eastern Europe (with a mean of 179 per million inhabitants in 2008), which is more than twice as high as for Western Europe (72 per million) and as much as ten times higher than for Central Europe (15 per million). Within the European regions there were also big differences between the individual countries. The highest rate in Western Europe was recorded for the United Kingdom in 2008 (with 120 per million, contrasting with just about 30 per million in Finland). The highest rates in Eastern Europe were registered in two of the Baltic States as well as in Ukraine and Moldova (with more than 400 per million in Estonia), contrasting with around 30 per million in Lithuania. Switzerland, with its more than 100 new HIV diagnoses per million inhabitants (2008), has one of the highest rates amongst the countries of Western Europe.

The heterosexual infection is most prevalent in the countries of Europe. The reason for that in Western Europe is the high proportion of cases among immigrants from countries with a high HIV prevalence, who probably became infected in their country of origin.

Unprotected sex between men is the dominant infection route especially in countries of Central Europe and those countries of Western Europe where HIV cases amongst individuals from countries with a generalised HIV epidemic have less of an impact. With the exception of Georgia, it is believed that this infection route is relatively rare or even nearly non-existent in the countries of Eastern Europe. It is to be assumed that this lack of data can be explained at least in part by ↘discrimination against ↘homosexuals and ↘homophobia, which is rife in many of these countries and hinders those affected from declaring their true infection route. Especially in those countries of Eastern Europe with high infection rates, infection via injecting drug use (IDU) dominates.

[23] The WHO's European Region includes 53 countries, of which 48 supplied data on notified HIV diagnoses to the ECDC. No data or only inadequate data is available for Austria, Denmark, Monaco, Russia and Turkey. The table lists 38 of the 48 countries. As far as the others are concerned, either the absolute numbers of cases were too small (Cyprus, Malta, Iceland, Albania, Andorra, Macedonia, Montenegro, Monaco and San Marino), or the figures were not available in a suitable format (Kazakhstan).

[24] ECDC/WHO Europe. HIV/AIDS surveillance in Europe 2008.

Country	Region	Total number of HIV diagnoses (2005–2008)	Rate per million inhabitants (2008)	Infection routes (proportions as percentages)			
				MSM	IDU	HET	Other/ unknown
United Kingdom	W	30'376	119	34	2	56	8
Portugal	W	6'003	106	15	23	59	3
Switzerland	W	3'028	102	34	7	42	18*
Belgium	W	4'200	101	26	1	36	37
Luxembourg	W	234	97	32	10	53	4
Italy	W	6'617	97	26	9	46	19
Ireland	W	1'475	92	22	14	47	16
Netherlands	W	4'608	83	60	1	32	7
Spain	W	6'035	82	37	12	43	8
France	W	21'255	64	24	3	42	32
Norway	W	1'042	63	30	5	60	5
Israel	W	1'436	55	28	12	51	8
Greece	W	2'309	48	44	2	25	28
Sweden	W	1'742	39	26	9	49	16
Germany	W	10'748	34	53	5	26	15
Finland	W	667	29	31	7	45	17
Slovenia	C	156	24	14	77	10	14
Poland	C	2'921	21	6	15	9	70
Bulgaria	C	249	16	12	38	35	14
Serbia	C	403	16	47	10	26	16
Croatia	C	424	15	54	5	33	7
Hungary	C	451	14	55	2	15	29
Czech Republic	C	450	14	61	6	29	4
Slovak Republic	C	140	10	58	4	29	10
Romania	C	818	8	7	1	55	37
Bosnia and Herzegovina	C	43	2	23	12	63	2
Estonia	E	1'178	406	0	13	0	87
Ukraine	E	53'695	341	0	51	44	4
Moldova	E	1'526	219	0	24	71	5
Latvia	E	1'306	158	13	87	5	35
Uzbekistan	E	10'594	113	0	56	21	22
Kirgizstan	E	1'375	102	36	23	0	59
Belarus	E	3'355	91	29	11	0	30
Georgia	E	1'213	81	66	4	2	55
Azerbaijan	E	1'324	50	37	5	0	64
Tadzhikistan	E	1'029	48	20	15	52	28
Armenia	E	386	44	2	36	57	5
Lithuania	E	421	28	20	6	59	21

* In the case of Switzerland, the reason for the relatively high proportion of infections through unknown routes is that the supplementary notifications are often only transmitted to the FOPH (and thus to the ECDC) with a considerable delay.

Table 1: Reported HIV diagnoses between 2005 and 2008 in countries of the WHO European Region. The countries are placed in groups according to parts of the region (W=Western Europe, C=Central Europe and E=Eastern Europe, in accordance with the ECDC classification) and with each of these part-regions sorted in declining order of infection rate per million inhabitants. It is impossible to compare the part-regions given the differences between the notification systems. For each country, the dominant infection route is shown in bold face. The abbreviated infection routes are MSM = men who have sex with men and IDU = injecting drug users

4.2 OTHER STI: EPIDEMIOLOGY IN SWITZERLAND AND EUROPE

4.2.1 STI WHOSE NOTIFICATION IS COMPULSORY IN SWITZERLAND

The data for the epidemiological surveillance of STI in Switzerland comes primarily from the compulsory notification system. Only a few prevalence studies exist and these were mainly carried out on population groups with a heightened STI risk. Estimates regarding the prevalence of the various STI are thus vague, and it is to be assumed that the prevalence in particular groups is higher than in the population as a whole (such as individuals with a higher infection risk, for instance MSM, sex workers and immigrants with an uncertain residence status[25]).

STI surveillance in Switzerland was subjected to an evaluation in 2005, which led to adaptations in the notification system from 2006 onwards[26]. One example of this is that the approved laboratories are obliged, since then, to notify all positive test results for chlamydia, syphilis and gonorrhoea to the cantonal medical department and the FOPH. The notification obligation also extends to hepatitis B and C, the first of these being a classical sexually transmitted infection, while the second is occasionally sexually transmitted. Whereas the notification obligation for chlamydia infections and gonorrhoea has existed since 1988, the situation regarding syphilis is more complicated. Between 1988 and 1998, the laboratories used to have to notify positive syphilis tests, but that obligation was suspended between 1999 and 2005, which means that no surveillance data is available for this period of time. In addition to this notification obligation, which the FOPH has imposed on laboratories since 2006, it has also introduced the obligation for doctors to file supplementary notifications of diagnoses of syphilis and gonorrhoea to the cantonal medical department within seven days. The supplementary doctors' notifications contain data on the tests performed and key information specific to each pathogen (such as the infection route or the stage of the disease).

With the existing surveillance system (2010), it is not possible to estimate the prevalence and incidence of the various STI reliably, since important denominators are not known (such as the number of negative tests or the total number of tests performed). The quality of the data is generally limited, given the missing or incomplete supplementary notifications, which renders the task of epidemiological analysis more difficult.

STI diagnosis and medical specialisations

In 2004, the FOPH for the first time recorded the specialisations of the doctors establishing STI diagnoses. This analysis shows that chlamydia infections were diagnosed more frequently in the specialist discipline of gynaecology, whereas gonorrhoea diagnoses tended rather to be made in general medicine and internal medicine.
Further analyses performed in 2007 and 2008 (and were extended to include the diagnosis of syphilis too) confirmed these observations.[27] Approximately 50% of the chlamydia infections were diagnosed by gynaecologists, whereas gonorrhoea and syphilis tended to be reported more by general practitioners (with nearly 45% and 32% respectively). These findings are important for assessing where it would make sense to strengthen prevention interventions (such as the provision of advice or the distribution of information material).

Chlamydia trachomatis

Chlamydia infections are caused by bacteria (most frequently by *Chlamydia trachomatis)* and constitute the most frequently diagnosed sexually transmitted infection of bacterial origin. However, no precise data is available for their incidence and/or prevalence in the general population in Switzerland. Depending on the age and population group, the proportion of sexually active individuals infected with chlamydia is estimated to be in the range of 3–10%. It is possible for the infection to be transmitted through oral, vaginal and anal sexual intercourse or from mother to baby during birth. A heightened risk exists during unprotected sexual intercourse with a new partner and also among individuals who have several sexual partners. Roughly 70% of the women and 25% of the men with a chlamydia infection have no symptoms at all or only minor ones. Where symptoms do exist, they are experienced above all as burning and pains when urinating.[28]

[25] Wolff et al. (2008) Chlamydia trachomatis prevalence in undocumented migrants undergoing voluntary termination of pregnancy: a prospective cohort study

[26] Swiss Federal Office of Public Health (2008) Sexually transmitted infections (STI) in Switzerland between 1988 and 2006: current status and prospects.

[27] Baillif et al. (2010) Diagnosed bacterial sexually transmitted infections in Switzerland: analysis of notification data, according to physician speciality and setting. Unpublished document.

[28] Krech T. et al (2002) Urogenitale Humane Papillomviren und Chlamydien. Epidemiologie bei Schweizer Frauen unter Anwendung neuer Nachweisverfahren.
Paget et al. National laboratory reports of Chlamydia trachomatis seriously underestimate the frequency of genital chlamydial infections among women in Switzerland.

***Chlamydia trachomatis*, 2000–2009**

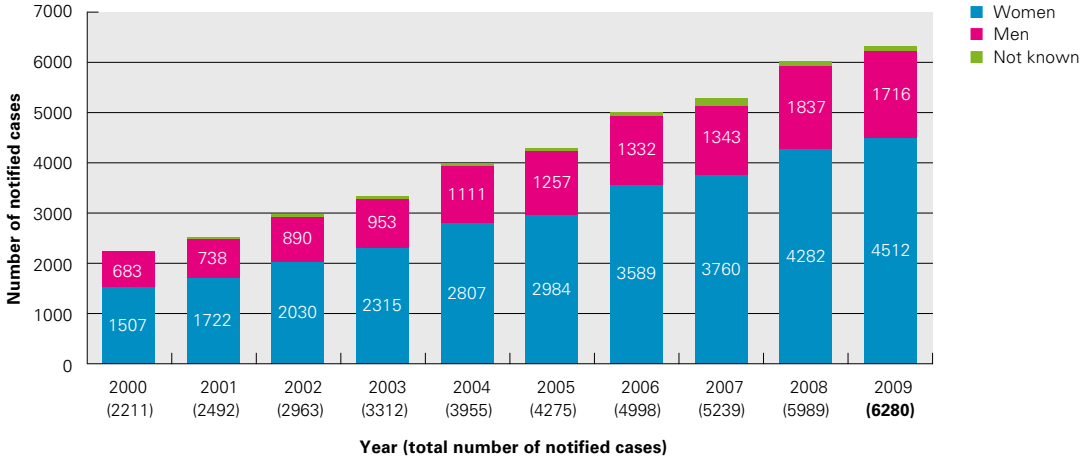


Figure 7: Notifications of *Chlamydia trachomatis* between 2000 and 2009, broken down by sex.

It is possible for a chlamydia infection to be cured with antibiotics, and spontaneous healing also occurs. In women, untreated infection can lead to infertility or occlusion of the Fallopian tubes, resulting in ectopic pregnancies.

Increase over the last ten years: The number of chlamydia infections notified annually has increased in the course of the past ten years[29]. In 2009, the FOPH received 6280 notifications. There has been virtually no change over time in the breakdown of cases by gender and age group. The proportion of women is roughly 72% (4512 out of 6280, Fig. 7). Around 87% of the notifications concerning women in 2009 dealt with the age range of 15–34. The infection appears to occur particularly frequently in young women in the age range of 20–24 years (Table 2). In the case of men, around 71% of the notifications concerned the 20–39 age range.

Age group	2009			
	Men	%	Women	%
0–14	19	1	39	1
15–19	85	5	841	19
20–24	377	22	1608	36
25–29	373	22	991	22
30–34	267	15	482	11
35–39	203	12	244	5
40–44	170	10	151	3
≥45	219	13	146	3
Not known	3	0	10	0
Total	1716	100	4512	100

Table 2: Notifications of *Chlamydia trachomatis* 2009, broken down by age group and sex.

[29] FOPH, Sexually transmitted infections (STI) in Switzerland between 2006 and 2008

Gonorrhoea – *Neisseria gonorrhoeae*

Gonorrhoea is caused by the *Neisseria gonorrhoeae* bacterium. The infection may be transmitted during oral, vaginal and anal sexual intercourse and also from mother to baby during birth. The disease is more widespread amongst homosexual and ↘bisexual men, individuals with several sexual partners and in the field of sex work than in the rest of the population.

Asymptomatic infections are very much rarer than with chlamydia[30]. The bacterial pathogens, gonococci, cause inflammation of the mucous membranes at the location of the infection. The first symptoms usually appear 2–7 days after infection. In the case of men, the first thing to happen is a reddening and a swelling at the urethral orifice with pain when urinating and a putrid discharge. If not treated, the infection will spread to the prostate and epididymis. A putrid discharge can also occur with women, who additionally suffer an urge to urinate and then pain when doing so; sexual intercourse might also be painful. It happens more frequently in women than men that the infection does not give rise to any symptoms, or only to milder ones, and thus goes unnoticed for a long time. Depending on sexual practice, infections may also occur in and around the mouth and throat and also in and around the anus, taking the form of reddening and irritation.

Cure is by treatment with antibiotics. Infertility can be a (rare) late consequence of untreated gonorrhoea in both women and men. Other rare complications are inflammations at the joints, skin and conjunctiva. Children of infected mothers may be infected during birth, which leads to a suppurative conjunctivitis in newly-born babies.

Gonorrhoea notifications: The number of gonorrhoea notifications in 2009 remained at a constant high level. There has been virtually no change in the proportions of the genders affected, with men accounting for more than 80% of cases (785 out of 963, Table 3). On the other hand, there has been a shift in the distribution over the various age groups compared with earlier years (Fig. 8). Considering both genders together, the number of gonorrhoea cases is highest in the 20–24 age group (whereas up until 2008 the largest number of diagnoses had been in the 25–29 age group). The age group most affected is thus the same as with chlamydia infections.

Exposure and risk factors (2009 data): For around 90% of the gonorrhoea cases notified by the laboratories in 2009, a supplementary doctor's notification was also filed. The results presented below are based on doctors' notifications (894 out of 963 cases, cf. "Total number of confirmed cases", Table 3).

In terms of sexual preference and the type of relationship, 37% of the men ascribe their infection to a heterosexual relationship and 25% to a homosexual one. Infections occurred more frequently in casual relationships (36%) than in steady ones (19%). Switzerland (47%) is indicated more frequently than abroad (13%) as the country where the infection occurred. Nearly 15% of the men indicated that they had already had one STI.

Amongst the women, the exposure occurred in 26% of the cases in a steady relationship and in 13% of the cases in a casual one. As with the men, the country where the infection happened is more frequently Switzerland (44%) than abroad (11%). According to their own indications, 9% of the women have already been through one STI.

[30] FOPH, Sexually transmitted infections (STI) in Switzerland between 2006 and 2008

Gonorrhoea between 2006 and 2009 (total for both genders)

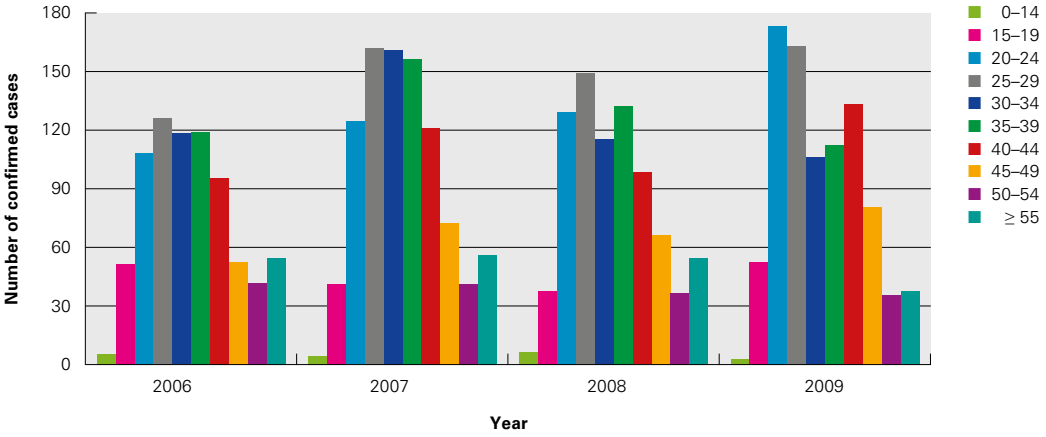


Figure 8: Confirmed gonorrhoea cases between 2006 and 2009, broken down by age group.

	2009			
	Men	%	Women	%
Sexual preference				
Heterosexual	268	37	90	56
Homosexual	180	25	2	1
Bisexual	14	2	2	1
No indication	270	36	68	42
Total number of confirmed cases	732	100	162	100
All reported cases	785		178	
Nature of relationship				
Steady relationship	141	19	43	26
Casual relationship	264	36	22	13
With sex worker	40	6	1	1
With paying customers	2	0	1	1
Unknown	91	12	12	7
No indication	194	27	84	52
Total number of confirmed cases	732	100	163	100
Exposure location				
Switzerland	344	47	72	44
Abroad	99	13	18	11
Unknown/no indication	289	40	72	45
Total number of confirmed cases	732	100	162	100

Table 3: Confirmed gonorrhoea cases 2009, broken down by exposure and risk factor.

Syphilis – *Treponema pallidum*

Syphilis is caused by the *Treponema pallidum* bacterium. The infection is transmitted during the primary, secondary and early latent stage through direct contact with skin or mucosal lesions, which can occur primarily in the genito-anal region but also in the oral cavity. A heightened risk of infection exists especially for men who have sex with men, for individuals with several changing sexual partners and for sex workers an their clients. During pregnancy and birth it is possible for the infection to be transmitted from mother to baby (congenital syphilis). That is why ↘screening is carried out for pregnant women in accordance with the WHO recommendations. In addition to that, during particular stages of the disease, it is also possible for it to be transmitted through blood transfusions.

If untreated, syphilis occurs in four different stages:
Primary syphilis: The first signs and symptoms may occur within a period of 5 to 21 days and up to three months after the infection and take the form of red patches at the pathogen's entry orifice (penis, anus, vagina, throat or other parts of the body). These patches develop into ulcers. It is possible for the symptoms of the first stage to remain undetected and for them to disappear again as a rule – even without treatment. The disease still remains, however, as does its contagiousness.
Secondary syphilis: The second stage follows on more or less directly from the first one and is characterised by a skin rash, which does not usually itch. This too disappears, also without treatment.
Latent syphilis: The next phase lasts for a period of months or years, during which the disease progresses without any visible symptoms. It leads, in particular, to damage to the nervous system. This latent stage is subdivided into early latency (up to one year) and late latency (beyond one year). Individuals in the early latent stage may still display sporadically occurring lesions of the skin and mucous membrane and are thus potentially still infectious.
Tertiary syphilis: During this stage, syphilis may be manifest as permanent damage to the heart, brain, bones and other organs. In the case of a neurosyphilis in the tertiary stage, the progressive degeneration of nervous tissues occurs in the brain or spinal cord. The possible consequences of the loss of brain tissues are personality changes, which may go as far as dementia.
Congenital syphilis: Congenital syphilis may cause deformities and other serious problems in the child, for instance inflammation or blindness.

Syphilis notifications: The quality of the data available for syphilis is less good than for the STI discussed above, since many of the supplementary notifications are missing or incomplete. Generally, supplementary notifications are filed for fewer than half the syphilis diagnoses. The inadequate representativity of the notified data limits the information value of the analyses.

After the number of syphilis notifications had been more or less stable throughout the period from 2006 to 2008, an increase was observed in 2009 in the total number of notifications filed and also in the number of confirmed cases. There has been virtually no change since 2006 in the breakdown of cases by sex. The male proportion in 2009 was thus greater than 80% (273 out of 336, Table 4).

Exposure and risk factors (2009 data): The results refer to the confirmed cases in 2009, i.e. to just short of 42% of all notified cases (336 out of 804 cases, Fig. 9 and Tables 5 and 6).

In relation to sexual preference and the type of relationship, 58% of the men ascribe the infection to a homosexual relationship and 29% to a heterosexual one; 44% ascribe it to a casual relationship and 29% to a steady one. The country where the infection occurred is more frequently indicated as Switzerland (53%) than elsewhere (18%). Around 78% of the confirmed cases in men are in an infectious stage (primary, secondary or early latent stage).

Regarding sexual preference and the type of relationship are concerned, 86% of the women ascribe the infection to a heterosexual relationship, whereas 3% indicate a homosexual one. In 51% of cases, the infection occurred in a steady relationship, in 16% in a casual relationship and in 5% in the context of sex work. No data is available for 29% of the cases. As with the men, the country where the infection occurred is more frequently Switzerland (48%) than elsewhere (25%). Around 55% of the confirmed cases in women are at an infectious stage (primary, secondary or early latent stage).

Number of cases (both sexes)	2009 n=804			
	Men	%	Women	%
All reported cases*	576		228	
Confirmed cases**	273	47	63	28

* All the cases reported for the corresponding year
** Confirmed case: Laboratory notification and the corresponding supplementary notification with the appropriate clinical information

Table 4: Number of syphilis notifications 2009.

Syphilis between 2006 and 2009 (total for both genders)

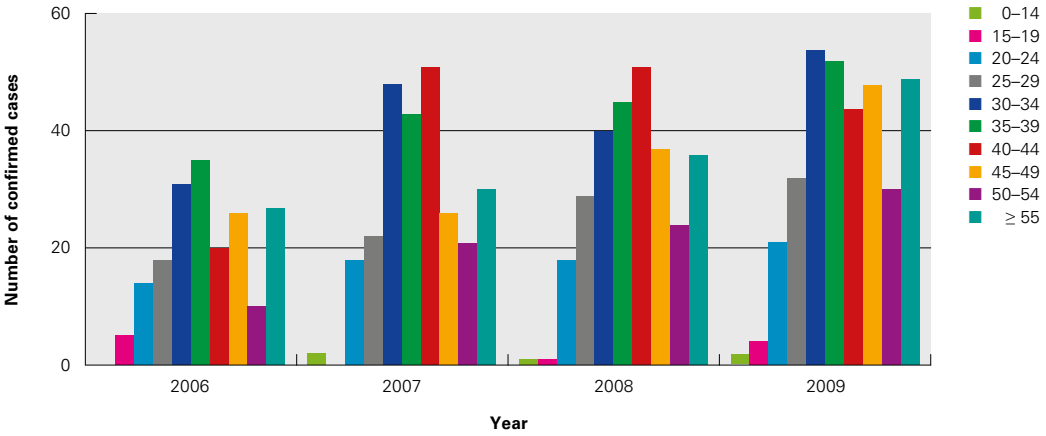


Figure 9: Confirmed syphilis cases between 2006 and 2009, broken down by age group.

	2009			
	Men	%	Women	%
Sexual preference				
Heterosexual	79	29	54	86
Homosexual	159	58	2	3
Bisexual	9	3	0	0
No indication	26	10	7	11
Total number of confirmed cases	273	100	63	100
Type of relationship				
Steady relationship	79	29	32	51
Casual relationship	121	44	10	16
With sex worker	9	3	1	2
With paying customers	2	1	2	3
Unknown/no indication	62	23	18	28
Total number of confirmed cases	273	100	63	100
Country of exposure				
Switzerland	146	54	30	48
Elsewhere	50	18	16	25
Switzerland and elsewhere	4	1	0	0
Unknown/no indication	73	27	17	27
Total number of confirmed cases	273	100	63	100

Table 5: Confirmed syphilis cases 2009, broken down by exposure and risk factor.

	2009			
	Men	%	Women	%
Stage				
Primary	118	43	14	22
Secondary	78	29	13	21
Early latent (<1 year)	16	6	8	13
Late latent (>1 year)	10	4	5	8
Unknown latency time	17	6	6	10
Tertiary	10	4	2	3
Congenital	3	1	2	3
Unknown	4	1	6	9
No indication	17	6	7	11
Total number of confirmed cases	273	100	63	100

Table 6: Confirmed syphilis cases 2009, broken down by infection stage.

Hepatitis B

Hepatitis B is an infectious inflammation of the liver, which is caused by the hepatitis B virus (HBV). The hepatitis B virus is easily transmitted through contact with the body fluids of infected persons (in particular blood and genital secretions), which may be through sexual intercourse and sharing unsterile injection syringes/needles and also through microscopic injuries of the skin or through the mucous membrane. It is possible for infected mothers to transmit the disease to their babies during birth. The clinical courses may be very different. In roughly one third of patients, the disease produces no symptoms, so it goes unnoticed. When hepatitis B appears in its classical form, non-specific general symptoms become evident between 45 and 180 days after infection, and these may include loss of appetite, nausea, vomiting and stomach ache and sometimes also painful joints, fever and skin rash. Jaundice does not always occur. In most cases, acute hepatitis B heals up completely. Fewer than 1% of sufferers die of the disease. In roughly 5–10% of the individuals who become infected as adults and around 90% of infants who are infected during birth, a chronic hepatitis B does, however, develop. This can lead to a liver cirrhosis or liver cancer. It is possible to treat a chronic infection with anti-retroviral drugs. As prevention against hepatitis B, vaccination is recommended for all young people and for particular risk groups. Safer sex, no sharing of unsterile syringes/needles and refraining from tattooing in countries where the disease is widespread in the population also reduce the risk of contracting the disease.

Acute hepatitis B notifications: The number of acute hepatitis B notifications has remained at a constant low level over the last five years of the evaluation (2003–2007). There has been virtually no shift over time in the breakdown by sex, and men are very much more widely affected by hepatitis B, with a proportion of approximately 75% (376 out of 500 cases over the period of time from 2003 to 2007, cf. Fig. 10).

In the breakdown of cases by age group, it is seen that nearly half the acute hepatitis B notifications (46%) concern individuals aged 40 years and more. By contrast, notifications concerning young age groups tend to be rather rare (cf. Fig. 11).[31]

[31] This development also reflects the introduction of the vaccination recommendation for adolescents. Between 1998 and 2002, all Swiss cantons began with the general hepatitis B vaccination of adolescents between the age of 11 and 15. (cf. Bundesamt für Gesundheit (2004) Hepatitis-B-Impfung von Adoleszenten in der Schweiz: Grosser Einfluss auf die Krankheitsinzidenz in dieser Altersgruppe.)

Acute hepatitis B, 2003–2007

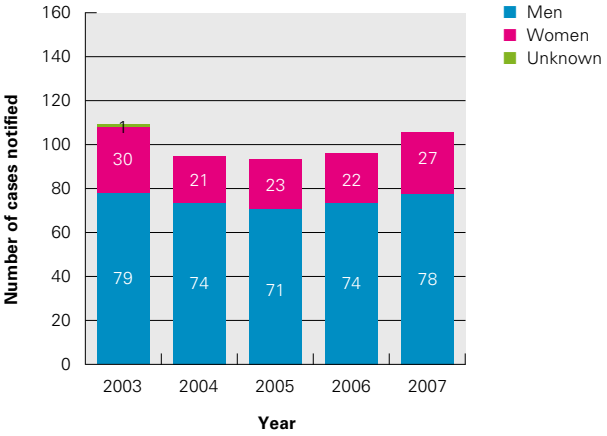


Figure 10: Notifications of acute hepatitis B between 2003 and 2007, broken down by gender.

Acute hepatitis B, 2003–2007 (total for both genders)

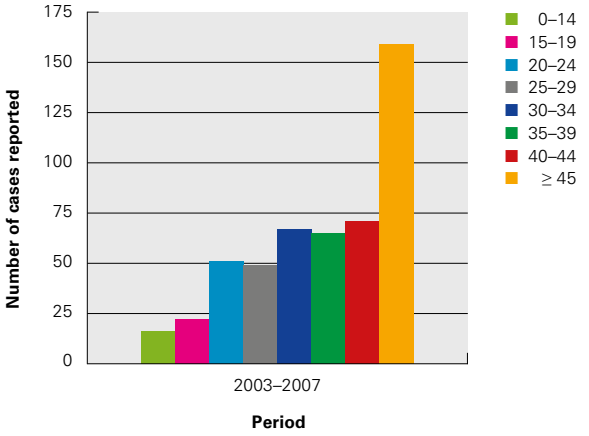


Figure 11: Notifications of acute hepatitis B between 2003 and 2007, broken down by age group for both genders.

Type of exposure

The proportion of acute hepatitis B infections that were transmitted sexually is around 45% for the period from 2003 to 2007. In terms of sexual preference, a good third of the acute infections during this period affected homosexual and bisexual individuals, whilst the other two thirds occurred in heterosexual relationships. Virtually no infections are due to exposure to sex workers or through working as sex workers (Table 7).

	2003–2007					
	Men		Women		Total	
Exposure	n	%	n	%	n	% (total)
Heterosexual	86	66	44	34	130	66
Homosexual or bisexual	63	98	1	2	64	32
With sex workers	0	0	1	0	1	1
As sex workers	1	100	0	0	1	1
Total	150	76	46	23	196	100
Transmitted through sexual contacts	174	79	47	21	221	45

Table 7: Type of exposure, hepatitis B.

Hepatitis C

Hepatitis C is also an infectious inflammation of the liver caused by the hepatitis C virus (HCV). Given that this pathogen is transmitted primarily through the blood of infected individuals, the danger of an infection exists above all with the shared use of injection syringes, with medical interventions using inadequately sterilised instruments, with tattooing and piercing interventions with unsterile instruments or with injuries caused by these. Another possible source of infection is blood transfusions in countries in which the blood from donors is not tested for antibodies. Sexual transmission of the virus is possible. The greatest cause for concern with HCV is the group of injecting drug users, since 60–80% of the cases are ascribed to the injection of drugs. Specialists draw attention to the fact that access to treatment is still inadequate.[32]

Clinical courses vary very considerably. The infection often produces no symptoms and is thus not noticed at all. Some sufferers display various symptoms after 6–9 weeks (and up to 6 months), such as loss of appetite, nausea, vomiting and sometimes painful joints, fever and skin rash. Some 5–10% of those infected suffer jaundice, with a yellowing of the skin, mucous membrane and eyes, dark-coloured urine and a light-coloured stool. In 20–30% of those affected, acute hepatitis C heals entirely. In approximately 70%–80%, however, a chronic infection develops, with the risk of developing a liver cirrhosis or liver cancer. No vaccination exists against hepatitis C.

Acute hepatitis C notifications: The number of acute hepatitis C notifications has been decreasing continuously since 2004. The male proportion is high, at around 66% (178 out of 268 cases between 2004 and 2007, Fig. 12). In the breakdown of cases by age group, there is a marked peak of acute hepatitis C infections especially in the age groups between 20 and 34 years and the over-45s (Fig. 13).

[32] Jeannin et al. (2010) System of accompaniment for the strategy for combating HIV/AIDS in Switzerland: Summary report for 2004–2008.

Acute hepatitis C, 2004–2007

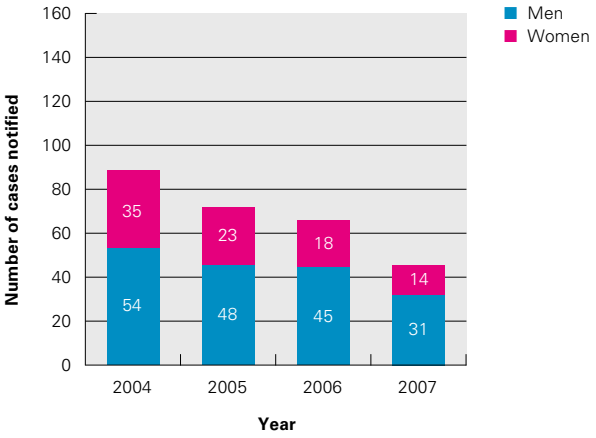


Figure 12: Notifications of acute hepatitis C between 2004 and 2007, broken down by gender.

Acute hepatitis C, 2004–2007 (total for both genders)

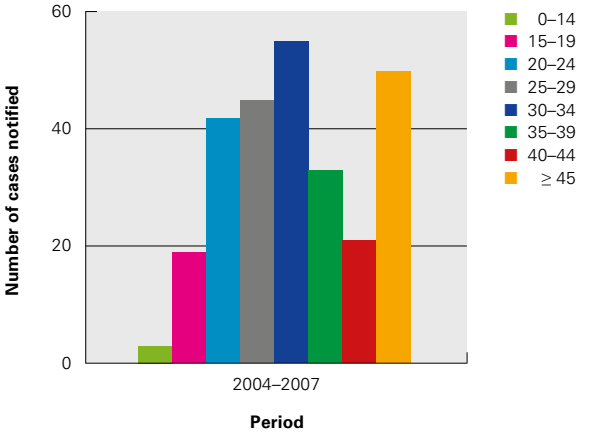


Figure 13: Notifications of acute hepatitis C between 2004 and 2007, broken down by age group for both genders.

Type of exposure: An overview for the time stretching from 2003 to 2007 shows clearly that acute hepatitis C cases affect predominantly IDU. More than half the notifications (53%) are ascribed to the intravenous consumption of drugs. The proportion of sexually transmitted hepatitis C infections is surprisingly high and stands at 19% for this same period of time (see Table 8).

	2003–2007					
	Men		Women		Total	
Exposure	n	%	n	%	n	% (total)
Professional exposure (medical professions)	3	43	4	57	7	2
Transfusion	1	17	5	83	6	2
Dialysis	6	50	6	50	12	4
IDU	110	68	51	32	161	53
Sexual contacts	30	52	28	48	58	19
Other contacts	9	64	5	36	14	5
Other exposure	15	88	2	12	17	6
Unknown (explicit)	22	79	6	21	28	9
Total	196	65	107	35	303	100

Table 8: Type of exposure, hepatitis C.

4.2.2 STI IN EUROPE

Generally speaking, the number of new diagnoses of chlamydia, gonorrhoea and syphilis has increased perceptibly in several European countries in the course of the past ten years. However, not all of these STI are subject to obligatory notification in all European countries. Another factor is that the surveillance systems are different in the various European countries. They are based, inter alia, on voluntary or obligatory declarations, on laboratory notification systems, on reports from ↘sentinel networks, on prevalence studies and on other sources as well. It is thus difficult to compare countries with one another, given the different notification systems, the variety of diagnostic methods and the differences in the health services organised in each of them. The incidence and prevalence rates of each of the countries are not known with precision.

Despite that, the most recent edition of the European Centre for Disease Control's "Annual epidemiological report on communicable diseases in Europe" (2009)[33] does contain comprehensive information regarding the epidemiological situation of STI in 2007. The following are the conclusions drawn from the analysis of the data from some thirty or so countries:

- Chlamydia infections are the most widespread sexually transmitted infections with bacterial pathogens in Europe. As in Switzerland, chlamydia infections are diagnosed above all amongst young women aged between 15 and 24.

- In three-quarters of the cases (73%), gonorrhoea diagnoses affect men. The number of diagnoses is tending to increase amongst men who have sex with men. Most diagnoses concerning men are established in the 15 to 44 age bracket, whereas the age bracket most concerned among women is 15 to 24 years. This breakdown as regards genders and age was similarly observed in Switzerland between 2006 and 2009 (albeit with minor differences).

- Syphilis too is diagnosed in men in approximately three quarters of all cases, especially in the 25 to 44 age bracket. As with the other STI, the situation in Switzerland is similar to that in other European countries.

[33] ECDC (European Centre for Disease Prevention and Control) Annual Epidemiological report on communicable diseases in Europe 2009. www.ecdc.europa.eu

5 BEHAVIOURAL SURVEILLANCE: AN OVERVIEW OF THE INDIVIDUAL POPULATION GROUPS

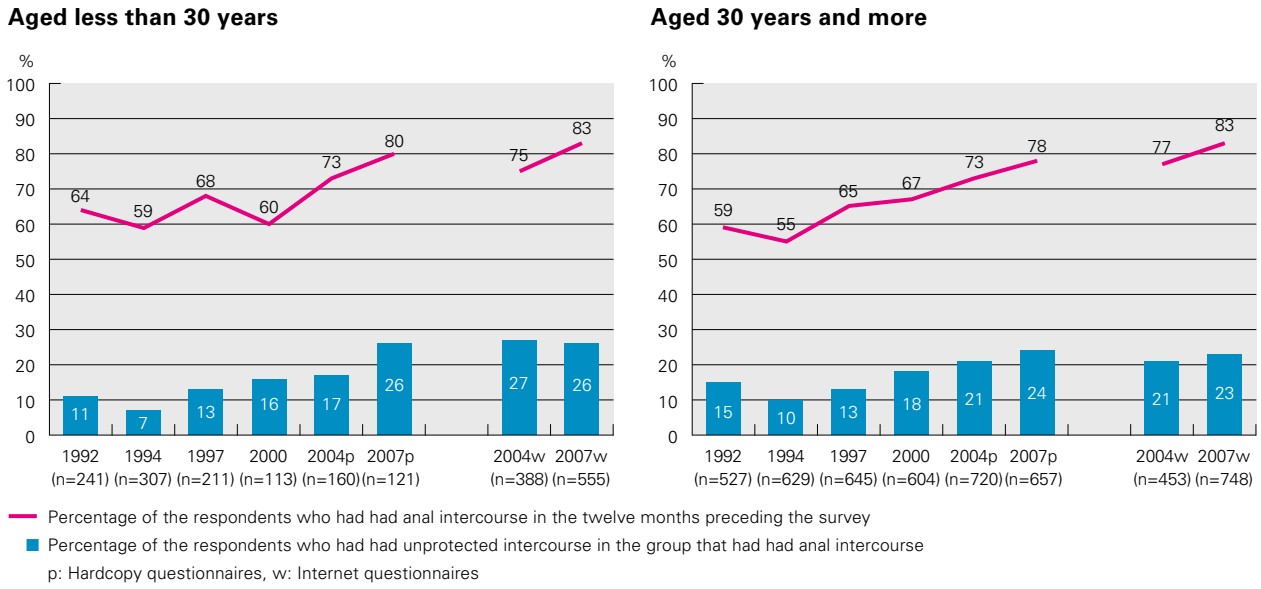


Figure 1: Proportion (percentage) of the respondents who had had anal intercourse with one or more *casual partners* in the course of the preceding twelve months and proportion of the respondents in this group who had had unprotected intercourse.

In addition to the epidemiological surveillance of HIV and other STI, Switzerland also has a system for monitoring behaviour in the form of a ↘second-generation surveillance system (cf. chapter on evidence). The IUMSP (University Institute of Social and Preventive Medicine in Lausanne) has drawn up a summary report for the 2004–2008 period under contract from the FOPH[34]. The report summarises the analyses that were carried out within the population groups affected. It provides an overview of the protective behaviour of the individual population groups up to and including the year 2008 and points to trends that are of importance for future efforts in the areas of HIV and STI. This chapter gives an overview of the most important results.

Men who have sex with men (MSM)

The majority of MSM continue to protect themselves against HIV. According to the IUMSP, however, there are signs of a certain lapse in protective behaviour over the period from 2004 to 2008.

Protective behaviour with casual partners: The number of sexual partners of the MSM remained stable between 2004 and 2007. Since the mid-1990s, however, there has been a regular increase in the proportion of those interviewed who state that they do not use a condom consistently when having anal intercourse with casual partners. The figure went up from 8.9% in 1994 to 24.2% in 2007 (mean figure for all age classes). No differences, or practically no differences, will be ascertained between young respondents (aged less than 30) and older ones (Fig. 1).

The use of condoms during casual contacts is influenced more or less strongly by what the respondents know about their partner (or what they believe they know about him). The readiness to indulge in unprotected sexual intercourse is greater if a man knows his partner well or is in love with him. It generally appears that the trust placed in the partner plays a central determining role in handling the risks in contact with casual partners. From the point of view of prevention, this trust manifestly represents a risk factor, since the partners in a casual sexual relationship are bound to have only incomplete information about one another.

[34] Jeannin et. al (2010) System of accompaniment for the strategy for combating HIV/AIDS in Switzerland: Summary report 2004–2008

Total

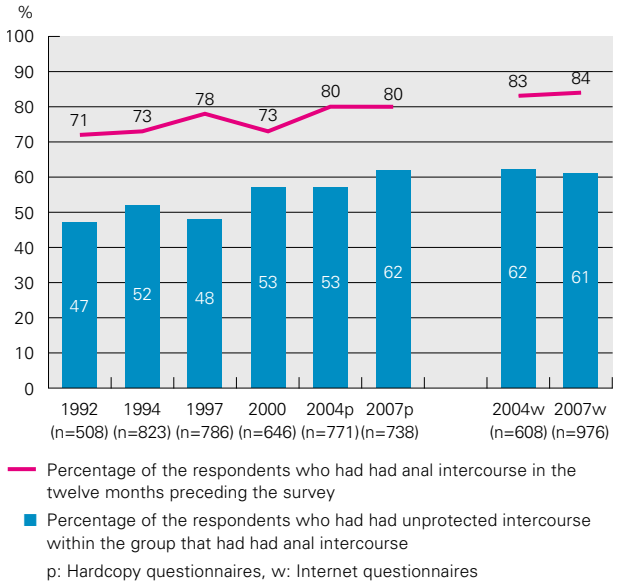


Figure 2: Proportion of the respondents who had had anal intercourse with their *steady partner* in the preceding twelve months and proportion of the respondents in this group who had had unprotected intercourse (percentages).

Prevention in steady relationships: In steady relationships amongst MSM the use of condoms has been declining since 2000. However, condoms were never very widespread in this segment, since other possibilities are available for use within couples for preventing infection with HIV (HIV test at the beginning of the relationship, mutual arrangements, and so on). The proportion of the respondents who do *not* systematically use a condom within a steady partnership has increased noticeably since the end of the 1990s. In 2007, 62% of the respondents did not, whereas the corresponding figure ten years earlier had been lower at 48% (Fig. 2). A high percentage of the couples (almost 40%) are not fully informed of the ↘sero status of their partner (or partners). Approximately one couple in six does not use condoms, although their circumstances are such that there is a risk of HIV transmission. Since this proportion has hardly declined within recent years, ensuring prevention within steady relationships still remains a major challenge.

In the analyses of risk exposure, social-stratification variables were considered amongst the risk factors (for the first time included in the history of the survey). MSM of a nationality other than Swiss and MSM who had had no post-compulsory education tend to expose themselves more to a risk of transmission. One factor leading to enhanced protective behaviour seems to be membership of a homosexual organisation.

It must be recorded as a fact that HIV infection correlates strongly with the decision not to use condoms – both in the setting of casual contacts and in intercourse with partners with a varying or unknown sero status. Such a conclusion is of itself nothing new, but it must be stressed that the majority of HIV-positive MSM do use condoms with their sexual partners.

Most of the MSM who had unprotected anal intercourse with casual partners applied alternative strategies whose effectiveness is still uncertain or even unknown.[35]

Migrants from countries with generalised epidemics

In this population, the greatest need for interventions is amongst immigrants from sub-Saharan Africa. The number of new infections amongst individuals from Africa south of the Sahara is still very high, especially considering that only a small group of people from this region live in Switzerland. Concordant information confirm that risk behaviour exists within this group. It is possible that access to prevention is inadequate, and the same applies to access to testing. As far as other migrant groups are concerned, there is nothing in the available data suggesting the existence of large gaps in prevention (apart from a number of countries with generalised epidemics in the Caribbean, and Central American and South American region; cf. "Epidemiology of HIV" section of this programme). One possible exception is formed by individuals with an uncertain residence status.[36]

Injecting drug users (IDU)

Amongst IDU, the situation as regards HIV is more encouraging. There are only a few new cases, and sharing syringes is rare. The provision of sterile injection material seems to be functioning well.

Despite that, problems still persist. As the high prevalence of abscesses shows, injection hygiene remains inadequate, and the extent of the risks taken by those in prison ought not to be underestimated. No information is available on the provision of injection material or disinfectants.

The biggest cause for concern is HCV (cf. Annex 15.4 with the detailed overview of the public-health-relevant STI).[37]

[35] Jeannin et al. (2010) System of accompaniment for the strategy for combating HIV/AIDS in Switzerland: Summary report for 2004–2008.

[36] Ibid.

[37] Ibid.

Sex workers (female and male)

In Switzerland, no direct data is available on the preventive behaviour of sex workers – unless they are also drug users and are hence covered by the surveillance in that field. The indirect data collected from specialists and those who pay for sex tends to agree that condoms are usually used in vaginal and anal sexual intercourse. Women with additional vulnerabilities such as drug dependency, illegal residence status or subjected to severe pressure of competition are probably less systematic in protecting themselves.

A very high proportion of the female IDU who are sex workers do protect themselves in contacts with paying customers; protection is, however, less widespread amongst male IDU who also are sex workers.

MSM who are sex workers face a more extensive risk of STI than do the other MSM. The paying customers of male sex workers frequently protect themselves with condoms when having anal intercourse, but not when having oral intercourse (Fig. 3).[38]

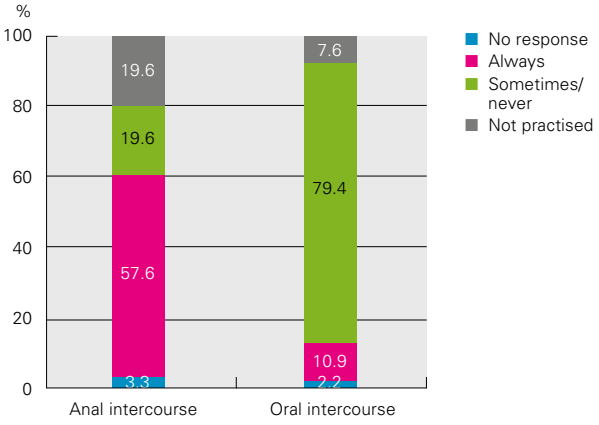


Figure 3: Use of condoms during sexual intercourse with male sex workers, gay survey 2007.

People with HIV

In 2008, nearly three-quarters of those who participated in the ↘Swiss HIV Cohort Study (SHCS) had had sexual intercourse with a steady partner in the course of the preceding six months. This proportion was lower than it had been in 2007. The decline is to be observed in both men and women, in all transmission groups and independently of the partner's status. Amongst these individuals the proportion making systematic use of condoms has also declined. In 2007 it had been 77.0% and fell to 72.0% in 2008.

In the case of ↘sero-different couples, protective behaviour was more predominant. Here, 84% of positive individuals with a negative steady partner (male or female) systematically used a condom (Fig. 4).

The proportion of the participants in the SHCS who had had penetrative sexual intercourse with casual partners in the course of the preceding six months has remained stable in aggregate terms. In this group too, there has been a decrease in the proportion of individuals using a condom systematically in these circumstances. In 2008, the overall figure was 80.2% (2007: 85.1%). Most of this decline is accounted for by men and, in particular, by those men who had been infected through a homosexual sexual contact.

The data from the 2007 gay survey also shows that amongst the HIV-positive respondents the frequency of unprotected anal intercourse with casual partners (but not, however, with their steady partner) had increased (cf. section on MSM).[39]

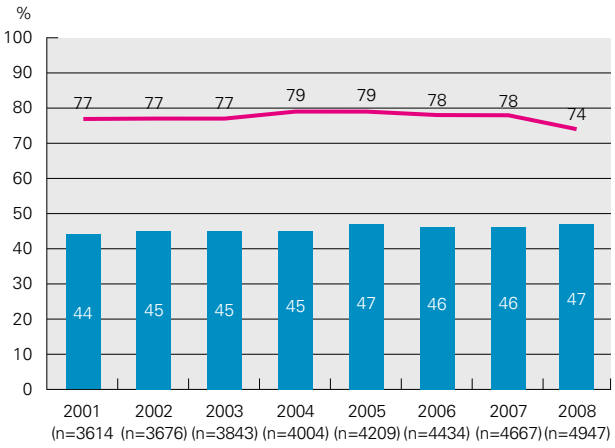
Amongst the IDUs, 7% of the HIV-positive individuals in 2006 indicated that they had passed a used syringe on to someone else in the course of the preceding six months (Fig. 5).[40]

[38] Jeannin et al. (2010) System of accompaniment for the strategy for combating HIV/AIDS in Switzerland: Summary report for 2004–2008.

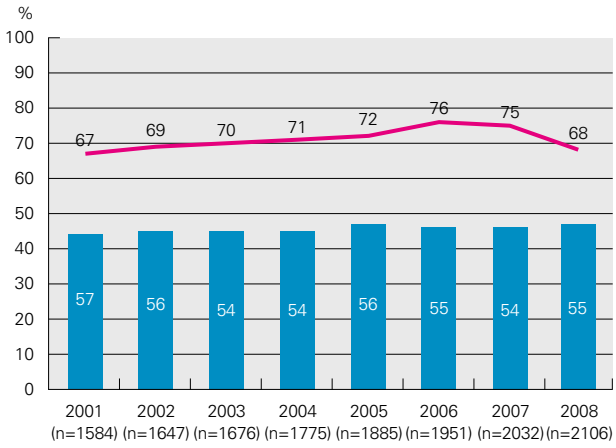
[39] Lociciro et al. (2010) Les comportements face au VIH/SIDA des hommes qui ont des relations sexuelles avec des hommes. Résultats de Gaysurvey 2009. Raisons de santé 163

[40] Jeannin et al. (2010) System of accompaniment for the strategy for combating HIV/AIDS in Switzerland: Summary report for 2004–2008

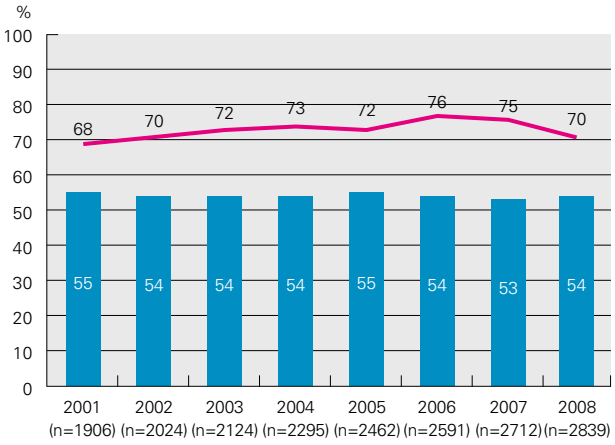
Men



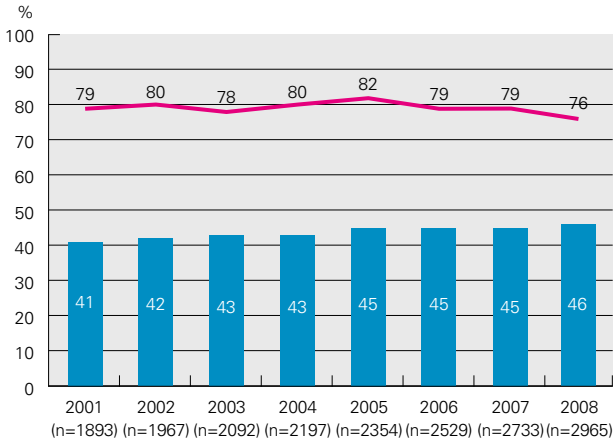
Women



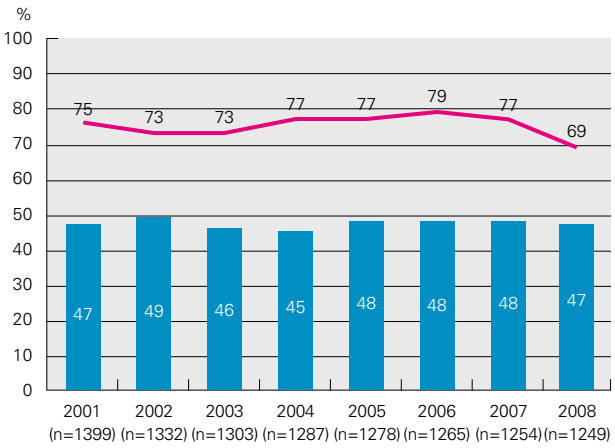
Heterosexuals



MSM



IDU



Total

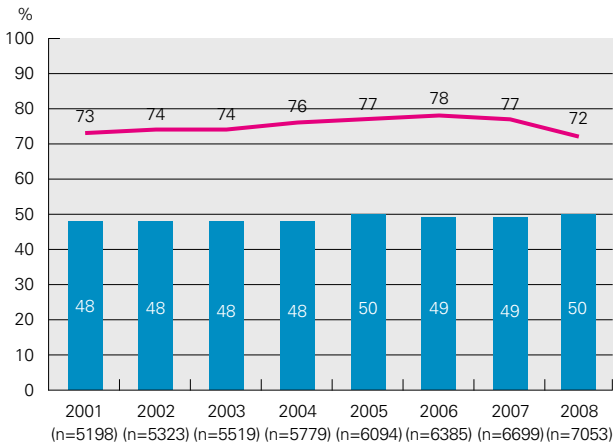


Figure 4: Patients participating in the SHCS who had had sexual intercourse *with a steady partner* in the course of the preceding six months; broken down into various patient groups (blue histograms). The red line indicates the systematic use of a condom with this partner.

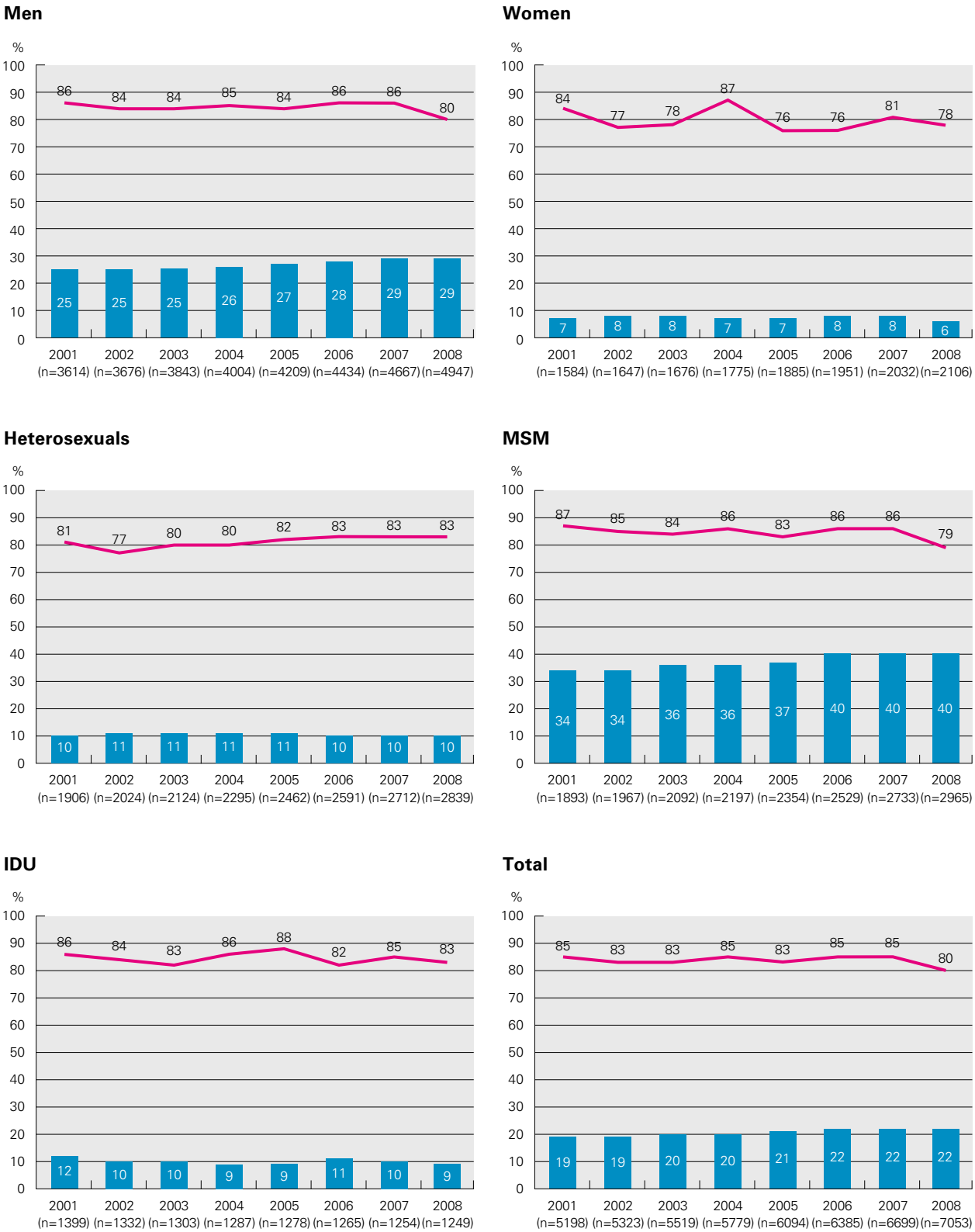


Figure 5: Patients participating in the SHCS who had had sexual intercourse *with one or several casual partners* in the course of the preceding six months, broken down into various patient groups (blue histograms). The red line indicates the systematic use of condoms with this partner.

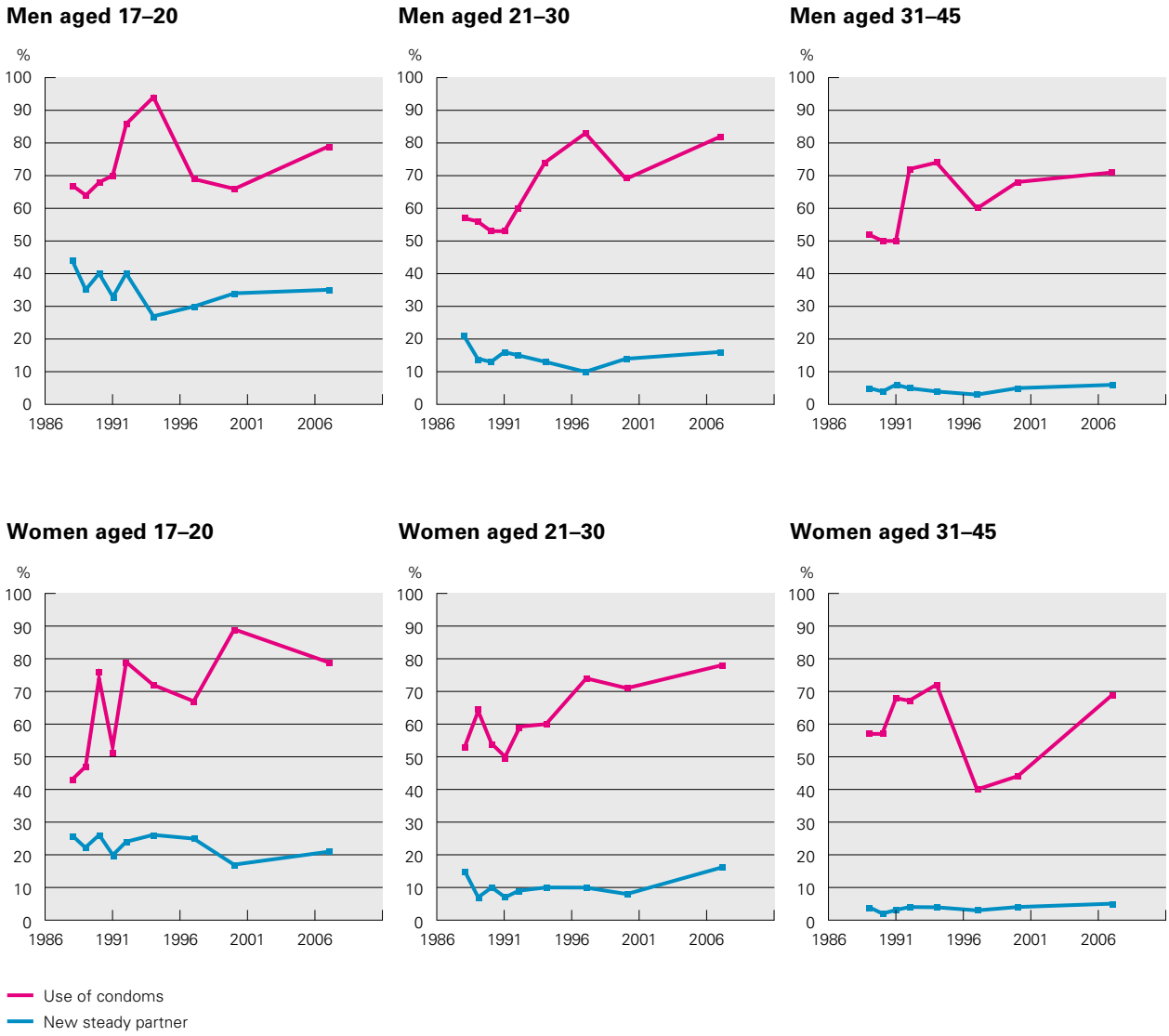


Figure 6: New *steady partner* in the course of the year and use of condoms with this partner at least to begin with. Proportion of respondents, broken down by sex and age.

Population at large and young people

In the age range 17-to-45-year-olds, the use of condoms was widespread in 2007 in all age and gender groups, at least at the beginning of a new relationship, and reached a high proportion in the range of 60–80% (Fig. 6).

Figure 7: Respondents with at least one *casual partner* in the preceding six months and proportion of these using condoms systematically with these casual partners – broken down by sex and age.

Taking the population as a whole and the age range from 17–45, encouragingly high values are still being recorded for the systematic use of condoms with casual partners, particularly among young people (90% amongst men between 17 and 20 and 80% amongst women in the same range). As people grow older (age range of 46 to 74) a clear decline is to be observed in condom use in risk situations (new partners and casual partners). This effect is more pronounced amongst the women than the men (Fig. 7).

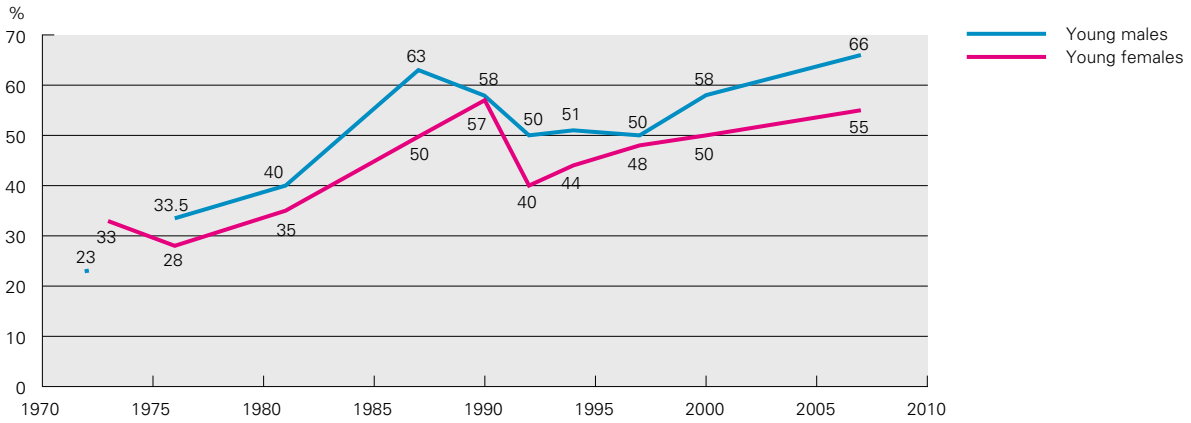


Figure 8: Proportion of the 17–20-year-olds who are sexually active at the age of 17.

Test rate: The proportion of individuals who have arranged for at least one HIV test to be performed on them in the course of their lives (apart from tests associated with blood donations) have increased over time. In 2007, it was 53% of the men in the 31–45 age bracket and 62% of women for this same age group. Some 10% of the age range 31–45-years had undergone a test in the preceding twelve months. Testing is less widespread amongst those aged 46 and more, even amongst those engaging in risky behaviour.

Sexual activity amongst young people: Amongst young people, the proportion of the respondents who are sexually active at a given age is continuing to increase. At the age of 17, roughly two thirds of males are sexually active and one female in two.
Some 80% of those aged 17–20 indicate that they use contraception. Most men use a condom and most women the pill.

↘Sexual health education in schools is of different intensities. A vast majority of adolescents had the opportunity while at school to talk about sexuality and/or HIV/AIDS. There are only minor differences between Switzerland's language regions. More than eight out of ten of the school pupils questioned had received information about the contact points and advice centres that are available for questions to do with sexuality. Only two-thirds, however, had had the HIV test discussed with them, and only roughly half of all the school pupils questioned had tackled the subject of homosexuality. Despite the obvious potential for improvement, three out of four of the school pupils state that they are satisfied with the information received through school.[41]

[41] Jeannin et al. (2010) System of accompaniment for the strategy for combating HIV/AIDS in Switzerland: Summary report for 2004–2008.

6 HIGH RATES OF INFECTION DESPITE COMMITTED EFFORTS AGAINST HIV

In recent decades, Switzerland has gained international recognition on account of its innovative HIV policy. Its amusing STOP-AIDS campaigns, closely mirroring reality, have won prizes in international competitions on numerous occasions. Its projects for specific target groups (such as Afrimedia) have served – and are still serving – as models of best practice. The practice of issuing sterile syringes as the most important means of containing the transmission of infection amongst injecting drug users set off passionate debates in the whole of Europe and is being copied in many countries.

Despite this committed efforts, Switzerland has one of the highest rates of new HIV diagnoses compared with the rest of Western Europe. What is the explanation for that?

In the context of a study organised by the Swiss National Science Foundation[42] researchers working on the Swiss HIV Cohort Study have reconstructed at molecular level how the AIDS pathogen, HIV, has spread in Switzerland over the last thirty years. They arrived at the finding that the reason for the spread of the epidemic are clearly the infection chains amongst homosexuals, on the one hand, and injecting drug users, on the other hand, as well as infections contracted abroad. Whereas infections between homosexual men and injecting drug users used to be rare, the infection of heterosexuals by IDUs was very frequent, especially in the early 1980s. An important role in this was played by drug-related sex work.

Consequently, the explanation for the relatively high HIV prevalence in Switzerland is to be sought in analysing the beginning of the epidemic in Switzerland: the accumulation of three negative circumstances led to an intense spread of the contamination right from the very beginning.

1. In Switzerland, a large community of homosexual men already existed back in the 1970s and 1980s. Thanks to Switzerland's economic prosperity, many of these men were able to afford to travel to the USA, where they fostered relationships with that country's gay community. One of the results of this was that HIV prevalence amongst homosexual men in Switzerland quickly became higher than in other Western European countries (such as Germany), where exchanges between domestic homosexuals and the gay scene in the USA were less intense. Currently, the situation in the MSM population group has become comparable with that in the northern countries of Western Europe.
2. The intravenous taking of drugs used to represent a massive problem in Switzerland in the 1980s and 1990s – and prosperity is likely, in the final analysis, to have played a part in that too. Given the habit that injecting drug users had to share their injection equipment, HIV was able to spread rapidly and effectively within this population. A lasting improvement in the situation was only achieved with the distribution of clean syringes, as evidenced in the study organised by the Swiss National Science Foundation referred to above. Thanks to the practice of distributing sterile syringes to drug users, which was launched in 1986, it proved possible to contain the epidemic amongst those. One consequence of this was that fewer heterosexual individuals became infected with HIV.
3. Switzerland is a country of immigration, and many immigrants from sub-Saharan Africa have settled down especially in the French-speaking part of the country. This migrant population, originating in a region with a generalised epidemic, is likely to have reflected the prevalence in their countries of origin which is higher than in the Swiss population.

The starting situation just described might also have been one of the factors contributing to individuals in Switzerland having themselves tested more frequently than in most countries. With more than 300,000 tests a year, the rate has remained high through.

The analysis shows that Switzerland was affected by three different concentrated epidemics simultaneously from the very beginning – and that has remained the case through to the present. A country that already has a comparatively high prevalence at the beginning of the epidemic then faces difficult conditions when it comes to engaging with HIV.

The situation was rendered even tougher in Switzerland's case as a drastic reduction was made in the prevention resources at the end of the 1990s (the Confederation's prevention appropriation still was at 16 million Swiss francs in 1994, but was trimmed to 10 million Swiss francs by 2000). The effects of the budgetary cuts were that the prevention efforts became less visible, and it was no longer possible to sensitise the population as a whole and the target groups to the same extent as before. In parallel with this, HIV lost its immediate life-threatening character with the emergence of the anti-retroviral treatments from 1996 onwards. This combination of facts is likely to have contributed to the renewed increase in the number of new HIV diagnoses in the following period (from 2000 onwards).

[42] Kouyios et al. (2010) Molecular Epidemiology Reveals Long-Term Changes in HIV Type 1 Subtype B Transmission in Switzerland, cf. Annex 15.5.

The adoption of the national HIV/AIDS programme in 2003 led to successes in once again stabilising the number of infections, in continuing to prevent the spread of HIV throughout the population at large and in increasing the awareness of the target groups.

The objective of the current programme is to decrease infection rates. The number of new diagnoses of HIV and STI subject to obligatory notification (syphilis, gonorrhoea, Chlamydia trachomatis, hepatitis B and hepatitis C) will be halved within the next seven years (and the indicator for this will be the number of diagnoses in 2017 compared with 2010). In order to achieve this, prevention measures that have proved successful so far will be continued, such as the ↘harm reduction programme for IDU, the sensitisation campaigns for the population as a whole, the sexual health education in schools and the activities for specific target groups. The latter will be given greater weight and be more sharply focused on the vulnerable population groups. That means that more ought to be done as regards highly specific projects for sexually active MSM, for instance in the places that they frequent. There is also to be a reinforcement of consumer friendly projects with low barriers access for male and female sex workers or for particularly affected immigrant groups. The most important innovations in the new programme are the combined action to prevent HIV and STI and the use of diagnosis and treatment as an instrument of prevention.

7 PREVENTION WORK FACING NEW CHALLENGES

In Switzerland, HIV has lost its particular status as a deadly infection with a menacing potential to spread. Epidemiologically, HIV is to some extent under control (at least in the general population in Switzerland), and medically the mastery of it is improving all the time. HIV-positive individuals undergoing consistent treatment are *de facto* no longer infectious, providing that they are suffering from no other STI[43] – and they can have a nearly normal life expectancy. Even AIDS is no longer synonymous with a rapidly approaching death and, with the administration of anti-retroviral and other medicines, it can usually be kept under control. This development represents new challenges for prevention work.

Main points and keynotes of the new programme

As the threat of an impending and inevitable death no longer exists, the current efforts are aimed at convincing the entire population in Switzerland to protect themselves against HIV and other sexually transmitted infections. Sexual health is an important element in a satisfying sexual life and vice versa. It thus plays a major role in the physical, emotional and psychological sense of well-being. This recognition needs to become second nature to the general population. For people to be capable of shouldering responsibility for their own sexual health, they have to know that fundamental rights are applicable in the field of sexuality, such as the right of freedom from bodily harm or the right of self determination and consent. They must also be informed of the prevention and care services offered and must have access to them. The new programme is thus setting out to improve the awareness of rights in the field of sexual health.

Its second emphasis is on primary prevention in population groups that are particularly affected by HIV and/or other sexually transmitted infections: "Put the effort where the virus is" was the advice of an expert panel under the leadership of Rolf Rosenbrock, Public Health Professor in Berlin, which evaluated HIV-work in Switzerland[44]. This means that prevention ought therefore to take place primarily in the context of these groups or individuals: where they live and socialize, and where prevention interventions are particularly worthwhile because of high prevalence. The NPHS puts this recommendation into practice.

Medical progress has a further implication for prevention: the early detection of an infection and the correct treatment of it have gained importance for public health. The Swiss National AIDS Commission specified in its statement that people whose HIV infection has been detected and consistently treated are no longer infectious, provided that they are suffering from no other STI[45]. The transmission chain is thus broken. The strategy being practised at present aims at detecting infections earlier and improving the quality of treatments and compliance with them.

The National Programme on HIV and other Sexually Transmitted Infections 2011–2017 is based on the following leitmotif:

- Prevent (whatever can be simply and efficiently prevented),
- Vaccinate (where vaccinations exist and are recommended),
- Detect early, and
- Treat correctly at the optimum time

The promotion of ↘partner information is essential in this respect:[46] Infected individuals ought as a general rule to inform their permanent partner and their sexual partners themselves or avail themselves of the anonymous partner information services provided by an institution.[47] Partner information must, however, be based on a consent. The informed partners are motivated to undergo the corresponding tests and, where appropriate, to take up treatment rapidly in order to avoid recurrent infections.

[43] On 30 January 2008, the Swiss National AIDS Commission (EKAF) published the following statement in a specialist medical journal, the "Schweizerische Ärztezeitung" (SAEZ): "The Swiss AIDS Commission considering the query addressed to it by the Swiss Federal Office of Public Health's Special Committee on HIV/AIDS Clinics and Therapies and after taking note of the scientific facts and discussing the matter in depth, is of the view that a person infected with HIV, but no other STD, and undergoing anti-retroviral therapy (ART) with a completely suppressed viremia (referred to hereinafter as "effective ART"), is not sexually infectious, i.e. he or she does not pass on the HI virus through sexual contacts, provided the following conditions are met:
– the anti-retroviral therapy (ART) is scrupulously followed by the person affected with HIV and is verified by the doctor providing the treatment;
– the virus load (VL) has been below the detection level for at least six months (i.e. viremia has been suppressed);
– there are no infections with other sexually transmitted pathogens (STDs)."

[44] Rosenbrock et al.: Review of the Swiss HIV Policy by a Panel of International Experts

[45] Statement of the Swiss National AIDS Commission (EKAF) of 30 January 2008 in the specialist medical journal "Schweizerische Ärztezeitung"

[46] The use of the term "partner information" instead of the internationally used term "partner notification" is deliberate and stresses the voluntary nature. Partner information can only be provided if the infected person is in agreement with it, in other words in line with the principle of informed consent. The reason for this is that in a highly sensitive, taboo-ridden area like sexuality and HIV/STI, coercion is the wrong means of achieving sustainable prevention. On the contrary, what is at stake is the creation of understanding within society for partner information – a culture in which partner information is regarded as matter-of-course and beneficial.

[47] Legal responsibility for providing information on one's HIV status prior to unprotected sexual intercourse fundamentally rests with the HIV-positive partner. The latter has to bear the consequences under criminal and civil law in the event of their not informing their partner. Responsible behaviour additionally requires an HIV-positive person to inform the sexual partners with whom they had unprotected sexual intercourse prior to the diagnosis. Providing support for the patient in informing their current and (where relevant) earlier sexual partner(s) of their positive serostatus is doubtless permitted from the legal point of view, and is even essential with regard to the obligation of care towards the patient (information on the criminal consequences of not providing this information). (See also Annex, Chapter 15.6.)

Learning strategy still remains valid

The described development could prompt the question as to whether the learning strategy pursued to date has been overtaken by events and ought to be replaced by an epidemic strategy including screening (in certain target groups for example) and the obligatory notification of partners. The classic epidemic strategy is driven by the answer to the key question: "how can we detect the largest possible number of infection sources as quickly as possible, and how can we prevent further infections?" The learning strategy, by contrast, provides answers to the question: "how can we organise learning processes as quickly as possible through which individuals, social groups and society at large will adopt preventive behaviour and learn to live with pathogens, which it will not be possible to eradicate for the foreseeable future, without discriminating against those affected?"

The basis of the learning strategy is its voluntary nature, and it is still valid despite the increased importance of early diagnosis for HIV. In such an intimate matter and one shrouded in taboos like sexuality, coercive measures ordered by the authorities (as envisaged in the epidemic strategy) run the risk of blocking the prevention that it is their intention to encourage. Anyone afraid of having their status compulsorily disclosed to all their sexual partners in the event of a positive diagnosis will do all they can to resist a test, will find ways of avoiding being screened and will undermine partner information instead of supporting it. Anyone in this situation is hardly likely to consult a recognised medical practitioner (even if he or she suspects an infection) and is likely to self-medicate. Effective prevention in the sensitive matter of sexual health can only function on a voluntary basis, through the tried-and-trusted principle of informed consent. What is important as a cross-cutting task for this programme is the unflagging commitment to eradicate the ↘stigmatisation and discrimination of infected individuals.

Meticulous surveillance of the HIV and STI epidemics is the key underlying factor for preventive efforts to be effective. This is one point of focus for the new programme, as it provides for the development of a model for the ↘third-generation surveillance of HIV and STI. This new surveillance model takes biological surveillance in the STI field further and closes gaps in behavioural surveillance. It combines the findings of HIV and STI surveillance. In addition, it incorporates the continuous monitoring of the various prevention measures (including cost/benefit analysis) creating the possibility for evidence-based policy making to be practised in future.

7.1 PREVENTION REQUIRES PARTICIPATION AND IS AIMED AT EMPOWERMENT

The prevention of HIV and other Sexually Transmitted Infections must reach people who are at particular risk – either because there is an increased prevalence of HIV and other STI in their group or because it is more difficult for them to maintain their health. The aim of all the efforts is to empower them so they can acquire the necessary competence to take their own decisions in matters of health, and influence their own health. The barriers to self-determination must be removed. In line with the federal strategy on "Migration and Health 2008–2013", the preventive interventions postulated in this programme are aimed at ↘empowerment of the target groups which are at risk; they thus set out to promote equal opportunities.

The majority of migrants are at above-average risk in the sense described above. This is due, firstly, to the fact that certain migrant groups have an increased prevalence of HIV and/or STI (such as people from sub-Saharan Africa) and, secondly, to the migration context having an unfavourable impact on health and health behaviour. The FOPH's health monitoring of Switzerland's migrant population[48] showed that the majority of migrants feel themselves to be less healthy and frequently do less for their health (e.g. engage in less sport) than the Swiss. This is also often related to the fact that many of them belong to socially disadvantaged social strata. In addition to this, language barriers and uncertainties regarding their residential status can considerably hinder access to health services.

[48] Bundesamt für Gesundheit (2007): Wie gesund sind Migrantinnen und Migranten? Die wichtigsten Ergebnisse des "Gesundheitsmonitoring der schweizerischen Migrationsbevölkerung"

Migrants from the sub-Saharan region are particularly vulnerable

The risks described are all found amongst migrants from sub-Saharan Africa, therfore particular attention still needs to be paid to this group. The sub-Saharan region is the region most affected by HIV/AIDS: two-thirds (67%) of those infected with HIV globally come from there. Over the past five years, migrants from the sub-Saharan region have accounted for between 16 and 23% of the newly diagnosed cases of HIV in Switzerland; the main transmission route in this group is via heterosexual contacts. At the same time, the subject of HIV and sexual health overall is still taboo in many African communities, as well as in others. The HIV infection is thus subject to stigmatisation, and those infected with HIV run the risk of being discriminated against and excluded from social groups. This leads to a number of those concerned keeping their infection secret, due to the threat of isolation. This, in turn, increases the risk of their partners becoming infected. And it is also more difficult to reach those concerned with medical services or psychosocial support.

The transcultural approach

In designing and implementing services for different migrant groups, it is essential to make allowance for the large range of migration-specific influences and also the complex composition of the migrant population and their many different demands. This is best done by adopting the transcultural approach. The transcultural approach assumes that cultural systems are in a constant state of change and that there are no self-contained cultural circles[49]. This approach does not focus on the differences but on the shared characteristics of people with different backgrounds. Transposed to the promotion of health, this means that prevention projects and models have to be designed in such a way that they correspond to the needs of migrant groups at all times, or can be adapted to these needs. The migrant population should thus not only benefit from specific interventions but should also be key stakeholder when elaborating prevention strategies and messages. In parallel to this, specific efforts must be made, where necessary, in order to reach specific migrant populations.

In its position paper on *Migration Mainstreaming in the Health System,* the Swiss Federal Office of Public Health propagates the adoption of a dual strategy: on the one hand, horizontal equality of opportunities is to be aimed for – which means that the migrant population and the indigenous population can benefit from the same health services when they experience the same needs. On the other hand, vertical equality is to be achieved. This means that different needs also call for different health services. The migrant population should thus also benefit from specific health services tailored to their needs insofar as they have requirements that differ from those of the indigenous population.[50]

Coordinating messages and language with the migrants' needs

Migrants who were questioned about their needs in respect of prevention and health promotion expressed a wish to be contacted to a greater extent by the prevention centres and for the role of persons of trust to be reinforced[51]. They wished the written information to be aligned to their language needs and more use should be made of pictures instead of a large amount of text. ↘Contextual prevention activities were welcomed in these surveys. Anyone wishing to reach the individual migrant groups with prevention interventions must take statements of this kind seriously. As demonstrated by studies, relatives and friends are highly trusted when it comes to prevention efforts in the migrant population.[52] This is why an emphasis must be placed on efforts via the migrant groups' networks (organisations, associations) and via persons of trust (members of these organisations or facilitators). In addition to this, "key persons" can make it easier to access specific migrant groups and can be of major importance for prevention. These "key persons" can, firstly, be individuals who inform the experts in prevention and health promotion about the habits and needs of the migrants – such as intercultural facilitators who are firmly anchored in the target group. Secondly, "key persons" can be people who share information about health and prevention to the migrant groups – such as family doctors, pharmacists or intercultural facilitators. Experience has shown that, for a large number of migrants, the efforts of these "key persons" are most effective if the latter convey the information verbally and in an informal context. A good level of understanding is essential – both in individual consultations and at information events for entire groups.

[49] Bundesamt für Gesundheit (2007) Wie gesund sind Migrantinnen und Migranten? Die wichtigsten Ergebnisse des "Gesundheitsmonitoring der schweizerischen Migrationsbevölkerung"

[50] Bundesamt für Gesundheit (2008) Migration Mainstreaming im Gesundheitswesen

[51] Pfluger et al. (2009) Transkulturelle Prävention und Gesundheitsförderung in der Schweiz, Grundlagen und Empfehlungen

[52] (U.a.) Salis Gross (2010) Nachhaltigkeit bei Suchtausstieg und Prävention durch starke Beziehungen

At the level of communication, it is important to involve representatives of the target groups (in this case, specific migrant groups) in the activities. This is because information is only credible and behavioural advice is only convincing if it includes the context in which those being addressed are living. It is not enough to simply translate the written material used in a campaign; instead, it should be reconsidered, redesigned and, where possible, disseminated by persons of trust in consultation with members of the target group[53]. It is never just a matter of sharing information. It is equally important to ensure that the target group is capable of using this information too (health literacy): that the people being addressed establish the link to their own health, that they recognise the value and benefit of their own health and that they learn how they can maintain and promote their health. Projects in this field must always be aimed at improving the competence of the target group in respect of health, so that this group can influence their health in a self-determined manner. In line with the Migration and Health Strategy (2008–2013) adopted by the Federal Council in 2007, the present programme contributes "to the elimination of avoidable health disadvantages and thus improves the conditions for people with a migration background in Switzerland to have the same opportunity as the indigenous population to develop their health potential."[54]

Gender-specific prevention and empowerment

Women will be taken into account in particular for the empowerment described above. In many cases, women look into questions of health and health promotion more intensively than men, and hence they should be won over for prevention through provision of appropriate information. They can also be facilitators in their family environment.

It must be borne in mind that a large number of women living in Switzerland – and precisely those in migrant groups – do not enjoy equality with men in their socio-cultural environment, either because of traditional patriarchal structures in their homeland or because they are financially and otherwise dependent on their husband. This often means that they also do not have complete self-determination over their bodies and are thus not in such a good position to protect them against infections. Patriarchal structures also frequently require absolute fidelity on the part of the women, while the man is permitted to engage in a certain degree of promiscuity. Added to this comes the fact that women are more vulnerable to HIV or other Sexually Transmitted Infections during heterosexual intercourse than are the men who are involved. This is particularly so if ejaculation takes place in the woman's body.

Consequently, prevention efforts must take gender-specific aspects into account: prevention can only contribute towards equal opportunities if it promotes or guarantees equality and self-determination of women. The men must not simply be ignored in this process: value systems and behaviour patterns that count as specifically "masculine" are also the result of socialisation. Anyone wishing to change masculinity models that threaten sexual health is thus faced with a whole series of challenges which cannot be overcome without the direct inclusion of men.[55]
The concept of gender mainstreaming must also be applied in the same dimension as the concept of migration mainstreaming. This means that a gender-specific perspective must also always be adopted at all levels and in all phases of prevention projects. A check must be conducted on all projects to ensure that they promote the self-determination of women and to establish whether they are sufficiently focused on the empowerment of women. What has been said about migration mainstreaming also applies to gender mainstreaming: the concepts of horizontal and vertical equality are central to achieving equal opportunities for men and women in matters of health.[56]

[53] Pfluger et al. (2009) Transkulturelle Prävention und Gesundheitsförderung in der Schweiz, Grundlagen und Empfehlungen

[54] Bundesamt für Gesundheit (2007) Strategie Migration und Gesundheit (Phase II: 2008–2013)

[55] Spencer (2001) "Und Gott schuf die Geschlechter." Geschlechtsspezifische HIV-Prävention

[56] Institut für Sozial- und Präventivmedizin der Universität Basel (2008) Fokusbericht Gender und Gesundheit

7.2 THE WAY THE HIV TEST IS HANDLED

The majority of high-income countries have formulated strategic guidelines for HIV. There are, however, major differences in the test strategies employed. Countries such as the USA and France have, for some time, recommended HIV screening for the entire population in contact with the medical system – irrespective of the reason of such a contact. Anyone not wishing to be tested must expressly reject the HIV test (opt-out). Persons who are tested will only receive advice in the event of a positive result.

The Swiss strategy, by contrast, is aimed at promoting voluntary HIV counselling and testing for people who take risks and/or who have contact with groups with an increased HIV prevalence, or who belong to such groups. The tests are either conducted at the request of the person concerned, on the basis of the principle of voluntary counselling and testing (↘VCT) or are suggested by the service provider, generally the doctor (Provider Induced Counselling and Testing, ↘PICT). The test is only offered systematically in specific, precisely-defined medical cases, such as during pregnancy, but only with the informed consent of the person concerned. The test is obligatory when donating blood. In addition, since March 2010, tests have similarly been conducted systematically on people with specific diagnoses (such as an STI or tuberculosis).

As set out in previous chapters, the early diagnosis and timely treatment of HIV and also of a large number of STI has taken on importance over the past few years, both for the health of those concerned and with regard to public health: the excessively late diagnosis and treatment of an HIV infection has serious consequences for the individual concerned (problems with opportunist infections, a greater risks of the development of resistance, and poorer treatment response). In addition, late diagnosis represents a missed opportunity for early counselling and an early behaviour change in the individual with HIV which would protect their sexual partners. Consequently the question how the current Swiss test strategy can be modified in order to detect HIV, and also other Sexually Transmitted Infections, at an earlier stage is under scrutiny.

The current situation

The HIV antibody test is widely deployed: the laboratories receive more than 300,000 blood samples per year to test for HIV antibodies. Added to this come several tens of thousands of rapid HIV tests that are conducted directly on capillary blood at different test centres. This means that up to 5% of the Swiss population has an HIV test performed each year. With 600 to 800 positive HIV test results each year, it is thus possible to work out that approximately one HIV infection is found per 500 tests. This low hit rate of positive results causes the high cost for each diagnosed infection (between 20 000 and 25 000 Swiss francs). Despite the high test rate, approximately one quarter of the diagnoses have been made at the stage of advanced immunodeficiency (CD4 values of below 200/ul) over the past few years, i.e. at a stage when clinical symptoms are already evident. The conclusion is that not the right individuals are being tested (or wish to be tested).

There is thus no need for a general increase in the extent of HIV testing in Switzerland. This would not make economic sense on account of the low prevalence of HIV within the population at large. The challenge lies much more in targeting tests to those people who are likely to have an HIV infection.

The problem of undiagnosed primary HIV infections

The primary HIV infection represents a key opportunity for establishing an HIV infection. At least half of all newly-infected people experience symptomatic clinical characteristics in the initial weeks after becoming infected, which include a high temperature and unspecific symptoms of a viral illness. Many of these people go to a doctor with their complaints. The diagnosis is missed in a large number of cases, because the symptoms, although typical of an HIV infection, stem from a different infection in 99 out of 100 cases. If the doctor does not think of the possibility of an HIV infection, no test will be performed. At least one third of the newly-diagnosed HIV infections include an acute event leading to contact with a doctor, who in the anamnesis notes symptoms highly likely to have been a primary HIV infection that was missed at the time of the consultation (as is described in an internal study at the St. Gallen Cantonal Hospital by Professor Pietro Vernazza). The undiagnosed primary infections represent a problem of public interest, as those individuals are 25–30 times more infectious during the primarily HIV infection than during subsequent chronic infection.

More recent methods make it possible to calculate the share of primary HIV infections amongst newly-diagnosed cases. It is clear here that HIV diagnoses are recognised at an earlier stage significantly more frequently amongst MSM and injecting drug users than amongst people who have become heterosexually infected. This confirms the assumption that diagnosis of the primary HIV infections are frequently missed because of a lack of indicating factors. It is now a matter of avoiding these missed opportunities for timely diagnosis.

Provider Induced Counselling and Testing (PICT)

As a result, an HIV test should always be carried out on persons with fever and the symptoms of a viral illness. The probability of an HIV infection is in the region of 1 to 100, which is considerably better than the low rate for the population as a whole (1:500). This means that a large number of people (99 out of 100), who have never been at risk for HIV, need to be tested if they show the symptoms of viral infection. The test recommendation of the former Special Committee for HIV/AIDS Clinics and Therapies (FKT) of 15.03.2010 thus suggests testing of all individuals with illnesses that frequently occur with HIV for HIV as well (e.g. tuberculosis, sexually transmitted diseases, lymphomas). [57]

In all these cases, the HIV test is induced by a standard clinical situation, being initiated by the service provider (doctor, medical staff) – PICT. The person concerned must be told that the test is being performed. A few exceptions to this may be made in the interests of the patient[58] which must be documented in writing. There is no evidence to support the demand for the probability of an HIV infection to be established in such standard clinical situations by carrying out a prior risk anamnesis. As the evaluation of primary infection studies shows, in half of all the primary HIV infections diagnosed, the HIV risk anamnesis was not known at the time of the HIV test.[59] The FKT thus recommended that, in the standard situations referred to, the HIV infection should only be excluded through an HIV test and NOT through a risk anamnesis.

The PICT concept, by contrast, makes it possible for doctors and other providers to propose HIV counselling and testing in the case of patients without corresponding illnesses or symptoms, if there are indications (such as in the ↘sexual anamnesis) that the patient is engaging in risky behaviour. The service providers should selectively recommend early testing to people who expose themselves to risks or who are themselves at risk. In these cases, it is appropriate to provide counselling for the patients concerned – even if the diagnosis is negative – in order to bring about a change in behaviour.

In the PICT situation, counselling should be given when it would appear to make sense i.e. if the person a) has undergone a risk or frequently undergoes risks or b) belongs to a population group with an increased prevalence and c) is susceptible to counselling. They must be in a position, in clinical terms, to follow the advice given to them; counselling does not make much sense for people in great pain or with serious health problems not associated with HIV or STI. It is, of course, essential for people with a positive diagnosis to be counselled at all events.

VCT: Voluntary counselling and testing

Voluntary counselling and testing (VCT) is a completely different situation: here, the initiative for the test is taken by the person concerned – the concept is based on free will and personal responsibility. The majority of HIV tests are still requested by people who would like to be sure that they are not infected with HIV because of risky behaviour or because they are in a new partnership. A risk anamnesis is required for in this situation, and it is essential to provide counselling for potential risk reduction strategies and on the reliability of the result (sensitivity of the test used). An HIV test without individual risk counselling is a missed opportunity for prevention. With VCT, a risk anamnesis and counselling on risk reduction strategies are therefore conducted as standard.

[57] Flepp et al. (2010) Der HIV-Test auf Initiative des Arztes: Empfehlungen zur Durchfühung bei Erwachsenen

[58] An example of a potential exception in the patient's interests would be a complex medical situation, such as if the patient were intubated.

[59] Vanhems et al. (1997) Acute human immunodeficiency virus type 1 disease as a mononucleosis-like illness: Is the diagnose too restrictive?

Post-test counselling makes a decisive contribution to ensuring that the desired change in behaviour happens in the person concerned – irrespective of whether the test result is positive or negative. Negative test results do not automatically mean that the persons concerned will protect themselves in future but can, if no counselling is given, lull them into a false sense of security (with regard to their own inviolability). A positive test result has extremely complex psychosocial consequences, and the HIV-positive person will generally require support to master these. Knowing that one has HIV will not, in most cases, lead to a reduction in risk behaviour. A number of studies, by contrast, have documented that the diagnosis of an HIV infection leads to a sustainable reduction in risk behaviour if the person with the diagnosis receives the appropriate counselling and support.[60]

Too many tests are still being performed without the corresponding counselling in Switzerland. The Swiss test strategy is thus aimed at promoting VCT and PICT. Individuals who are at risk will be motivated by means of specific offers or incentives to make use of VCT. The existing, low-threshold services provided for self-evaluation of the risk (including the internet tool ↘www.check-your-lovelife.ch) will be expanded. In contrast to this, the Swiss Federal Office of Public Health still decisively advises people against the HIV home test kits that can be obtained on the internet. Even if at first sight these would seem to promote personal responsibility and autonomy, they have serious disadvantages: there is no support in interpreting the results, no individual counselling, and the quality of the test is not assured.

No screening in risk groups

The low prevalence of HIV in the population at large in Switzerland means that screening is impossible for economic reasons (as set out above). Screening could perhaps be cost-efficient in risk groups with a high prevalence (e.g. MSM, migrants from countries with a generalised epidemic). All the same, the Swiss strategy does not recommend mass screening for those who belong to the risk groups. This is because many of those in the risk groups would consider screening of this type to be stigmatising, and stigmatisation tends to impede prevention. A large number of men who have sex with men do not *a priori* feel that they belong to a specific gay community and would do everything they can to ensure that they were not identified as such, which would "automatically" involve them being tested as part of a screening programme. In addition, screening could undermine personal responsibility, which constitutes one of the basic pillars of HIV and STI prevention.

Prospects

Switzerland's test strategy, which is based on VCT and PICT, needs to be further optimised: in future, the sexual health advisory centres as well as the young people's, pregnancy and family advice centres could offer HIV and STI tests, insofar as they have specifically trained staff and the necessary infrastructure. The rapid tests that are available are of a very good quality if they are applied by competent personnel in the framework of a quality assurance system. Additional facilities, including ↘checkpoints should be opened for specific target groups in the bigger cities which would give vulnerable groups (such as sex workers) easier low-threshold access to counselling and testing. In addition to ensuring that the advice they offer is of a professional quality, VCT centres of this type must make sure that a blood sample can be taken at any time. This is essential for people who are suspected of having a freshly-contracted infection and for those who have tested positive in a rapid test.

Medical staff must be made more aware of the PICT concept, and must also be motivated and trained for this, so that certain symptoms can become an indication for conducting an HIV test as part of the standards of good clinical care.

[60] U.a. Weinhardt (2005) The effects of HIV diagnosis on sexual risk behaviour

7.3 THE PREVENTION MESSAGES

Everyone living in Switzerland will be familiar with the core prevention messages. These are:

- Everyone must assume responsibility for themselves, within their individual capabilities, to protect themselves against a sexually transmitted infection or HIV.

- Anyone who has sexual contact with a casual partner regardless of gender or with a person possibly affected by HIV or another STI must follow the rules of safer sex in order to protect themselves:
  1. Penetration only with a condom
  2. No seminal fluid or blood in the mouth, and
  3. Consultation of a medical practitioner in the event of itchiness, discharges or pain in the genital region

- Anyone who suspects that they have engaged in risky behaviour should check their risk by going for a consultation or by using the check-your-lovelife internet tool.

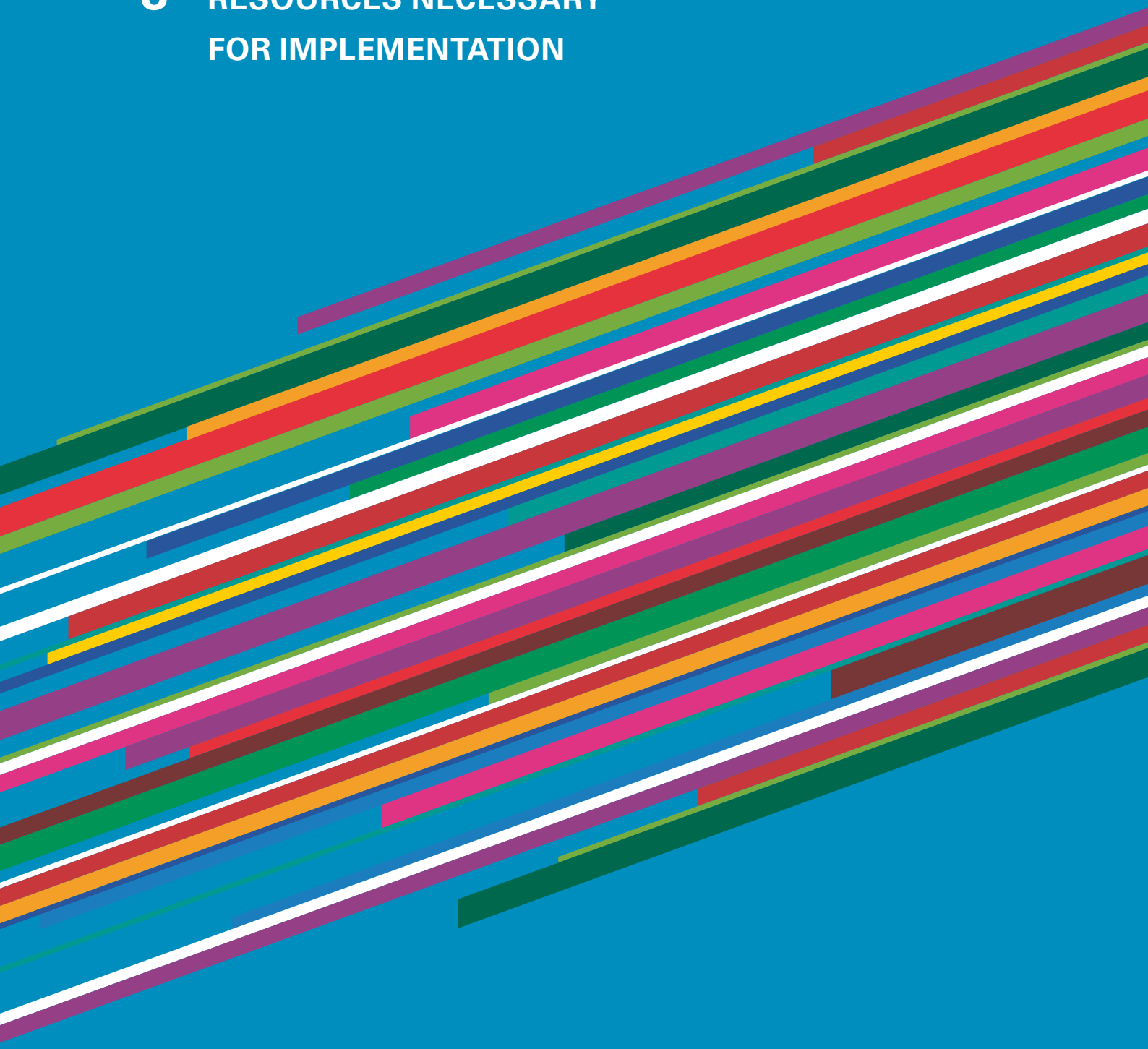
- HIV and AIDS can be treated, but they cannot be cured. The treatment may cause side effects, is time-consuming, laborious and expensive. The best protection against HIV for sexually active individuals is the use of condoms.

- Most STI are easier transmitted than HIV. Often they do not give any symptoms, which does not mean that they are harmless. Anyone having frequent risky sexual contacts with different partners should get themselves tested for STI regularly.

- One way of achieving anxiety-free sexuality is the ability to talk about sexual health and any possible infections with one's sexual partners. This is something that sexually educated people do.

- Individuals who have been given a diagnosis of an STI or HIV support the process of informing their partners. When establishing new sexual contacts, they inform their partners of their infection adhere strictly to the rules of safer sex. There must be no stigmatisation or discrimination against individuals diagnosed with HIV and/or other STI. It is still essential to support them and to show solidarity towards those diagnosed and those at risk.

8 RESOURCES NECESSARY FOR IMPLEMENTATION



According to the mandate of the Swiss Epidemics Act, the Confederation in combination with the cantons is responsible for ensuring that the number of new infections with HIV and other Sexually Transmitted Infections declines again. The Confederation and the cantons fulfil this task in close cooperation with communal authorities and with the private organisations active in this field (NGOs). Within this relatively complex structure of HIV and STI work, the National Programme on HIV and other Sexually Transmitted Infections 2011–2017 defines the goals that are to be pursued throughout Switzerland for engaging with STI (including HIV). The strategy and goals are binding for Switzerland.[61] The individual actors decide on how the programme is to be implemented in specific terms and on how the available resources will be deployed. The Confederation has the job of coordinating the measures.

This starting situation means that the resources required for the full range of efforts in the field of HIV and STI can only be estimated, particularly since there is no up-to-date study that puts a figure on the resources currently deployed at the different institutional levels. A study published in 2001[62] put the overall cost of HIV prevention at 41 to 62 million Swiss francs in 1998. Currently, the cantons and communes together probably spend around 50 million Swiss francs, to which the federal AIDS appropriation has to be added, which has stood at 9 million Swiss francs annually since 2002. Over the past few years, some 15 million Swiss francs have been spent on research into HIV – most of this by the Swiss National Science Foundation, which is also funding the Swiss HIV Cohort Study.

Compared with this, the direct costs of medical treatment, medicines, psychotherapy and nursing care occasioned by HIV and AIDS amounted to 168 million Swiss francs in 1998, according to the study already mentioned. If the indirect costs are added to this (caused by lost working days and premature deaths), the resultant total figure is 443 million Swiss francs. The authors' working assumption at the time was an annual growth rate of 3% and they thus forecast that the costs occasioned by HIV and AIDS would be 522 million Swiss francs in 2005. These sums cannot be compared with the estimated 200 million Swiss francs spent by the compulsory health insurance system, since this latter figure only includes the expenditure on treatment with anti-retroviral drugs. HIV thus remains one of the most relevant infectious diseases from a public health perspective, the costs of treatment are many times higher than the money spent on preventing it – even if these costs of the disease are estimated more conservatively and the indirect costs are not taken into consideration.

No supplementary resources needed

In order to pursue the targets defined in the current programme, the resources needed for prevention remain on the same scale as in the past, although some of the sums of funds involved need to be allocated differently to the individual tasks than has been the case to date. One example of this is the poorly-frequented consultancy centres in rural districts, which should cut back on the services they offer so that this money can be used for specific prevention services for the target groups particularly affected by HIV and STI in urban areas. Any duplication of effort in the field of sexual health education should be avoided. Whether all the cantons implement the recommendations addressed to them or not (cf. also Annex 15.2) and pledge the resources required for this to the same extent as previously, is left to their discretion. If the cantons cut their prevention budgets considerably, the result would be that not all the necessary activities can be implemented, thus jeopardising the aims of the programme.

Since 1987, the Swiss Confederation has included an allocation for HIV prevention in the budget of the Federal Office of Public Health (cf. Table). The extent of the appropriation by the Confederation does not need to be increased any further for implementing the NPHS 2011–2017. The human resources required for implementing the NPHS and for carrying out the permanent work that needs to be done within the FOPH still remain at 8.9 FTE (full-time equivalent posts).

Federal budgetary appropriations for AIDS prevention from 1985 to 2010 (in Swiss francs)

1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
3,5 mill.	3,5 mill.	11,8 mill.	12,2 mill.	12,6 mill.	13,1 mill.	12,0 mill.	13,5 mill.	14,3 mill.	16,0 mill.	14,1 mill.	15,0 mill.	14,0 mill.	13,5 mill.
1999	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**		
11,9 mill.	10,0 mill.	9,5 mill.	9,1 mill.	9,1 mill.	9,1 mill.	9,1 mill.	9,1 mill.	8,1 mill.	8,1 mill.	8,1 mill.	8,1 mill.		

[61] Under the terms of Article 118, Para. 2, Letter b of the Swiss Constitution, the Confederation issues instructions on the combating of transmittable, widespread or virulent diseases in humans and animals. HIV and other STI come under this category. The Confederation is thus competent to lay down guidelines for the cantons and communes on how to implement the HIV&STI programme. Under the terms of the Epidemics Act, the Confederation is also in overall control and is responsible for coordinating the cantonal measures (Art. 9 Epidemics Act). The Confederation is therefore in charge of strategy development and monitors the implementation of the strategy. Its instructions are thus binding in this respect.

[62] Zurn et al. (2001) Social cost of HIV infection in Switzerland

9 THE VISION OF THE NATIONAL PROGRAMME ON HIV AND OTHER STI

The conditions in Switzerland are such that people can fully live undisturbed, low-risk sexuality in a self-determined manner and with mutual respect. The National Programme on HIV and other STI 2011–2017 makes a decisive contribution to this by empowering inhabitants to exercise their sexual rights and maintain or improve their sexual health.

The World Health Organisation (WHO) describes health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.[63] This comprehensive definition of health is set out in the Ottawa Charter for Health Promotion,[64] which views health as a major resource for social, economic and personal development. This includes sexual health: the capacity to reproduce is a fundamental function of the human body, and hence a decisive component of physical well-being. A satisfactory and enjoyable sexual life constitutes a key aspect of the quality of life and has a major influence on mental well-being.

Sexual health thus makes a decisive contribution to achieving a fulfilled life in good health. The National Programme on HIV and other Sexually Transmitted Infections 2011–2017 works on the basis of a holistic approach to health in the same way as the basic WHO documents referred to and in accordance with the overall strategy adopted by the FOPH[65]. It aims at improving the competence of the country's inhabitants in matters of sexual health, to ensure that everyone is in a position to exploit their health potential in a self-determined manner. In legal terms, the programme is based on the Epidemics Act, which assigns the Confederation and the cantons the task of engaging with transmitted diseases. The strategy is thus focused on heightening the population's awareness of the threat to sexual health and empowering them to maintain their own sexual health and to protect themselves against sexually transmitted infections.

[63] WHO: Preamble to the Constitution of the World Health Organisation, adopted by the International Health Conference, New York, 19 to 22 July 1946, signed on 22 July 1946 by 61 States, which entered into force on 7 April 1948. (Constitution of the World Health Organisation of 22 July 1946 [SR 0.810.1]).

[64] WHO (1986) Ottawa Charter for Health Promotion. First International Conference on Health Promotion

[65] Swiss Federal Office of Public Health (2002) Gesamtstrategie BAG

10 THE DIRECTION OF FUTURE ENGAGEMENT WITH HIV AND STI WORK: FOUR MAIN GOALS

Three specific main goals are derived from the vision for the programme in the three areas of 1. Heightening awareness, 2. Prevention, and 3. Counselling, diagnosis & therapy. A fourth main goal defines the framework conditions which are indispensable for achieving the first three main goals. The tasks which ensue from the fourth main goal are called supporting tasks due to this supporting effect.

1. Main goal of heightening awareness of rights with regard to sexuality

In Switzerland human rights with regard to sexuality (sexual rights) are in principle guaranteed, but not everyone is equally informed about these rights and in a position to exercise them. Sexual health education is neither nationally obligatory nor bindingly enshrined in the curricula in all cantons, which prevents equal access to appropriate knowledge for all children and adolescents[66]. Also, not everyone succeeds in achieving protection from the undesirable consequences of sexual encounters. Surveys show serious differences between Swiss women and migrant women – the number of pregnancy terminations is three times greater for migrants than it is for Swiss women[67]. This can indicate an absence of condoms and femidoms perhaps explained by a shortage of funds, an uncertain residential status or inhibitions regarding condoms and femidoms. Dependent situations in partnerships, or difficulty accessing advice due to language barriers, for example, can mean that some people do not exercise their rights with regard to sexuality.[68]

Main goal:
People living in Switzerland are informed, educated and capable of exercising their rights with regard to sexuality.

Knowledge of rights with regard to sexuality forms the basis for promoting sexual health and is a prerequisite for prevention achieving a lasting effect; it starts in the parental home and is supplemented in school. Only informed people are in a position to look after their health and to have recourse as required to services to which they are entitled. Equality under law and the legal prohibition of discrimination (on grounds of ↘sexual orientation or ↘gender identity, for example), the right to physical integrity (protection from sexual abuse), and the right to personal freedom, which includes the right to sexual self-determination, are explicitly mentioned in this context. The right of every individual to freely decide whether he or she wishes to enter into a marriage and when children should be born is also part of this. These rights are guaranteed by the Swiss Federal Constitution. In health policy terms, they are set out in the Ottawa Charter for Health Promotion[69].
These principles play a decisive role in efforts against HIV and STI and in the avoidance of unwanted pregnancies, as they are intended to ensure equal access for everyone to sexual healthcare, including prevention, diagnosis and treatment. Adolescents, homosexual, bisexual and transsexual people, individuals from a migrant background and those with a disability, in particular, should be able to better exercise their rights with regard to sexuality. Knowledge of these is promoted for this purpose, and should take place in the parental home and be supplemented in school within the scope of appropriate sexual health education. Competent advice centres further offer counselling; their services combine information about sexual rights and sexual and ↘reproductive health with the prevention of HIV and other STI, and the prevention of unwanted pregnancies. Qualified advice is always given on the assumption that sexuality represents a significant part of each individual's personality that it should be recognised as a positive aspect of life and must therefore be based on consent and mutual respect between sexual partners.

[66] Eidgenössische Kommission für Kinder- und Jugendfragen EKKJ (2009) Jugendsexualität im Wandel der Zeit

[67] Federal Strategy for Migration and Health 2008–2013

[68] Bihr (2009) Migration und sexuelle und reproduktive Gesundheit. Bestandesaufnahme bei den Beratungsstellen für Schwangerschaft und Familienplanung. Definitiver Bericht für das BAG

[69] WHO (1986) Ottawa Charter for Health Promotion. First International Conference on Health Promotion.

2. Main goal of preventing HIV and other Sexually Transmitted Infections

Sexual health is a decisive factor in physical and mental well-being. It is important for people to understand this connection and to take care of their sexual health, which includes avoiding becoming infected with HIV or another sexually transmitted pathogen, because HIV and other STI are hazardous for health and also restrict the quality of life in the longer term of those affected. The health of various population groups would be endangered by a spread of HIV or certain STI. In addition, treating HIV or other STI (especially treating the eventual consequences of an STI, such as syphilis, gonorrhoea or chlamydia trachomatis) sometimes incurs high costs. As a result of persistent prevention efforts in recent decades, Switzerland has succeeded in preventing the HIV epidemic and most STI from becoming generalised. HIV is, however, still spreading to a worrying extent in certain population groups, and the number of new infections is increasing in the case of specific STI.

Main goal:
A decrease in the risk of transmission of HIV and other Sexually Transmitted Infections.

The inhabitants of Switzerland will be encouraged to continue reliably applying the rules of safer sex in risk situations[70] to protect themselves against HIV and other STI. Specific situational and ↘behavioural prevention measures, vaccination programmes and effective testing and treatment plans will mean that in patricular people with an increased risk of exposure will be able to better protect themselves against HIV and long-term damage to health as a result of other STI. As a consequence, the number of new infections with HIV and other STI will fall both in the Swiss population overall and in the population groups particularly affected by HIV and other STI[71]. The further spread of the HIV epidemic will be slowed down to the greatest possible extent, and the spread of various STI prevented.

[70] Risk situations are to be understood as sexual encounters between people who do not know whether they are infected with HIV or another STI.

[71] The time-scale for the last programme, 2004–2008, forms the reference parameter. Indicators are, on the one hand, epidemiological data as of the end of 2008 and, on the other, the results of behavioural surveillance in the monitoring report: Jeannin et al. (2010) System of accompaniment for the strategy for combating HIV/AIDS in Switzerland: Summary report for 2004–2008.

3. Main goal of counselling, diagnosis and therapy

AIDS remains a serious, incurable disease but, in most cases, HIV infection can be kept under control by treatment with timely and consistent drug therapy. Priority is therefore attached to early diagnosis and the correct treatment of HIV, as this increases the life expectancy of those affected and improves their overall quality of life.

Certain STI are relatively easy to cure at an early stage, or the correct treatment can at least alleviate problems and prevent later damage, such as serious chronic diseases or infertility. Early detection of infection therefore plays an important role in STI too, in order to deter longer-term impairment of personal health. Some STI do not display any symptoms, which make early detection more difficult.
Early detection of infections is sensible and necessary not only from the perspective of the individuals concerned; it is also extremely significant for public health. Rapid and effective treatment of STI prevents their transmission to other individuals and is preventive in nature.

Main goal:
Early detection and correct treatment of HIV and other STIs.

People in Switzerland are encouraged to contact the appropriate services (counselling, suitable testing) following real exposure to risk[72]. People with symptoms of HIV, an STI or undefined genital ailments should immediately seek medical assistance and advice. They will be provided with a correct diagnosis on the basis of recognised test concepts. Infected people will receive optimum, high-quality medical and psychosocial counselling, treatment and/or support. People diagnosed with HIV are encouraged to start treatment in optimal time. They receive the combination of ART that is optimum for them and are assisted with adhering to this treatment in the long term. People with an STI receive immediate treatment and are cured (if possible). The number of cases of HIV and STI diagnosed late or undiagnosed and the associated subsequent consequences (such as mortality, AIDS, chronic diseases, cancer, infertility, complications in pregnancy and neonatal problems) are reduced.
Early diagnosis and correct treatment of infections reduce their spread and contributes to prevention.

[72] Real risk of exposure is to be understood as unprotected sexual encounters with a partner about whom there is no reliable information as to whether he/she is infected with HIV or an STI and who can be allocated to a population group with increased prevalence.

4. Main goal regarding socio-political and structural conditions

Two fundamental conditions must be fulfilled for the strategy addressing HIV and STI to be successful. Firstly, there should be neither stigmatisation of, nor discrimination against, people affected by HIV or STI, because fear of stigmatisation prevents open debate of the subject. Secondly, the target groups and people affected by HIV and/or STI must be involved in strategic and operational levels of prevention, because only if the interventions meet the needs of the target population will they have a sustained impact. In view of the limited means, it is also important for funds allocated to prevention to be used where maximum benefit can be obtained from a public health perspective; this requires the accurate analysis of the epidemic and the behaviour of individual population groups. The fact that the majority of infections occur in urban areas (in both MSM and heterosexuals)[73] must be taken into consideration.

Projects and activities in HIV and STI work should basically be measured by the recognised criteria of effectiveness, expediency and value for money. Where this is not possible they are guided by evaluated best-practice models. At the same time, there should be scope for the development of promising innovations.

Main goal:
The impact of efforts related to HIV and STI is sustained, because it relies on target group participation, is based on scientific evidence and is supported by the population.

The quality of the prevention, counselling, diagnosis and treatment system is continually developed in collaboration with the people affected and the target groups for the interventions.[74] This system's services are always focussed on empowerment and are guided by its needs and requirements.

Use of proven scientific quality assurance tools (surveillance, monitoring, evaluation and research) ensure that the available resources are deployed effectively and the interventions achieve a long-term impact. The HIV and STI service providers from the various government and private levels cooperate with each other. Switzerland thus takes its place in the international initiative to comprehensively address HIV and STI. It is guided by international best practice models and itself contributes to the further development of best practice.

[73] See information on place of infection in Chapter 3 "Biological Surveillance; HIV: epidemiology in Switzerland and Europe".

[74] This issue is guided by the GIPA principle (Greater Involvement of People living with HIV and AIDS). The principle maintains that there should be significant involvement of people with HIV and AIDS in HIV work on all levels and in all programmes and institutions and that they should be empowered for this as applicable. The resolution on GIPA was passed in the "Paris Declaration 1994" at a summit meeting of 42 states. See also UNAIDS (2007) The Greater Involvement of People Living with HIV (GIPA). Policy Brief.

11 THREE AXES OF INTERVENTION AS THE FRAMEWORK FOR FUTURE HIV AND STI WORK

The National Programme on HIV and other Sexually Transmitted Infections 2011–2017 groups HIV and STI interventions and measures into three axes. Each ↘axis of intervention is directed at specific population groups.

Grouping the interventions along three axes helps to structure the HIV and STI work. It firstly facilitates the setting of strategic targets. Secondly, it permits the HIV and STI system to be divided up in organisational terms, thereby ensuring that the roles and responsibilities can be assigned more clearly to the different actors.

The prevalence determines the target groups for the individual axes

The definition of the three axes of intervention is based on considerations of prevalence and vulnerability. The three-axis model is based on the logic that everyone should have access to a basic range of preventive measures, thus ensuring that they are able to protect themselves effectively against HIV, the potential health hazard of an STI and unwanted pregnancies. Axis 1, which takes in the population as a whole, is where the foundations for the prevention activities are laid. Axis 2 is about individuals who engage in risky behaviour or are vulnerable in an environment with an increased prevalence. They require additional, specific measures, since they have a greater risk of infection. Axis 3 is aimed at infected individuals and their partners. It is here that the risk is greatest: not only for the negative partners, but also for the infected persons themselves, because they are more susceptible to contracting a further STI (or HIV) in addition to their existing infection. This is why particularly comprehensive, individually-based care is required in axis 3.

The axis model is thus configured on a cumulative basis: an individual who belongs to a vulnerable population group in axis 2 also comes under axis of intervention 1 – as a member of the population as a whole – and thus benefits both from the measures for the population as a whole and from the specific interventions for the vulnerable population group[75].

In line with this logic, the three axes are defined as follows:

- **Axis 1** is aimed at all those living in Switzerland.
- **Axis 2** is aimed at sexually active people with an increased risk of exposure, i.e. those who belong to population groups with an increased prevalence or increased vulnerability.
- **Axis 3** is aimed at people with HIV and/or an STI and their (non-infected) sexual partners.

According to UNAIDS[76], Switzerland is experiencing a concentrated HIV epidemic. This means that the prevalence of HIV in the overall population is less than 1 percent[77]. There are, however, groups within the population with a far higher prevalence of HIV: men who have sex with men (MSM), people who come from regions with a generalised epidemic and injecting drug users (IDU)[78]. As far as the other STI are concerned, only rudimentary prevalence estimates are available. For certain STI (syphilis, gonorrhoea, lymphogranuloma and hepatitis viruses), it can similarly be assumed that there is a concentrated epidemic – to some extent in the same population groups as for HIV (MSM). The prevalence in the general population appears to be increased in the case of certain STI[79].

[75] Evidence from the field of gender studies and intersectionality research shows that in reality this standardised representation does not apply to every case. Particular caution is advised where people subject to multiple discrimination are concerned. A gay injecting drug user thus might not feel addressed by any axis, as he neither identifies himself with IDU ("I'm gay, not an addict!") nor wants to access MSM offers "I'm not really gay, because I only sleep with men to make money"). Particular caution and sensitivity is required here when devising elaborating preventative measures, so that such people do not fall through the prevention net.

[76] In North America and in Western and Central Europe, national epidemics are concentrated among key populations at higher risk, especially men who have sex with men, injecting drug users and immigrants. UNAIDS et al. (2009) AIDS epidemic update: November 2009

[77] According to the Swiss Federal Office of Public Health's calculations, the number of people in Switzerland with a diagnosed HIV infection is between 14,000 and 21,000. To this is added those who may be infected but do not know it. An estimate can be prepared for Switzerland using studies conducted in comparable industrialised nations (UK and Canada): a total of at least 20,000 people are likely to be living with HIV. For a population of 7.8 million, this results in a prevalence in the total population of approx. 0.3%.

[78] Of those people with a diagnosed HIV infection in Switzerland, some 25% are MSM and some 25% IDU (i.e. between 3,600 and 5,500 people in each case). This shows that the prevalence in these groups is considerably higher than in the general population. In the case of sexually active MSM, the prevalence is estimated at between 6 and 10 percent on the basis of prevalence studies conducted in years past and Swiss Federal Office of Public Health calculations. For the IDU, estimates even put the prevalence as high as 30% or so. The prevalence amongst migrants from African countries south of the Sahara cannot be estimated on a precise basis, but is likely to reflect the prevalence in their country of origin.

[79] In the case of certain viral STI (human papilloma virus [HPV] and herpes simplex [HSV]), it can be assumed, on the basis of studies, that they have a prevalence of more than 5% in the general population. For chlamydia trachomatis, the prevalence is estimated at more than 3%, with predominantly young women seeming to be affected.
Krech, Thomas et. al. Urogenitale Humane Papillomviren und Chlamydia trachomatis, Epidemiologie bei Schweizer Frauen unter Anwendung neuer Nachweisverfahren, Schweiz Med Forum, 2010; 10: 230–232
Swiss Federal Office of Public Health, Sexuell übertragbare Infektionen (STI) in der Schweiz von 2006 bis 2008, status 06/2009.
AHS et al. (2008) Sexuell übertragbare Infektionen. Informationen für Beratende

Intervention axis 1 Total Swiss population
Intervention axis 2 People with a higher risk of exposure
Intervention axis 3 Infected individuals and their partners

Alongside prevalence, vulnerability also plays a role in the classification of the axes. People who are at particular risk of STI are those who frequently have sex with different or anonymous partners (of either gender) – such as women and men engaged in sex work. Studies and observations conducted over the past few years would also indicate that the incarcerated population similarly has a particularly high risk of STI[80].

The prevalence of the different STI is not increased in the same population groups as the prevalence of HIV. Despite this, the NPHS employs the same axis breakdown for prevention against all the STIs as it does for HIV prevention. This is for practical reasons: an axis model that was differentiated according to the individual STI would be so complicated that it would scarcely be of any use as a structuring aid and would thus fail to fulfil its primary aim, i.e. that of providing clarity.

[80] International: a good overview is provided in: Niveau, Gérard (2006). Prevention of infectious disease transmission in correctional settings: a review. Public Health, 120:33 41. For Switzerland: Iten et al. (2005) Epidémiologie et prévention des infections dans les prisons de Suisse Romande (EPIPS). Deuxième phase de l'étude. Rapport Final.

Different levels of communication in each axis

The definition of the target groups in the individual axes corresponds to an analysis of the present situation. This analysis can change as a function of the course taken by the epidemics, thus necessitating a reassessment of the situation. The Swiss Federal Office of Public Health thus considers it necessary to place the allocation of the axes in the hands of the body that advises the Federal Council – currently the Swiss National AIDS Commission (EKAF): this body is to monitor the allocation of the axes on the basis of the surveillance and make adjustments where necessary.

In view of the current data situation and the considerations set out above, the target groups of the individual axes can be specified as follows at present:

Axis 1:
Everyone living in Switzerland. Particular consideration is paid to:

- Teenagers and young men and women
- Migrants from countries without a generalised HIV epidemic
- Clients of sex workers
- People travelling to countries with an ↘endemic prevalence of HIV and other STI.

Everyone living in Switzerland ought to know that HIV and STI represent a problem and ought to know how to protect themselves in the event of risk contacts. The focus in axis of intervention 1 is thus on heightening the population's knowledge of the potential threat to their sexual health, on sexual health education and on the trans-cultural promotion of health. In specific terms, this means getting heterosexual persons to practice safer sex in exceptional situations – such as when travelling or engaging in unforeseen sexual experiences with casual partners, and also during difficult phases of their lives marked by psychosocial problems. Teenagers will be motivated to adopt a reliable form of protective behaviour through sexual health education. In the case of migrants, the challenge lies in making sure that the prevention messages reach them more effectively than has been the case to date and to enhance them to make use of counselling and care services when required. Special educational efforts are required for certain migrant groups to ensure that they exercise their sexual rights and can thus maintain their sexual integrity and health.

Axis 2:
People with a higher risk of exposure
- Men who have sex with men (MSM)[81]
- Migrants from countries with a generalised epidemic
- Sex workers[82]
- Injecting drug users (IDU)
- Prison inmates

The target for this axis is that people who socialise and have sexual contacts in an environment with a high prevalence should remain HIV-negative and as STI-free as possible (even in exceptional situations), despite the increased risk. This requires the provision of additional services, correctly tailored to the special needs of the target groups. The focus is on the specific heightening of awareness, plus information and motivation to increase protection and also on interventions aimed at contextual prevention in the immediate environment of the individual target groups.

Axis 3:
People with an HIV infection and/or an STI plus their sexual partners

People with HIV ought to receive therapy in good time, in the correct fashion and in a stable manner over time, so that their viral load becomes undetectable and they are no longer infectious. People with STI must receive therapy and be cured as rapidly as possible. A further challenge lies in keeping the partners of those infected free from infections. This can only be done successfully if the partners are informed about the infection of the persons concerned. The focus is thus on intensifying the information provided to partners and also on the individual medical, curative and – if necessary – psychosocial and legal support (including protection against discrimination) for those concerned and their partners.

The axis model as a basis for HIV and STI work

The individual target groups for an axis are not homogeneous, but display a great variance. Allowance must be made for this variance in prevention. Hence, not every homosexual man is at risk of infection. The target groups can also be divided up into sub-groups, which may need to be motivated with different interventions and messages relating to prevention.[83]

The axis model structures the entire range of efforts in the field of HIV and STI, taking in all the different interventions in the fields of prevention, diagnosis, therapy and support. In all three axes, interventions are planned that have a broad impact (such as the LOVE LIFE campaign in axis 1 or the awareness-heightening campaigns for MSM in axis 2), as well as measures which impart more in-depth knowledge (such as information on the potential risk of HPV for young women or the education of the clients of sex workers in axis 1), and also individual counselling or treatment options (one example here would be the sexual health advisory centres in axis 1 or the specific advisory and testing services offered by the checkpoints for MSM in axis 2). It is only through this wide range of different interventions that it is possible to prevent HIV and other STI on a sustainable basis.

[81] The reason why not all homosexual and bisexual men are given as a target group, but only MSM, is their increased risk. Lesbians and other women who have sex with women are therefore part of axis of intervention 1, as are transgender people. In the event of them working as sex workers, they fall within axis of intervention 2. There is currently no evidence in Switzerland to say that lesbians, and other women who have sex with women, and transgender people, have a greater risk of infection than the heterosexual population.

[82] Reference should be made, where female sex workers are concerned, to the particular problem of human trafficking, or female trafficking. Women from poorer regions of Europe, Africa, South America and Asia are lured to Switzerland with false promises of work or marriage, are abducted or sold, or come to Switzerland as cabaret dancers and are subsequently forced into sex work. They are in a very heavily dependent situation (illegal aliens), have no access to information and no possibility of sexual self-determination. The consequence can be that that they (have to) dispense with the use of condoms and femidoms. These women are very difficult to reach, which is why particular attention must be paid to this group.

[83] Female sex workers, for example, are not an homogeneous group – studies have shown that they can be divided up into the following sub-groups: cabaret dancers and bar hostesses, regular sex workers indoors and outdoors, irregular sex workers and IDU sex workers.

12 PREAMBLE TO THE PROGRAMME'S GOALS

Legal requirements of the programme

The basic values of the National Programme on HIV and other Sexually Transmitted Infections is based on the fundamental rights. Hence, if the goals of the NPHS are to be achieved, the following legal prerequisites must be fulfilled:

International Human Rights Conventions: The UN Universal Declaration of Human Rights of 1948[84] constitutes the underlying foundation of the international protection of human rights. The Universal Declaration of Human Rights and the other international UN[85] and the Council of Europe[86] agreements in the field of human rights form the basis of this programme. The programme respects people's dignity and equality under the law and supports the legal prohibition of discrimination in any form, whether it be on the basis of sexual orientation or identity or on account of an infection with HIV or another STI.

Federal Constitution: The programme is based on the fundamental rights of the Federal Constitution[87]. In addition to protection of human dignity (Federal Constitution, Article 7), equality before the law and the prohibition on discrimination (Federal Constitution, Article 8), the right to personal liberty, including sexual self-determination (Federal Constitution, Article 10, paragraph 2) and protection of privacy in private life (Federal Constitution, Article 13) are of particular relevance, as is the protection of children and young people (Federal Constitution, Article 11).

Epidemics Act: The programme is based on the Federal Law of 18 December 1970[88] on Combating Communicable Diseases in Humans (Epidemics Act), which assigns responsibility to the Confederation and the cantons for taking the necessary measures and of protecting people from pathogens (Art. 1 Epidemics Act). The Confederation has the role of supervising enforcement of the law and, if necessary, of coordinating the measures implemented by the cantons (Art. 9 Epidemics Act). The Confederation thus assumes the lead when it comes to strategy development and monitors implementation of the strategy.

Human rights with regard to sexuality: The programme is aimed at implementing individual rights with regard to human sexuality. The term "sexual rights" refers to existing norms in the domain of fundamental and human rights which are applied to sexuality. The International Planned Parenthood Federation (IPPF) has defined these rights in a declaration.[89] These sexual rights comprise freedom, equality, privacy, self-determination, integrity and dignity of all people. In Switzerland, these rights are guaranteed at constitutional level.

Sociopolitical requirements of the programme

The implementation of the NPHS goals additionally requires a consensus on the following socio-policy principles. It is only through these principles that efficient HIV and STI work is possible at all:

Equal opportunities: In the field of sexual health, all Switzerland's inhabitants have equal access to information, counselling, diagnosis, therapy and care – irrespective of their origin, race, gender, age, language, social position, way of life, their religious, ideological or political convictions and any health impairments (c.f. Art. 8, para. 2 Federal Constitution). The plurality of society is addressed: the measures and messages concerning prevention, and also the care provisions, make allowance for the different needs of the individual population groups. Specific prevention measures or care provisions are in place for particularly vulnerable groups where necessary. The interventions always take into account to the individual target groups' socio-cultural and linguistic backgrounds (in the case of migrant groups, inter-cultural facilitators will be involved if required). Their organisations are encouraged to be involved in prevention.

[84] UNO (1948) The Universal Declaration of Human Rights

[85] The International Covenant on Economic, Social and Cultural Rights, 16 December 1966 (SR 0. 103.1);
The International Covenant on Civil and Political Rights, 16 December 1966 (SR 0. 103.2);
The International Convention on the Elimination of All Forms of Racial Discrimination, 21 December 1965 (SR 0. 104);
The Convention on the Elimination of All Forms of Discrimination against Women, 18 December 1979 (SR 0. 108);
The UN Convention on the Rights of the Child, 20 November 1989 (SR 0. 107).
UNAIDS (2010) HUMAN rights and HIV

[86] The European Convention of 4 November 1950 for the protection of human rights and fundamental rights (SR 0.101)

[87] Federal Constitution of the Swiss Confederation, 18 April 1999 (SR 101).

[88] The Swiss Confederation's Federal Authorities (1970) Federal Act of 18 December 1970 on combating communicable diseases in humans (Epidemics Act) SR 818.101.

[89] Sexual Rights: An IPPF Declaration, International Planned Parenthood Federation, London, October 2008.

Sexual orientation and gender identity:[90] Homosexuality, bisexuality, ↘transgender identity and ↘intersexuality are accepted and respected as a sexual orientation or gender identity. Homosexual, bisexual, transgender and intersexual people enjoy the same respect in Switzerland as heterosexuals. The NPHS is based here on the recommendation by the Committee of Ministers of the Council of Europe to the Member States, which deals with efforts against discrimination on the basis of sexual orientation and gender identity. The recommendation is the first legal instrument to deal expressly with discrimination against lesbian, gay, transgender and bisexual individuals (LGBT)[91]. It does not mention intersexual people, but these naturally have the same right to self-determination and protection against discrimination.

Participation of the target groups and those concerned (↘GIPA): The target groups and people affected with HIV and/or STI, or their organisations, are involved in strategic and operational prevention activities. They contribute their knowledge or actively help shape appropriate policies and programmes. All services aimed at target groups or affected persons are designed to support them and to encourage them to act responsibly (empowerment).

Principle of self-protection: Since 1987, prevention in Switzerland has been based on the principle of self-protection; people who are mentally and physically capable of protecting themselves against HIV and/or STI bear responsibility for their own protection in the case of voluntary sexual contacts.[92] This principle does not, however, relieve them of their responsibility towards their sexual partners; sexuality with mutual respect only exists if a potentially infected person either practices safer sex with their partner or provides them with transparent information about a potential infection.

Informing partners: People infected with HIV and/or an STI are aware of their responsibility towards their (sexual) partners. They support the (anonymous, if necessary) information of partners in order to prevent the further spread of the pathogens and to allow partners to receive any treatment that may be required. Informing partners is always performed on the basis of the voluntary and informed consent of the infected person, who appreciates the benefit of partners being informed.

Principle of informed consent: All individual interventions in this programme are based on the principle of informed consent. This means that the beneficiaries, addressees, clients or patients of an intervention (e.g. an HIV test or a treatment) must be informed and give their agreement to a specific measure (e.g. an HIV test or a treatment) – their consent based on information and explanation (informed consent) to the intervention must be available.[93]

[90] Unlike EU Directive 2000/78/EC the NPHS does not use the term "sexual inclination", but "sexual orientation" combined with the term "gender identity". This expresses the fact that there are people who feel emotionally and sexually drawn to the opposite sex (heterosexual), the same sex (homosexual) or to both sexes (bisexual). The gender identity describes the personal convictions of an individual that they are a woman or a man. One therefore speaks of transgender identity if the gender identity does not accord with the biological gender.

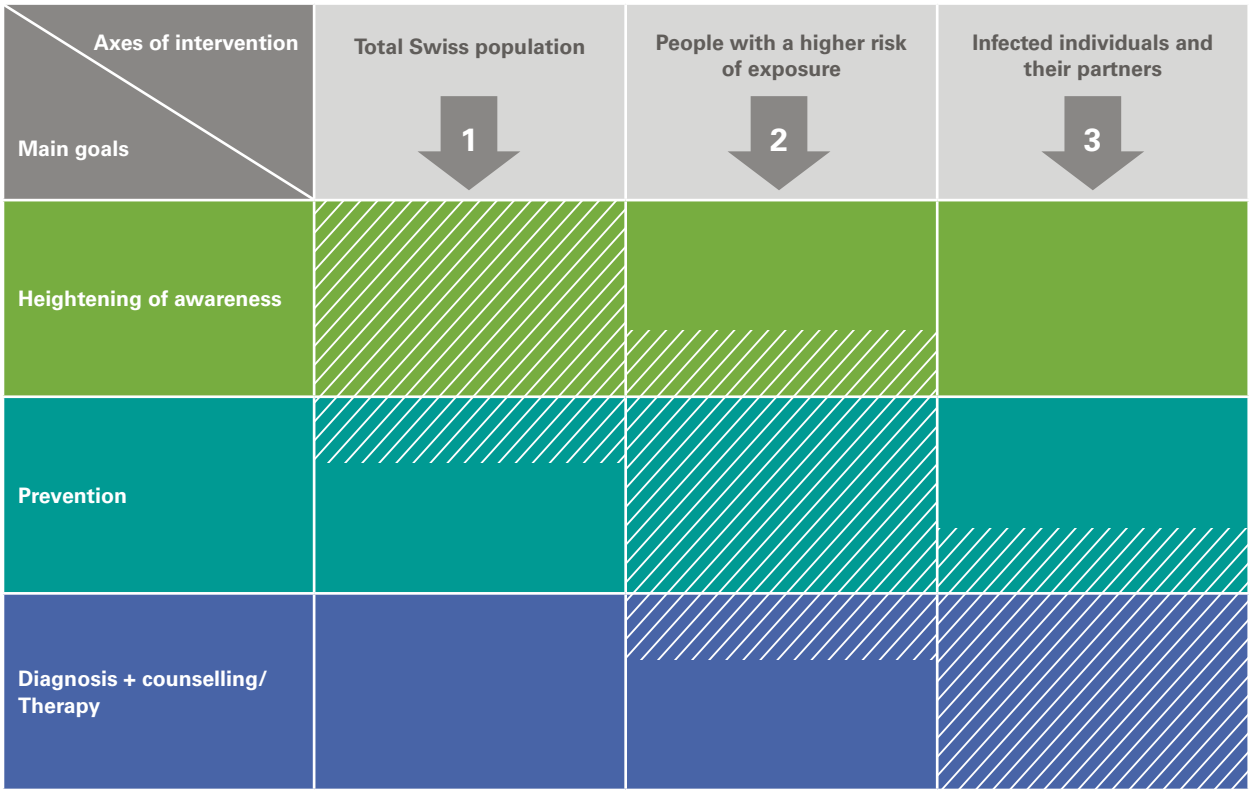
[91] Council of Europe et al. (2010) Recommendation CM/Rec(2010)5 of the Committee of Ministers to member states on measures to combat discrimination on grounds of sexual orientation or gender identity

[92] The understanding of self-protection on which the Programme is based is in accordance with the Federal Constitution (Article 6), which states that each person should take self-responsibility.

[93] In this sense the "individual interventions" are interpreted as actions which occur within the scope of treatment by a doctor. The doctor's treatment obligation is limited in this case by the patient's right of self-determination. This principle can, however, be violated in the field of collective preventative measures, such as sexual health education or awareness campaigns. It is not permitted, for example for children (or their parents) to invoke the principle of informed consent to cause them to be exempted from compulsory sexual health education.

13 GOALS ACCORDING TO AXES OF INTERVENTION, CONCOMITANT MEASURES AND RESPONSIBILITIES

Matrix with axes of intervention and main goals:



The matrix shows an overview of the main goals in the various target groups (intervention axes). For each main goal there are goals to be met. The emphases in the intervention axis are each indicated with hatching. This means for example, that awareness raising measures are offered to the whole population and there is also an offer in terms of prevention. For persons with increased risk, the emphasis is placed on prevention, although measures for raising awareness and for diagnosis, counselling and therapy are also offered. For infected persons and their partners, the focus is on diagnosis, counselling and therapy. Attention here is also paid to prevention. HIV-infected persons are alerted not to pass on the virus; uninfected partners are motivated not to become infected.

13.1 GOALS, MEASURES AND RESPONSIBILITIES IN AXIS OF INTERVENTION 1

Axis of intervention

Total Swiss population

Heightening of awareness (goal 1 in axis 1)

Heightening of the awareness of Swiss residents to the value of sexual health and individuals' rights with regard to sexuality.

Heightening of awareness paves the way for individuals to exercise their sexual rights and not to discriminate against their peers who are infected. It causes them to identify a potential risk of HIV and other Sexually Transmitted Infections. Individuals effectively and independently protect themselves against HIV, other STI and unwanted pregnancies – including in unusual situations (e.g. on holiday, under the influence of drugs or in the event of mental health problems) – and quickly clarify their risk in the event of a suspected exposure to risk and support the information of partners in the event of infection.

Measures/responsibilities (the list makes no claim to be exhaustive and can be amended according to the evidence): The raising of awareness via the LOVE LIFE campaign, counselling services, the medical profession.

Responsible: Confederation in cooperation with relevant umbrella organisations and associations and their members, cantons, the medical profession, other professionals (carers, social workers, teaching staff, sexual and marriage counsellors, migrant organisations as needed).

Prevention (goal 2 in axis 1)

The population is informed about HIV and other STI. Access to vaccination services and preventative measures is guaranteed for all.

The information embraces an individual's rights with regard to sexuality and propagates the primary measures to protect against unwanted pregnancies, HIV or longer-term health problems caused by STI. These primary measures are:

1. Prevention through protective measures (safer sex),
2. Vaccinations (where vaccinations are available and recommended),
3. Early detection,
4. Correct treatment at the right time.

Individuals have ease of access to further information, or to qualified counselling services.

Responsible: Information brochures and leaflets are available in different languages. The following strategy is propagated in terms of protection: practice safer sex with casual partners; couples within a monogamous relationship can only dispense with safer sex after testing negative for HIV.

Axis of intervention

Total Swiss population

1

A platform for the exchange of information and opinions among all actors, "↘isis-info.ch" provides reliable information for professionals and the general public.

Sexual health is included in the information material handed out to migrants when regularising their residency status.

Information about general prevention for travellers (inoculations etc.) to be extended to include the issue of self-protection with casual encounters and sex with sex workers.

Responsible: Confederation in cooperation with relevant umbrella organisations and associations and their members, cantons, the medical profession, other professionals (carers, social workers, teaching staff, sexual and marriage counsellors), and migrant organisations as needed, as well as travel medicine clinics and the travel industry.

In cooperation with and with the agreement of the cantons, the aim is to integrate age-appropriate sexual health education into the curricula of obligatory and post-obligatory schools in all cantons as part of health promotion[94]. This conveys information, embeds knowledge about sexual health and combats the stigmatisation of individuals with HIV and other STI. It deals with various sexual orientations and gender identities without attaching value judgements and thus makes it easier for adolescents to find their ↘sexual identities. The aim, in close cooperation with the cantons, is for ↘sexual health education to be taught in teacher training colleges (under the political responsibility of the cantons) and in Universities with the faculties of Social Work and Social Education.

Measures: Further training for teachers on the subject of sexual health education is an integral part of lectures at teacher training colleges and universities offering social work courses. A closer look at the subject in the form of obligatory modules during the bachelor's degree course at universities with social work faculties is under discussion.

The Central Switzerland Teacher Training College (PHZ) centre of excellence for sexual education has joined forces with the Swiss Foundation for Sexual and Reproductive Health (PLANeS) and interested cantons to establish standards for sexual health education at school as part of this programme.
PLANeS is setting up standards for youth work carried out by professionals outside schools and makes these available to the parties concerned and those with an interest in the matter. PLANeS monitors compliance with these standards at the actors' request.

Responsible: Cantons, PHZ centre of excellence and other educational institutions, PLANeS.

[94] Federal Office of Public Health ((2009) Sex Education and School; Pädagogische Hochschule Zentralschweiz (Central Switzerland Teacher Training College) (Pub.), white paper on the Switzerland-wide embedding of sex education in schools and considerations on training and continuing education for teaching staff at universities.

Axis of intervention

Total Swiss population

High-quality, continuing professional education for specialists in the field of prevention, multipliers and the medical profession is assured.

Measures: Suitable continuing education concepts are being created in cooperation with the institutions and Federal agencies concerned.

Responsible: Swiss National AIDS Commission (EKAF); Confederation in cooperation with the medical profession, other professionals.

Adolescent and adult residents are encouraged to undergo vaccination according to the recommendations of the Federal Vaccination Commission (EKIF).

Measures: Information on vaccinations (via campaigns or at schools) motivates all adolescents to undergo vaccination against hepatitis B. Young women (eventually young men as well) are advised to be vaccinated against HPV. Adults are motivated to have themselves vaccinated against hepatitis B.

Responsible: Confederation in cooperation with Federal Vaccination Commission (EKIF), the medical profession.

Preventative measures and condoms are available throughout Switzerland.

Diagnosis and counselling (goal 3 in axis 1)

Access is guaranteed through high-quality services, commensurate with needs, of counselling, testing and diagnosis and emergency intervention.

Following suspected exposure to risk, residents quickly clarify their personal risk by means of a consultation or on an anonymous basis (e.g. using an Internet tool). Sexually active individuals with changing partners regularly check their risk (several times a year).

Measures: Tool for individual risk assessment (Check your Lovelife) will be adapted for STI and propagated further.

Responsible: Confederation in cooperation with relevant umbrella organisations and associations plus their members.

Axis of intervention

Total Swiss population

In the event of sexual health problems, sexually active women and men take recourse to the support system of their own accord.

Individuals with a negative STI and/or HIV test result receive comprehensive, personalised information about protective strategies.

People with a negative STI and/or HIV diagnosis receive a comprehensive and individual counselling about protective measures.

Recognised test concepts for HIV and other STI are available to the medical profession and to VCT centres. PICT is intensified in conjunction with competent partners. The concepts also include the screening of pregnant women and entail informing partners. The aim is to reduce the number of undiagnosed HIV infections and STI. In Switzerland there is no vertical transmission of HIV or of STI that are hazardous to health.

Measures: Test concepts are drawn up and pilot projects created to prevent chlamydia trachomatis.

Responsible: Confederation in cooperation with the medical profession, EKAF.

There are medically supervised "walk-in" clinics in the domain of HIV and other STI – in the bigger towns and cities where possible – where individuals receive low-threshold counselling, are tested if the presence of HIV or an STI is indicated and are treated, or receive an emergency intervention (e.g. post-coital prophylaxis) on the basis of the VCT principle. The assumption of the costs for these services is organised in such a way that it does not impede access.

Responsible: Cantons in cooperation with the cities/towns concerned and, if necessary, with umbrella organisations, health insurers (health insurance fund).

HIV and STI prevention is an integral part of sexual and reproductive health counselling services. Doctors must carry out expert, careful sexual anamnesis and provide high-quality consultations.

Measures: Specific facilities are created for certain target groups of axis 1 – namely for adolescents as well as for vulnerable migrant groups – or the standard facilities available should be designed to cater for their specific needs (for example migrant-friendly medical services).

Responsible: Cantons, municipal authorities, relevant umbrella organisations and associations, migrant organisations.

13.2 GOALS, MEASURES AND RESPONSIBILITIES IN AXIS OF INTERVENTION 2

Axis of intervention

People with a higher risk of exposure

2

Heightening of awareness (goal 1 in axis 2)

The awareness of target groups in axis of intervention 2 is additionally and specifically heightened.

Additional and specific heightening of awareness makes individuals belonging to target groups realize that they are active in an environment with increased prevalence of HIV and/or other STI and are therefore subject to a greater risk of exposure.

Measures/responsibilities (the list makes no claim to be exhaustive and can be amended according to the evidence)

- *Target-group-specific leaflets, flyers, programmes/campaigns, Internet*
- *Programmes involving opinion leaders from the individual target groups*
- *Separate telephone hotlines/helplines for members of the target groups*

Responsible: Confederation in cooperation with relevant umbrella organisations and associations as well as their members, cantons, municipal authorities, the medical profession, other professionals (social workers, teaching staff, sex and marriage counsellors, and migrant organisations as needed).

Specialists and carers (e.g. doctors, prison staff) who work with members of the corresponding target groups are made aware of HIV and STI prevention.

Measures: Professionals and care providers will be supplied with the necessary information, and further education materials will be created.

Responsible: Confederation in cooperation with relevant umbrella organisations and associations as well as their members, cantons, municipal authorities, relevant federal agencies, prison governors, prison doctors.

Prevention (goal 2 in axis 2)

The risk of infection is reduced through specific information and contextual prevention concepts in the individual target groups. The Confederation and the cantons regard target-group-specific prevention during axis of intervention 2 as a priority.

Responsible: Confederation in cooperation with relevant umbrella organisations and associations as well as their members, cantons, municipal authorities, counselling services, the medical profession, other professionals.

Axis of intervention

People with a higher risk of exposure

2

The additional information for members of the target groups includes:
- Factors/settings/behaviours that favour risk
- Various protective strategies and risk-reduction strategies and their reliability
- Recommended vaccinations
- Possible identifiers for HIV and other STI (e.g. primary infection)
- Specific contact points for testing and counselling

Measures: Specific vaccination recommendations for the target groups, in their language and context.

Responsible: EKIF, Confederation in cooperation with relevant umbrella organisations and associations.

Specific concepts are established for the individual target groups for contextual prevention in their environment. These act as reminders of the need for protective measures and facilitate their use. The actors themselves set the goal of increasing awareness of HIV and STI prevention in individuals who are in situations which present obstacles to prevention (e.g. individuals in relationships of dependency).

The target group networks and organisations are committed to a consumer-friendly culture in their communities and are committed to opposing discrimination against individuals affected by HIV and STI and the stigmatisation of them.

Measures:

Men who have sex with men (MSM)
- *Availability of specific information and specific prevention material targeting the different MSM subgroups*
- *Specific Internet tool for risk anamnesis encouraging the user to take advantage of counselling and testing in the event of a relevant indication*
- *Entertainment venues and organisers that increase the risk of transmission with their events will offer prevention measures and information material and/or to admit prevention specialists to their venues*
- *Low-threshold vaccination facilities for MSM at places they frequent (hepatitis A and B, HPV for MSM aged below 20)*

Migrants from countries with a generalised epidemic
- *Outreach health promotion*
- *Mediation activities*
- *Specific information material giving addresses of specialist centres when regularising residency status at the municipal aliens' office*
- *Specific Internet tool for risk anamnesis encouraging users to take advantage of counselling and testing in the event of a relevant indication*
- *Asylum-seekers from countries with a generalised epidemic to be encouraged to take advantage of counselling*
- *Counselling services to be instructed in how to take a transcultural approach*

Axis of intervention

People with a higher risk of exposure

2

Sex workers

- *Specific Internet tool for risk anamnesis encouraging users to take advantage of counselling and testing in the event of a relevant indication*
- *Entertainment venues and organisers that increase the risk of transmission with their events are to offer prevention measures and information material and/or to admit prevention specialists to their venues*
- *Aliens' offices to recommend cabaret dancers attend an STI and HIV info event*
- *Preventative street work among streetwalkers*
- *Low-threshold vaccination services for sex workers in settings they frequent*

Injecting drug users (IDU)

- *The harm reduction measures are basically maintained, and adapted to the needs*
- *Centres for IDU to also encourage prevention of HIV and other STI*
- *Preventative measures, specific information for IDU working as sex workers*
- *Raising awareness about the risk and high prevalence of hepatitis C*

Prison inmates

- *BIG*[95] *project to be developed further*
- *Facilities for the prevention, vaccination, testing and treatment of infectious diseases as well as treatment for substance abuse, with these facilities fulfilling the assumption of equivalence (identical healthcare for prisoners as for the rest of society).*

Preventive services for target groups in axis of intervention 2 could also comprise services which are not directly linked to HIV and STI prevention, but which have a positive impact on the individual's health.

Responsible: Confederation in cooperation with relevant umbrella organisations and associations as well as their members, relevant federal agencies, cantons, municipal authorities, the medical profession, contact points for prevention, owners of establishments where contextual prevention is practised, other professionals and actors.

[95] The project entitled "Combating infectious diseases in prisons (BIG)" is being jointly implemented by the Confederation (FOPH, Federal Office of Justice (FOJ) and the Conference of Cantonal Justice and Police Directors (KKJPD). It pursues the following objectives:
1. Minimum risk of infectious diseases being transmitted within prisons;
2. Minimum risk of infectious diseases being spread from prisons to the community and vice versa;
3. Prison-based testing, prevention, counselling, treatment and care for infectious diseases equivalent to those available in the community;
4. Prison-based substance abuse treatment equivalent to that available in the community;
5. Ensuring the sustainability of the measures and instruments developed.

Axis of intervention

People with a higher risk of exposure

Diagnosis and counselling (goal 3 in axis 2)

Specific counselling, emergency intervention, testing (VCT) and treatment services are available to members of the various target groups.

If the presence of HIV or an STI is indicated, they quickly obtain the correct tests and a suitable emergency intervention if need be (e.g. ↘Post-Exposition Prophylaxis PEP). Integrated centres, combining various services, are promoted.

There are specific test concepts (which are primarily guided by PICT and VCT), which aim to promote early diagnosis of HIV and other STI in members of the target groups during axis of intervention 2. Testing is reasonably priced for them, and access is straightforward, as are the procedures. Home HIV tests are discouraged as they are not used within the framework of professional counselling and diagnosis. The test concepts also include standards on informing partners. The medical profession and qualified institutions know the test concepts and act accordingly.

Measures: Laboratory/PICT/VCT concept for STI differentiated according to the individual target groups. Education about problems with HIV home test kits (incorrect interpretation, no control over test quality, etc.).
Testing services at meeting places (for sex workers or their customers) and in locations where sexual encounters take place (develop mobile checkpoints).

Responsible: Relevant umbrella organisations and associations, EKAF, medical profession, regional HIV and STI centres.

Individuals with a negative STI and/or HIV test result are encouraged through suitable incentives not to infect themselves in the future.

Individuals, whose sexual health is compromised because of psychological problems, receive support if required.

13.3 GOALS, MEASURES AND RESPONSIBILITIES IN AXIS OF INTERVENTION 3

Axis of intervention

Infected individuals and their partners

3

Heightening of awareness (goal 1 in axis 3)

Individuals diagnosed with HIV and/or STI and their partners are able to improve or maintain their health according to their situation.

Individuals who are HIV positive or have an STI are made aware of the relevant factors in connection with their infection – i.e. suitable protective behaviour, the risk of ↘co-infection and interruptions to treatment. They appreciate the benefits of partners being informed.

Negative partners of individuals with HIV or STI are made aware of their specific situation with an increased risk.

Prevention (goal 2 in axis 3)

Individuals diagnosed with HIV or STI receive and understand all the important information in connection with the infection. Partners of individuals with HIV and/or STI are informed about their partner's infection.

Measures/responsibilities (the list makes no claim to be exhaustive and may be amended according to the evidence): Guidelines and recommendations for the medical profession and for prevention specialists and institutions.

Responsible: Confederation in cooperation with relevant umbrella organisations and associations, e.g. AHS, PLANeS.

Individuals with an STI and/or HIV infection receive counselling and support in order to protect themselves against other pathogens and are encouraged to avoid transmitting the pathogen to their partner. HIV-positive individuals follow safer sex rules as long as their virus load is detectable. They are informed in detail of the ↘EKAF statement.[96]

Pregnant women who are HIV positive and/or suffering from an STI receive all the necessary information and medical measures to prevent transmission of the pathogen to their unborn child, or to the newborn.

[96] See Chapter 7: Prevention work facing new challenges.

Axis of intervention

Infected individuals and their partners

3

Measures:

Information takes place:

- *at a collective level (tools, Internet pages, leaflets). The provision of information at a collective level enables individuals to make demands on service providers in terms of quality.*
- *at an individual level. Service providers offer full information about all aspects of individual treatment (side effects, possible alternatives, importance of ↘adherence due to formation of resistance) to individuals with an indication for HIV and/or STI treatment.*

Responsible: Confederation in cooperation with medical profession, qualified service providers and relevant umbrella organisations and associations.

Partners of individuals diagnosed with HIV and/or an STI are informed of their partner's infection with the consent of the person concerned. For each diagnosis, the service providers pick out the main partner information and encourage and support infected individuals to inform their partner, thus complying with the dictates of voluntary participation and data protection.

Responsible: Confederation and cantons in cooperation with relevant umbrella organisations and associations, inclusion of suitable data protection specialists and organisations for those concerned.

Partners of those who have HIV or an STI receive comprehensive information about suitable protection strategies so that they do not acquire the pathogen. They are to be included in the infected partner's counselling, with their consent, or avail themselves of counselling and quickly have the appropriate tests carried out. Incentives ensure that qualified service providers arrange optimum partner management and that partners who do not have HIV or an STI remain permanently negative.

Responsible: Confederation and cantons in cooperation with regional testing centres.

Axis of intervention

Infected individuals and their partners

3

Diagnosis and treatment (goal 3 in axis 3)

Individuals with HIV or an STI receive timely, correct and comprehensive treatment; if necessary their partners are included in the treatment.

Individuals with a curable STI receive successful treatment as soon as possible. The qualified service providers adhere to best practice guidelines or refer patients to specialists. The success of treatment is systematically reviewed.

Partners of individuals with an STI receive rapid treatment (if possible jointly with the person concerned) in the event of a genuine risk of exposure, or if positive test results are present.

Individuals diagnosed with HIV or an STI are recommended to take further tests according to the test concept and their personal exposure to risk.

HIV patients receive professional support and counselling to keep their quality of life as good as possible.

Individuals with HIV for whom treatment is indicated are encouraged to start this treatment quickly. They achieve the treatment aim of a virus load below the detection limit in the long term and without interruption. They receive professional counselling and psychological support to underpin their willingness to receive treatment and adhere to it. They have access, if necessary, to paramedic support services, or legal assistance, with the objective of empowering them.

Measures: Pilot project for verifying a ↘disease management model in the field of HIV and STI.[97]

Responsible: Medical profession, ↘managed care institutions in the healthcare sector.

HIV treatment is evidence-based. Medical specialists ensure appropriate treatment of individuals with HIV; primary care providers treat them in conjunction with specialist doctors or centres. Integrated care models (managed care) are available for individuals with HIV, which guarantee the quality of treatment tailored to the individual in the long term and which assume preventative roles (e.g. preventing ↘co-morbidities). The integrated care models work with suitable incentives to achieve the treatment aim.

Measures: Develop and/or revise treatment guidelines for the relevant STI and HIV.

Responsible: EKAF and Confederation.

[97] The term "disease management" describes a system which improves integrated provision for patients (especially those who are seriously ill). The fonctioning cooperation between the various stakeholders and the pliants' active inclusion are significant aspects of the concept.

Axis of intervention

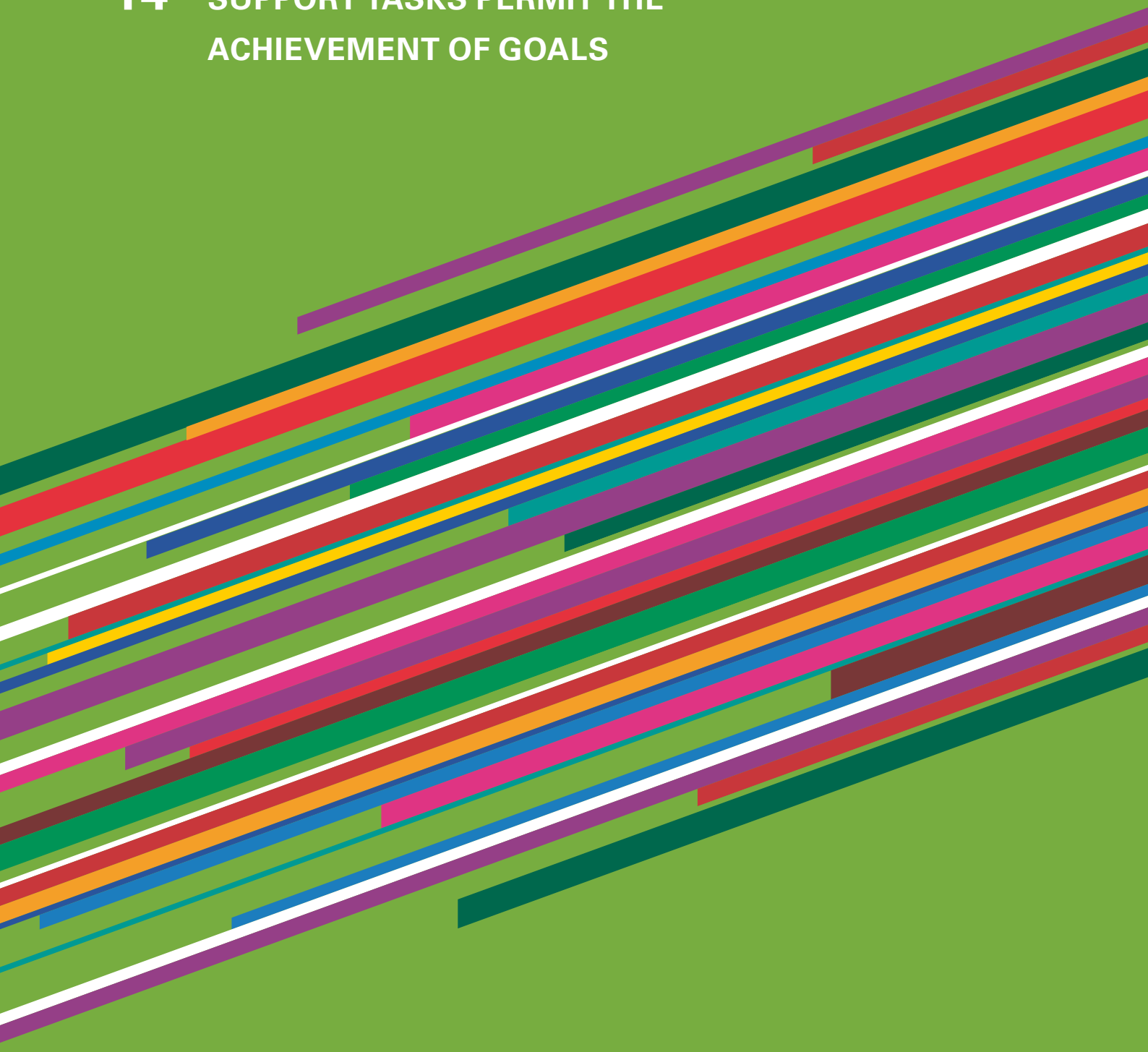
Infected individuals and their partners

Service providers adhere to the Swiss Federal Office of Public Health's treatment guidelines.

Palliative care is available as a service to patients who are seriously ill with, or dying of HIV and/or an STI, for whom other treatment is no longer effective.[98]

[98] Palliative care improves the quality of life of patients and families who face life-threatening illness, by providing pain and symptom relief, spiritual and psychosocial support from diagnosis to the end of life and bereavement. Patients will be accompanied and supported by a network of qualified personnel, support staff and volunteers, They will decide as far as is possible how and where they would like to spend their last phase of life. In the context of the "National Health Policy" the Confederation and Cantons have resolved to promote palliative care in Switzerland. The "National Strategy for Palliative Care 2010–2012" sets the objectives for strengthening the offer of palliative care (see also: Bundesamt für Gesundheit et al. [2009] Nationale Strategie Palliative Care 2010–2012).

14 SUPPORT TASKS PERMIT THE ACHIEVEMENT OF GOALS



The support tasks are decisive factors for achieving the first three main goals (1. Heightening awareness, 2. Prevention, 3. Counselling, diagnosis and therapy). They represent the socio-political and structural framework, in the absence of which successful and sustained activities in the field of HIV and STI will not be possible. The activities involved in the support tasks are described in the following chapters and include indicators and milestones as in the case of the programme goals.

14.1 COMMITMENT AGAINST DISCRIMINATION AND STIGMATISATION OF INDIVIDUALS HAVING OR BEING VULNERABLE TO HIV AND/OR STI

"Human rights form the foundation for any policy for containing HIV and STI. The National Programme must be guided by them. It is especially necessary to promote respect of human rights in the context of prevention and support for people with HIV – both in Switzerland and internationally."[99]

"Discrimination against those affected impedes prevention. For that reason, it is crucial to address discrimination against those affected and to promote solidarity with them."[100]

Commitment against discrimination as an important universal element in the programme

Discrimination against individuals who are HIV-positive or have an STI is unacceptable. Discrimination against persons on grounds, for instance, of a bodily disability is prohibited by the Universal Declaration of Human Rights[101], numerous other international conventions and declarations[102] and the Swiss Federal Constitution.[103] In the context of international activities with HIV and AIDS, Switzerland has always campaigned for this fundamental right to be respected.

The commitment to react against the discrimination suffered by those with HIV/STI and the campaign against all forms of stigmatisation surrounding HIV and STI remain an obligation for Switzerland domestically and form an important universal element of this strategy. This is especially so because the efforts to ensure prevention, diagnosis and treatment of HIV and STI cannot lead to success if those concerned have grounds for fearing that they are going to be excluded from society or disparaged by it as soon they allow others to know that they are carriers of such an infection. The fear of stigmatisation and discrimination may act as a barrier for those concerned, preventing them from being open with their (sexual) partners about their infection with an STI or HIV and from talking to them about suitable protective measures. Such a negative situation can also deter people from having a test performed in time or from making use of available treatments, something which is counteractive to the strategic aim of promoting the early detection and treatment of HIV and other STI. Issues in relation to this might be particularly likely amongst those migrant groups in which sexuality and sexual health have traditionally been subject to taboos and where the fear of stigmatisation may be massive, and even existential.

The activities still needing support in Switzerland include, on the one hand, building a consensus in society that people infected, concerned or particularly threatened by HIV or an STI belong to society as members with equal rights and that they have the same rights and duties at all levels as people who are not affected. It is also necessary to encourage support for people with HIV or an STI as well as understanding that they find themselves in a special situation which entails limitations for them and means they have specific needs.

[99] Thesis 1.1 taken from BAG et al. (2009) Theses for the development of the National HIV and STI Programme 2011–2017.

[100] Thesis 1.6 taken from BAG et al. (2009) Theses for the development of the National HIV and STI Programme 2011–2017.

[101] Universal Declaration of Human Rights, Article 7: "All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination." 1948, United Nations.

[102] See footnotes 85 and 86, Chapter 12.

[103] Swiss Federal Constitution, Article 8: "Nobody shall suffer discrimination, particularly on grounds of origin, race, sex, age, language, social position, lifestyle, religious, philosophical or political convictions, or because of a bodily or mental disability."

Comparatively good situation in Switzerland – but still room for improvement

By international comparison, the situation for people with HIV in Switzerland is regarded as good. One example of this is that Switzerland came in at third place in a recent comparative study called the "Euro HIV Index 2009"[104]. This study was carried out by an independent research institute during Sweden's presidency of the Council of the European Union and classifies 29 European countries according to their efforts to deal with the HIV epidemic. Switzerland owes its favourable position to its cohort study in particular. The study did, however, establish that there were problems in Switzerland in terms of discrimination and/or stigmatisation. HIV-positive individuals are not always treated in the same way here as those who are not infected, still being excluded from certain insurance benefits. According to the Swiss AIDS Federation (Aids-Hilfe Schweiz) there is often no justification for such exclusion, particularly given the new options for the treatment of HIV. Any such unjustified discrimination must be avoided, whether in relation to insurance cover or other matters. Various forms of discrimination against HIV-positive employees occur frequently at the workplace, as revealed by the monitoring activities of the Swiss AIDS Federation carried out on behalf of the Swiss National AIDS Commission (EKAF). Such acts of discrimination affect the entire employment relationship, from recruitment to dismissal and include other issues such as employee insurance schemes. In addition, there are also several countries in the world that impose travel restrictions on individuals with HIV, making it impossible for them to enter or stay in those countries.

One of the negative findings of the above study is the circumstance that a relatively high number of individuals with HIV are subject to criminal prosecution and conviction in Switzerland on grounds of having exposed other people to the virus. According to Swiss case law[105] it is an offence for an HIV-positive individual to risk spreading HIV by having unprotected sexual contacts, even if the other person consents and knows about their sexual partner's illness. This way, the burden of responsibility is placed unilaterally on HIV-positive individuals, relieving HIV-negative individuals of the obligation to actively protect themselves against HIV. Efforts are being stepped up at an international level to decriminalise the transmission of HIV where no intent is discernible. The driving force behind such efforts is UNAIDS.[106] It should also be mentioned that the criminal law of countries such as France, Italy, Spain, the Netherlands and Great Britain does not include specific articles governing HIV or other STI. However, the deliberate transmission of HIV and other STI is liable to prosecution on the basis of their criminal law.

According to UNAIDS, making the transmission of HIV a criminal offence can have the effect of undermining prevention. It may prevent individuals from having an HIV test carried out in good time if ignorance of their own HIV status appears to them to be the most convincing line of defence in subsequent criminal proceedings. A further argument is that making the transmission of HIV a criminal offence might erode trust between those with HIV and the professional service providers if those concerned fear that information about their status could be used against them in criminal proceedings.

Prosecution under criminal law and the perpetrator/victim perspective inherent in criminal law are in contradiction to the fundamental concept underlying the Swiss HIV and STI prevention strategy, which makes sexually active individuals responsible for themselves. They ought to be personally responsible for maintaining their (sexual) health. The aim of prevention is to ensure that they have the wherewithal to do that.

Obligation of equal treatment as the foundation for all services

Prevention can only succeed once discrimination and stigmatisation have been eradicated. This explains the commitment to equal treatment for those with HIV and STI, which is pursued in the context of the strategy. It is the heightening of awareness that is at stake here – not just of the general population, but also of insurance companies, employers and those with other roles to play. In this sense, the obligation of equal treatment should form the foundation for all services available in the field of HIV and STI. All prevention measures should be organised so that they do not discriminate against individuals with HIV or chronic STI.

[104] The data, which encompasses some thirty basic indicators, was acquired from national health ministers or national NGOs (cf. also http://www.healthpowerhouse.com/files/Report%20Euro%20HIV%20index%20091008-3.pdf).

[105] cf. Swiss Criminal Code, dated 21 December 1937 (SCC, SR 311.0), Articles 122 ff. (Bodily injury) and 231 (Spreading dangerous diseases).

[106] In his "Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health", presented to the UN Human Rights Council on 4 June 2010, Anand Grover illustrated to what extent the criminalisation of HIV transmission violates the principles of Human Rights (cfr: http://www2.ohchr.org/english/bodies/hrcouncil/docs/14session/A.HRC.14.20.pdf). A new initiative, launched by UNDP und UNAIDS takes stock of the various court rulings relating to HIV and human rights. (Global Commission on HIV and the Law (http://www.hivlawcommission.org).

The programme does not name any specific aims in the field of anti-discrimination and anti-stigmatisation, but it does define the necessary conditions for the strategy to lead to success. These conditions are also linked to measurable indicators, and checking for compliance with them should be mandatory and take place on a regular basis.

Tasks:

1. **Equal treatment and non-discrimination**
   Individuals living with or affected by HIV or a chronic STI have the same rights and the same responsibilities in all facets of life as individuals who are not infected. Those actively involved in HIV and STI activities will ensure that this consensus in society is upheld and that the population is aware of the obligation of equal treatment. The commitment to eradicate discrimination against those affected by HIV and other STI and the campaign against the stigmatisation of HIV and other STI will be integrated as a compulsory part of sexual health education in schools.
   Individuals with HIV or STI will not suffer any form of discrimination or stigmatisation because of their infection, especially in their family, at their place of work or education or in terms of culpability or insurance cover. Instances of discrimination and stigmatisation will continue to be identified by the Swiss AIDS Federation and reported to the Swiss National AIDS Commission (EKAF) subject to the data protection laws. Specific measures will be adopted to ensure that such forms of discrimination and stigmatisation are combated effectively and so prevented.[107] There will be specific measures for migrant groups where the discrimination and stigmatisation of people with HIV or STI is especially prevalent. Research in this field will clarify the reasons for such discrimination and offer a deeper understanding in this regard.

2. **Participation and empowerment**
   Individuals with HIV will be invited to be part of the HIV and STI activities. They will be involved in the development of the strategy, in working out suitable measures and in implementation and evaluation.[108] The activities benefiting people with HIV or STI are always aimed at empowerment. The Swiss Confederation will encourage the creation and networking of representative organisations for those concerned.

Milestones

1. Following a review, the Swiss National AIDS Commission will propose suitable countermeasures to eradicate discrimination against people with HIV and/or other STI at the end of 2012 for the first time and then at regular intervals thereafter.

2. By the end of 2013, the Swiss National AIDS Commission will publish a report providing information about compliance with the GIPA principles by the NGOs and NPOs.

Competences

- The *Swiss Confederation,* in cooperation with the Swiss National AIDS Commission (EKAF), will organise regular verifications of the status of equal treatment and make sure that the results are communicated and published in suitable ways. In addition, the Swiss Confederation and the Swiss National AIDS Commission will monitor the situation regarding organisations violating the equal treatment obligation and ensure that suitable countermeasures are put forward.
- The *Swiss Confederation,* acting jointly with the cantons, will ensure that the issue of non-discrimination and anti-stigmatisation is integrated in sexual health education at schools.
- The *Swiss Confederation* will support the creation and networking of representative organisations for those concerned.
- The *Swiss National AIDS Commission* will check periodically that the representative organisations are properly involved in HIV and STI prevention.

[107] UNAIDS has identified ten areas of discrimination:
I. health care
II. employment
III. justice/legal process
IV. administration
V. social welfare
VI. housing
VII. education
VIII. reproductive and family life
IX. insurance and other financial services
X. access to other public accommodations or services (such as funeral services)
UNAIDS (2000) Protocol for the identification of discrimination against people living with HIV

[108] The idea that the first-hand experiences of people with HIV should and could be leveraged in shaping a response to the HIV epidemic was formally adopted at the Paris AIDS Summit in 1994 when 42 countries declared the "Greater Involvement of People Living with HIV and AIDS (GIPA)" to be one of the criteria for planning ethical and effective responses to the epidemic.

- The *FOPH* is to insist that anyone doing paid project work on its behalf in the field of HIV and STI must ensure that their products and services encourage the equal treatment of people with HIV or a chronic STI.
- *Organisations* for those concerned will be involved in a mutual commitment to eradicate discrimination against those with HIV and STI and the campaign to eradicate stigmatisation surrounding HIV and STI. They will have a decisive say in the projects in this field.
- The *Swiss AIDS Federation* will assist all institutions providing advice to people with HIV and STI as the reporting unit for instances of discrimination. It will make this information available to the Swiss National AIDS Commission and will support the latter in the development and implementation of suitable measures preventing discrimination.
- The *Swiss AIDS Federation* will help raise awareness of discrimination and stigmatisation among the population.

14.2 GOVERNANCE – COORDINATED COOPERATION AS A KEY ELEMENT OF SUCCESSFUL HIV AND STI ACTIVITIES

"The programme defines the goals for the individual prevention axes and clarifies the responsibilities of the umbrella associations. It makes provision for these to create synergies and to coordinate their activities."[109]

Cooperation between actors

The National Programme on HIV and other Sexually Transmitted Infections 2011–2017 is a joint undertaking by the Confederation, cantons and the key actors in HIV and STI activities. The Confederation has been assigned the lead role in drawing up and coordinating the strategy in accordance with the Swiss Epidemics Act, while implementation of the strategy is performed on a partnership basis, with the cantons and other stakeholders playing a decisive role. The harmonization of the cooperation between the different players is also known as ↘"governance".[110]

While cooperation between the different actors, which has evolved historically, results in a complex system of engagements in the field of HIV, this cooperation has always constituted a strong point. Experts from a wide range of specialist areas, with their different competences, are all committed to the same cause. The new programme was thus compiled in this spirit and ties in with the tradition of a joint approach.

During the concept phase of programme development, the Swiss Federal Office of Public Health wished to conduct a survey among stakeholders, firstly allowing them to rate the strengths and weaknesses of the National HIV/AIDS Programme 2004–2008 and secondly, to express their wishes regarding the next programme (NPHS 2011–2017) to be developed (Kessler et al. 09). For this reason, the FOPH commissioned the Swiss Tropical and Public Health Institute to conduct a web-based survey amongst the actors involved in HIV and STI activities. Around a hundred stakeholders took part and came to a clear conclusion: the programme had succeeded in defining a joint goal and direction for the HIV activities. However, coordination between the different actors had been inadequate. The stakeholders hoped the Confederation would improve this coordination and harmonization; in addition, the roles of the individual actors were to be more clearly defined and hence the responsibilities pinpointed more precisely.[111]

An international panel of experts evaluating the preceding programme under the leadership of public health specialist Rolf Rosenbrock arrived at a more critical assessment of the structures of Switzerland's HIV system: the Swiss system is characterised by structural rigidity, and insufficient allowance has been made for the dynamics of the HIV epidemic over the last few years. In addition, contrary to international trends, HIV prevention has not been tackled to a sufficient extent in the context of sexual health (Rosenbrock et al. 09)[112].

The new programme now incorporates the field of other STI. As a result, it is necessary to switch from HIV prevention to HIV and STI prevention in structural terms. In addition, a clear allocation of roles and resources, based on public health considerations, ought to ensure that HIV and STI activities are organised more efficiently in future. Interventions must be evidence-based, practical and cost-efficient. At the same time, there should be scope for innovation (Kessler et al. 09)[113].

[109] Thesis 1.7 taken from BAG et al. (2009) Theses for the development of the National HIV and STIs Programme 2011–2017

[110] This term stands for a control or regulating system in the sense of structures (organisational structure and process organisation) of a politico-social unit such as the state, an administrative authority, a local government body or a private or public organisation (for a detailed explanation: see Glossary).

[111] Kessler et al. (2009) Nationales HIV/Aids & STI Programm: Webbasierte Stakeholderbefragung 2009

[112] Rosenbrock et al. (2009) Review of the Swiss HIV Policy by a Panel of International Experts. Expert Report.

[113] Ibid.; see also: Kessler (2009) International Context Analysis. HIV & STI Strategies and Programmes: The European and International Reference.

Tasks

1. Coordination

A concept exists for the allocation of roles and tasks in Swiss/international HIV and STI prevention work: the FOPH takes the lead in development of the national strategy and coordinates the implementation of this strategy at federal level. Activities at an international level are implemented by the Swiss Agency for Development and Cooperation (SDC) in cooperation with the FOPH. The NPHS is additionally integrated in a worldwide system for the prevention of HIV and other STI and bases its efforts on the recommendations, guidelines and quality standards of the international specialist organisations (e.g. WHO, UNAIDS). For all the stakeholders involved (Confederation, cantons, NGOs and others), the NPHS constitutes the widely accepted standard practice ("unité de doctrine").

2. Quality

In order to guarantee a high quality of HIV and STI activities in Switzerland and also the efficient use of resources, the fulfilment and allocation of the individual tasks and resources will be regularly monitored and, where appropriate, adjusted in relation to the following factors: epidemiological development[114], relevance for public health, quality of the individual prevention measures, cost/benefit analysis.[115]

3. Extension to include STI

The present VCT centres, regional HIV centres and other key service providers in HIV prevention extend their counselling and test services to include STI that are of relevance for public health.

4. Strategy monitoring

The competent non-parliamentary commission, which advises the Federal Council (currently the Swiss National AIDS Commission – EKAF), is responsible for monitoring developments in the field of prevention, diagnosis and therapy as well as medical advances. The commission decides whether new evidence calls for strategic adaptation of the National Programme for HIV and other Sexually Transmitted Infections 2011–2017. Where appropriate, it recommends relevant modifications be made by the Federal Office of Public Health.

5. Innovation

A pool is set up to promote innovative projects. The pool funds projects that offer impressive approaches, employ new methods or introduce innovative activities.

Milestones

1. By 1 January 2012 – the start of the new four-year period of the non-parliamentary commissions – the mandate of the National AIDS Commission (EKAF) will have been redefined based on the role description of the NPHS 2011–2017, making allowance for the inclusion of STI. The working groups in existence – possibly involving additional experts – will also have been clarified.

2. By the end of 2011 a project financing pool will have been set up for promoting innovative projects. The associated concept is being drawn up by the FOPH with the help of key umbrella organisations and associations.

Annex

The Annex 15.2 puts forward the roles of the individual actors for the operationalisation of the NPHS 2011–2017. This allocation of roles also serves as an overview of HIV and STI activities in Switzerland.

[114] Here it is not only of importance which pathogens are spreading, and at what rate. The local dimension is also of significance: For example, whether most new infections occur in the urban or rural environment – or whether certain regions are specially affected by one virus.

[115] See also the chapter on evidence under "Third Generation Surveillance System".

14.3 EVIDENCE PROVIDES THE BASIS FOR PLANNING (PREVENTION) MEASURES

"The measures contained in the new HIV and STI programme should be evidence-based, practical and cost-efficient."[116]

A need for innovation in terms of surveillance

Prevention of HIV and STI in Switzerland is evidence-based. Monitoring the transmission of HIV and other STI as well as terminations of pregnancy form the basis for interventions in this field. The behaviour of the population as a whole and individual population groups strongly affected here is also registered at regular intervals in the framework of surveillance.

At the time of programme development, strategic decisions about the allocation of resources for the prevention of HIV and other STI are being made more difficult by the fact that the various prevention measures are not comparable as far as their effectiveness and costs are concerned. In order to harmonize data, the programme will define cost/benefit analyses with suitable indicators to fill any gaps in knowledge in relation to surveillance.

Within the scope of the NPHS the creation and implementation of a comprehensive system of **third-generation surveillance**[117] is thus required. This will make it possible, on the one hand, to improve the identification of changes in the number of new diagnoses and changes in the behaviour of various population groups that are particularly affected. On the other hand, political decision-makers will be given a more precise set of instruments so they can assess what interventions are likely to be worthwhile in which circumstances. Third-generation surveillance thus supplies an important instrument for quality assurance as well as for measuring its effectiveness.

Given that the pathogens that cause HIV and STI do not stop at national borders, it is imperative that Switzerland with its HIV and STI surveillance should fit into a pan-European system. Building up a European surveillance system has been going on since 2008 under the aegis of the ECDC.[118] The indicators proposed by the ECDC for behavioural surveillance are now broadly compatible with the Swiss indicators, thus there are no major barriers to integrating the Swiss scheme into the European system.

Surveillance in Switzerland (situation in 2010)

Switzerland has an HIV prevalence of less than 0.5% in the general population and over 5% in groups at risk (MSM, migrants from high-prevalence countries and injecting drug users (IDU), which, according to the UNAIDS definition, constitutes a concentrated HIV epidemic[119]. Estimates put the prevalence of most other STI at less than 1% among the population as a whole. Exceptions to this are trichomonas, HSV 1+2, chlamydia (especially in young women) and HPV, where the prevalence in the general population is likely to be significantly higher. In the case of the other STI, these pathogens are especially widespread in certain groups of the population; in the case of syphilis and gonorrhoea this in particular applies to MSM and in some cases to sex workers (both female and male).

For countries with a concentrated HIV epidemic, the UNAIDS/WHO "Working Group on Global HIV/AIDS and STI Surveillance" recommends the following measures[120]:

- Notification system for new diagnoses of HIV
- Screening of blood donations
- Surveillance of STI and other biological risk factors
- Biological surveillance in groups at risk or groups with high-risk behaviour
- Collection of behavioural data in groups with high-risk behaviour (cross-sectional survey)
- Collection of biological and behavioural data in so-called "bridging groups" (individuals with both high-risk behaviour and contact with the general population)
- Cross-sectional studies of behaviour in the general population, especially amongst young males (the hope being that such studies will produce evidence of links between individuals with low-risk behaviour and groups with a higher HIV prevalence); it is recommended that these cross-sectional studies be repeated every 4–5 years
- HIV sentinel surveillance of the general population (e.g. pregnant women), especially in urban regions.

[116] Thesis 1.4 taken from BAG et al. (2009) Theses for the development of the National HIV and STI Programme 2011–2017

[117] Third Generation Surveillance (TGS) is the name given to a comprehensive surveillance system, in which in addition to biological and behavioural surveillance, the individual prevention measures and the care services offered are subjected to monitoring to establish their effectiveness. Monitoring also includes cost/benefit analysis. The aim of TGS is to arrive at a situation in which it will be possible to compare prevention measures in terms of their benefit and costs and thus to assign priorities to them.

[118] European Centre for Disease Prevention and Control ECDC (2009) Mapping of HIV/STI behavioural surveillance in Europe. Technical Report

[119] Office fédéral de la santé publique (2010) Rapport de la situation nationale à l'intention de l'UNGASS. Suisse. Période considérée: janvier 2008–décembre 2009

[120] UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance (2000). Guidelines for Second-Generation HIV Surveillance.

Switzerland adheres to the WHO recommendations in principle, but its surveillance system does have a number of gaps. Given that the obligation to notify HIV (and also gonorrhoea since 2008) works relatively well, it is possible to describe the epidemiological evolution of these infections and to analyse it in terms of the affected groups. In the case of syphilis, fewer supplementary notifications have been reported by medical practitioners, something that makes it difficult to draw differentiated conclusions here (for instance regarding the transmission route). In the case of other STI, there are either no supplementary notifications at all (Chlamydia trachomatis) or no notification obligation exists (for example for HSV), thus making it impossible to reliably appraise the number of cases for those pathogens.

Behavioural surveillance is now established and is in part exemplary in some areas, as in the general population, amongst young persons, MSM, injecting drug users and persons living with HIV. Behavioural surveillance has only just started in other groups at risk (such as migrants) or is based solely on the views expressed by experts (as regards sex workers).[121]

Switzerland does not have comprehensive sero-surveillance. Therefore, efforts are needed to obtain parameters to estimate prevalence and incidence in the general population and groups at risk. At the time of developing the programme, only rudimentary answers to questions regarding incidence or prevalence can be given.

Molecular epidemiology makes a key contribution to our understanding of the HIV epidemic. It allows us to reconstruct which strains of HIV are spreading through which chains of persons. Molecular epidemiology can be used to identify "clusters", i.e. groups of people who have all become infected with the same strain of the virus. This means molecular epidemiology can offer decisive support for strategic prevention measures – without ever infringing data protection or personal rights – and lets us investigate the impact of specific measures (e.g. the distribution of sterile needles and syringes to drug users). The possibilities offered by molecular epidemiology in this regard have not been fully exploited to date.

Monitoring/evaluation

Switzerland has several prevention activities which are evaluated on the basis of their quality, and the above surveys also provide indications of their effectiveness. There is a lack of systematic cost/benefit analyses of the individual prevention measures (which would be part of a third-generation surveillance system).

The Swiss HIV Cohort Study supplies dependable data on the quality of the treatment and therapy of people with HIV. Regarding STI there is, however, no systematic collection of data on the quality of diagnosis and treatment.

Tasks

1. **Evidence base**
   Surveillance, monitoring, evaluation and research will form the basis for effective HIV and STI activities. The interventions in the fields of prevention, diagnosis and therapy will be based on the evidence produced through these activities and networking. The findings derived from (national and international) evidence will be made available to all actors. The Swiss Confederation and its partners will work out best-practice models and implement them.

2. **Third-generation surveillance**
   Switzerland will establish a reliable, coordinated, complementary system of third-generation surveillance for HIV and defined STI.[122] The data will be collected with the consent and active involvement of those concerned. Data protection and human rights will be respected here.

[121] Jeannin et al. (2010) System of accompaniment for the strategy for combating HIV/AIDS in Switzerland: Summary report for 2004–2008, page 10.

[122] The concept defines and accords priorities to the public health relevance of the individual STI.

Task components

a) Surveillance

The notification obligation for HIV cases and the total number of HIV tests will remain unchanged; the high level of quality will be maintained and optimised.

The notification obligation for STI relevant to public health will undergo revision. The concept for this will be jointly elaborated by the FOPH and its partners. Data will be compatible with the data from the notification obligation for HIV, with the concept exploiting the potential for synergy with the HIV notification concept. It is accepted by the actors involved in the system.

The FOPH will perform regular and systematic evaluations of the resulting data and forward these to the relevant international bodies, bringing them to the attention of those actively involved in HIV and STI activities.

Early detection: In order to obtain more detailed findings as regards the development of HIV and STI case numbers and trends in groups of the population particularly affected or at risk (especially MSM, sex workers of both genders and migrants), a sentinel system to act as a warning system will be established at selected centres (such as checkpoints, specific test centres for sex workers of both genders and the gynaecological centres of university hospitals). Those centres are responsible for permanent monitoring and constitute a "quality circle" among themselves and with the FOPH, so guaranteeing a regular exchange of data. The centres thus take on the role of an early detection system.

Surveillance axis 1: The Swiss Confederation will organise regular surveys of sexual behaviour in the general population using the Swiss health questionnaire or special surveys.

Surveillance axis 2: Groups of the population that are particularly affected by HIV or STI will be systematically monitored on behalf of the Swiss Confederation by means of behavioural surveys and, where necessary, by prevalence studies.

Surveillance axis 3: Within the cohort study, persons living with HIV are systematically and regularly asked about their physical and mental health, their satisfaction with the (medical and psychosocial) services offered to them and their behaviour in terms of adherence to medication and sexual health.
In the case of individuals who have been treated for an STI, follow-up surveys based on random samples provide data on whether patients were treated successfully.

Drug resistance is also documented and a reliable resistance monitoring system is in existence.

b) Monitoring/evaluation

The measures carried out for the prevention of STI and HIV are subject to professional monitoring, with their effectiveness being appraised in regular evaluations. The evaluation includes a cost/benefit analysis of the activities, especially those focusing on individuals belonging to the defined target groups.

Cost/benefit analysis: The prevention measures and care services offered are regularly examined using key indicators and are subjected to a cost/benefit analysis. A suitable indicator (such as QALY) will be defined.

c) Molecular epidemiology

Investigation at a molecular level (by means of phylogenetic analysis) identifies the transmission paths taken by HIV while spreading through Switzerland. Such studies are carried out on a regular basis with the consent of the persons concerned. Data protection and human rights are respected. The aim of such investigations is to determine prevention measures that are especially suitable or essential here.

d) Networking and transfer of knowledge

Individuals and institutions working in the field of surveillance, monitoring, evaluation and research in Switzerland will exchange their findings regularly with one another and the relevant institutions and experts abroad. The channels required for regular exchange are now established (e.g. internet platform).

Improved cooperation between medical service providers will ensure a rise in the number and quality of supplementary notifications.

The data collected in Switzerland will be harmonised, and the indicators rendered compatible with those used in the European Union.

e) Analysis/assessment

A panel of experts under the direction of the competent non-parliamentary commission (currently the Swiss National AIDS Commission – EKAF) will be responsible for comprehensive, contextual analysis of the data and findings from surveillance. Analysis and assessment will be performed in accordance with the concept drawn up jointly by the experts. This group will produce a description of the current situation at least once a year. This particular task involves:

1. assessing the development of the number of cases of HIV and STI and trends as well as the risks in the various population groups, and
2. reporting the conclusions and recommendations to the competent non-parliamentary commission and FOPH so provision can be made for the necessary correction of the existing interventions or the introduction of additional interventions.

Milestones

1. By 2012 a concept (including a feasibility analysis) for the introduction of an effective third-generation surveillance system will have been drawn up. Its indicators will be compatible with those of the ECDC and UNGASS. The concept will contain a definition of the public health relevance of individual STI (including HIV) and will assign priorities accordingly. The FOPH's data protection advisor should also be consulted when the concept is being drawn up.

2. By 2012 a concept including a preliminary study to clarify outstanding issues for a modern, efficient system for the notification of STI of relevance to public health will be available. The partners will be involved in drawing up the concept.

3. At the end of 2013 the notification system will be evaluated for the first time. Later on, periodic evaluations will identify the error rate of the notification system.

14.4 SYSTEMATIC RESEARCH TO CLOSE GAPS IN KNOWLEDGE

Need for research in the field of sexual health

Research findings, together with data from notification, monitoring and evaluation and supplemented by insights from practice, deliver the basis for effective, efficient HIV and STI activities. Research is well developed in the field of HIV and will in future also take on a more significant role for HIV activities as it has become apparent during development of the NPHS that there are serious gaps in knowledge in the area of sexual health and the spread of STI. The members of the Swiss National AIDS Commission (EKAF) have thus repeatedly proposed moves to close such gaps and gather evidence for a future innovative sexual health strategy. The Swiss Federal Office of Public Health has commissioned an external research specialist[123] to analyse Switzerland's research landscape in the field of HIV, STI and sexual health and advise it on how such research can be stepped up (cf. Annex 15.6). The following chapter is based on the study by this expert[124].

Various approaches to research

As in many areas of health research, there are three primary avenues for research into the areas of sexual health, HIV and other STI:

- **Biomedical basic research:** Biomedical basic research looks at the biological and genetic causes of disease, with the aim of researching its causes to enable them to be treated in causal terms and/or to prevent them effectively. Close collaboration between basic research and clinical research is crucial. Without appropriate basic research, it is impossible to measure the clinical effects of treatment. Pharmaceutical companies are the most prominent stakeholders in biomedical research. However the Swiss National Science Foundation (SNSF) carries out research into sexual health and STI, along with a number of university hospitals and the medical faculties of some universities.

- **Clinical research:** Clinical research seeks ways of curing diseases or alleviating their symptoms. The field of clinical and therapeutic research covers aspects of research focusing on both the disease and the patient, as well as on epidemiology and prevention. The impact of medical treatment on the course of a disease is studied.

[123] Dr. Barbara Haering, former Swiss National Councillor, an expert sitting on various committees and member of various research policy bodies, e.g. Board of Swiss Federal Institutes of Technology and European Research Area Board (ERAB) of the European Union.

[124] Haering et al. (2010) econcept: Forschung und Sexual Health/STI: Übersicht und Möglichkeiten der Förderung

The largest research vehicle currently active in clinical research is the Swiss HIV Cohort Study (SHCS)11[125]. A range of different clinical and surveillance studies make use of the SHCS11[126]; most clinical studies, quite a few epidemiological studies, and some socio-scientific studies are based on data from the SHCS. In addition to this major project, individual institutes attached to university hospitals and universities are engaged in smaller clinical research projects. Moreover, various pharmaceutical companies carry out a significant amount of clinical research in this area.

- **Public health and socio-scientific research:** Health and public health research addresses the individual, economic, legal and social conditions under which the population can achieve and maintain good health (Swiss Federal Office of Public Health 2003). In the area of public health and socio-scientific research, the NPHS gives priority to practice and problem-oriented issues in the research fields of disease management and disease prevention. Research is carried out in the following areas: primary, secondary and tertiary prevention of HIV, living with HIV from the viewpoint of the individuals concerned and associated social, economic, legal and political aspects, as well as research into the treatment and support system. Health policy issues on the subject of sexual health and STI are dealt with by some universities and applied science institutes. Private-sector research institutes carry out research in this field within the framework of departmental research projects from time to time.

Development of promoting research into sexual health in Switzerland

In terms of sexual health issues, to date only HIV research has received a meaningful level of funding from the public purse in Switzerland. In early 1990, the Swiss Federal Council resolved to specifically promote HIV research on a centralised basis. A national research programme, heralding the first phase of promoting research into HIV, was initiated. The non-parliamentary AIDS Research Control Commission (KKAF) manages this programme. The KKAF was an innovation in the history of promoting research in Switzerland: the promotion of basic research by an independent, multidisciplinary commission established by the Federal Council, organisationally affiliated to a federal office, which not only took on the financing, but also the public relations tasks, quality control and coordination of the research, remains unique.

The KKAF was dissolved at the beginning of 2000 and specific HIV research was integrated into the activities of the Swiss National Science Foundation (SNSF). The SNSF founded the AIDS Special Commission and elected the members of the KKAF to this new commission. When the mandate of the AIDS Special Commission expired in 2004, the entire task of promoting research into sexual health, including HIV and AIDS, was then incorporated into the normal SNSF project funding system (Section I for Arts and Social Sciences and Section III for Biology and Medicine). This means there are no longer any special structures within the SNSF for HIV or sexual health in either a national or an international context.[127]

While there has been intensive research in the fields of HIV and AIDS since the 1980s, little interest has been shown in other Sexually Transmitted Infections, which have thus been neglected. Currently there are gaps in knowledge and research in virtually all areas relating to STI. At many public research institutions (principally universities), the focus firmly remains on HIV research. On the other hand, the change in the research structures as described above has put financial pressure on public health research in all aspects of sexual health (STI and HIV) as there is no longer any special funding vehicle available for it. The two other routes of research (biomedical basic research and clinical research) have been able to compensate for the dissolution of the HIV/AIDS Special Commission by having recourse to other funding vehicles. In the case of clinical research, this has been through the Special Committee for Patient-oriented Clinical Research (PaKliF), and for biomedical research it has been through private trusts and the general funding activities of the SNSF Section III. In the clinical and biomedical fields there are significant privately funded research interests. The three research routes thus receive differing degrees of attention at present.

[125] Read more about SHCS in the Glossary (chapter 16)

[126] Examples Haering et al. (2010), Annex A3.

[127] For a more detailed description see Haering et al. (2010)

Promoting research in the area of sexual health

An analysis of the situation in Germany[128] shows that research in sexual health – particularly public health research – will wither away without specific support. Pharmaceutical companies do not prioritise public health research in sexual health but focus on drugs and vaccines for HIV: this situation is not likely to change in future. Other research institutions are feeling intense pressure from the competition and will find it very difficult to launch research projects. Often, the planned research projects are too small or too application-focused to qualify for inclusion in the SNSF's normal research funding activities.

The NPHS is aiming to promote research in the area of sexual health, particularly research relating to STI and public health research in the area of HIV and STI. This is due to the fact that there is a lack of fundamental evidence-based information to ensure effective and efficient government action.

The study[129], which was commissioned by the Federal Office of Public Health and addressed the issue of how this research could most effectively be promoted, reached the following conclusion:

In order to successfully strengthen the funding of research into sexual health/STI and public health, not only is it important to submit clearly defined research projects to the funding institutions, but at the same time, the subject of research in the area of sexual health/STI must be embedded in the strategic concepts of these institutions, and the general public made aware of this.

The tasks of the NPHS result from this conclusion:

Tasks

1. **From AIDS research to research into HIV/STI and sexual health**
   - STI and sexual health will be given greater weight in research. Important upcoming research needs will be identified and their submission to appropriate institutions for research funding supported.
   - Projects on the subject of sexual health will be put out to tender in the framework of departmental research by the Federal Office of Public Health.
   - The autonomy, interdependencies and overlapping existing among the research fields of HIV, other STI and sexual health will be taken into consideration in calls for tenders and project submissions.

2. **Public health research to be stepped up**
   - Besides basic and clinical research, research into public health will become an independent stakeholder in the quality assurance services of the public authorities in the area of HIV, other STI and sexual health.

3. **A public health research platform for HIV/STI and sexual health will be networked to serve all relevant research players.**

4. **Swiss HIV Cohort Study (SHCS)**
   - Financing of the Swiss HIV Cohort Study must be assured.
   - It is opened up to public health research and contributes to a public health research platform in terms of personnel.

Milestone

From 2012, a public health research platform will be established as a coordination, harmonisation and contact point to serve action-focused research stakeholders.

[128] Frey et al. (2006) Sozialwissenschaftliche HIV/Aids-Forschung in der Schweiz 1987–2006. Förderung, Vermittlung und zukünftige Entwicklung. 2. aktualisierte und überarbeitete Auflage. Zürcher Politik- und Evaluationsstudien Nr. 4

[129] Haering et al. (2010)

14.5 EMBEDDING EFFORTS IN RELATION TO HIV AND STI IN THE INTERNATIONAL CONTEXT

The thesis:

"The new National Programme for HIV and other Sexually Transmitted Infections 2011–2017 is incorporated in a worldwide system for the prevention of HIV/AIDS and STI. This incorporation pursues three different axes:

- *Switzerland orients its HIV and STI programme in accordance with the recommendations, guidelines and quality standards of the international specialist organisations (such as WHO and UNAIDS) and it abides by the commitments and agreements (such as UNGASS) by other countries and supranational organisations.*
- *As one of the countries with the most experience with HIV and a country that has sufficient resources, Switzerland will continue to show its solidarity with the countries concerned by committing itself to development cooperation. It is precisely in development cooperation that the link between sexual and reproductive health and HIV and STI is of central importance for establishing a sustainable basis for development in this field. The corresponding responsibilities are laid down in the programme.*
- *Good cooperation with Switzerland's European partners contributes to enhancing the quality of the programme."*

Initial situation

Transmitted diseases do not stop at national borders. Starting from this simple statement of fact, the efforts against HIV and other STI must, by its very nature, have an international dimension to it. Given international integration, mobility and migration, global measures are an imperative of solidarity and are in Switzerland's own best interest.

The directions to be taken by HIV efforts at the international level are stated clearly in the Declaration of Commitment on HIV/AIDS (2001)[130] and represent Goal number 6 of the Millennium Development Goals (2000) of the General Assembly of the United Nations[131]. These global obligations were repeated and further strengthened in 2006, when the United Nations General Assembly adopted a new political declaration, highlighting the concept of general access to prevention, diagnosis, therapy and support.[132]

Switzerland has accepted its share of responsibility in engaging against HIV and AIDS at global level. It actively lives up to its international obligations in a consistent manner through its technical and financial commitment to bilateral and multilateral cooperation (for instance through international networks of NGOs, such as Aidsfocus and IPPF, or via international organisations such as UNAIDS, WHO, GFATM (The Global Fund to Fight Aids, Tuberculosis and Malaria), UNFPA (United Nations Population Fund) and the World Bank as well as through the transfer of technology and knowledge. Switzerland also makes a contribution to the international dialogue by offering its expertise and experience, along with the best practices from its national programme for HIV activities.

Switzerland also regularly keeps the UNGASS monitoring process updated with domestic data on the status of the efforts against HIV in Switzerland and participates in different ways in the major international HIV/AIDS conferences. Since the time when Switzerland's preceding programme (NHAP 04-08)[133] was adopted, major developments have taken place regarding the coordination of the efforts against HIV at European level.

On 24 February 2004, all the member states of WHO EURO adopted the "Dublin Declaration on Partnership to engage with HIV in Europe and Central Asia". With this declaration, a coordination framework for HIV activities was set up at European level for the first time and the necessary structures for this were established.[134]

[130] The Declaration of Commitment on HIV/AIDS was adopted in 2001 at the United Nations General Assembly's Special Session on HIV/AIDS (UNGASS), in which Switzerland participated. This declaration describes the scale of the HIV epidemic, its effects and what constitutes adequate responses to it. It also reflects the corresponding commitment of the participating states.

[131] The Millennium Development Goals, to be implemented by 2015, form part of the Millennium Declaration adopted at the United Nations General Assembly in 2000. Goal number 6 includes, inter alia, combating HIV/AIDS.

[132] UNO (2006) Political Declaration on HIV/AIDS

[133] FOPH (2003) Nationales HIV/Aids-Programm 2004–2008

[134] Member States of the WHO European Region (2004) Dublin Declaration on Partnership to fight HIV/Aids in Europe and Central Asia

The European Union arranged for substantive measures to follow on from this declaration by setting up the HIV think tank as one of its initial steps. Membership in this discussion forum, which meets twice a year, is possible for the other European countries that are not members of the European Union (including Switzerland). In 2005, the European Union went on to set up the ECDC, a specialist agency with its seat in Stockholm, with the mission "to identify, assess and communicate current and emerging threats to human health posed by infectious diseases" including HIV and other STI. During the consultations for preparing the national HIV and STI programme, the idea of Switzerland joining the ECDC met with a very positive response from the vast majority of those involved in HIV and STI activities. Full participation, however, depends on current negotiations possibly leading to the conclusion of a bilateral health care agreement between Switzerland and the European Union.

Mobility and migration: a field for international interventions by its very nature

Migrants from the sub-Saharan region coming to Switzerland continue to constitute a key group, given the higher prevalence of HIV in their countries of origin (see also Chapter 7.1 "Prevention requires participation and is aimed at empowerment").

It is likely that the migratory flows from Africa towards Europe will continue in coming years and possibly even increase. Not only Switzerland is affected by this, but numerous other countries in Europe. Since the agreement on the freedom of movement of persons took effect, the mobility of population groups within Europe has intensified. Among migrants who have proper residence status in Switzerland there are clear signs of increasing mobility between the receiving country and their country of origin.

This is a situation which makes cooperation essential and requires making the most out of synergies, especially with Switzerland's neighbouring countries in Europe. The federal administration (represented by the Swiss Federal Office of Public Health, the SDC and the FOM) as well as NGOs (such as the Swiss AIDS Federation and those with a focus on sub-Saharan migrants) must be actively concerned to exploit the possibilities for exchange, dialogue and coordination. In this context, they must be willing to look at innovative strategies as well as cross-border prevention projects and approaches.

The situation as regards HIV and STI epidemics in Eastern Europe is also of interest for Switzerland as we can offer Swiss experience in action to those countries in engaging innovatively and effectively in interventions against these epidemics. Furthermore, the migratory movements and the strong mobility due to economic relations, tourism and sex workers from countries with an increasing prevalence are likely to influence the Swiss domestic situation. In the context of the NPHS, Switzerland is carefully monitoring the situation and is preparing in advance for adequate measures if and when appropriate.

Allocation of roles

Switzerland's set of international instruments and its international position entail various responsibilities in connection to its international relations, and it is necessary to clarify these in more detail.

On the one hand, the efforts put in by Switzerland in the context of its international development cooperation will be continued in accordance with its foreign policy instruments, primarily under the coordination of the Swiss Agency for Development and Cooperation (SDC).

On the other hand, national efforts must be based on the guidelines determined by the international instruments and the commitments that Switzerland has assumed. It is necessary to cooperate more intensively at European level than ever before on account of the significant developments in European coordination of HIV and STI activities since 2004, Switzerland's geographic position at the heart of Europe, the increased mobility of people and the similarity of the key data for the epidemic in Switzerland and other industrialised countries in Europe. The body with primary responsibility for this is the FOPH, which coordinates its work with the Federal Office for Migration (FOM) and the SDC.

Both of these international facets of HIV and STI efforts naturally require good coordination between the various actors. Since 2006, the Swiss Confederation has had an interdepartmental agreement between the Federal Department of Home Affairs (FDHA) and the Federal Department of Foreign Affairs (FDFA) regarding the goals to be pursued in this field, ensuring that Switzerland is consistent in its actions in the health policy aspect of its foreign policy (Foreign Health Policy – GAP[135]). This policy provides a platform for close cooperation and coordination between the Federal Department of Foreign Affairs (more specifically by two of its units, the SDC and the political directorate) and the Swiss Federal Office of Public Health. The health policy aspect of foreign policy is dealt with regularly by an interdepartmental conference and an interdepartmental working group. These bring together the other units of the federal administration involved in matters of health. Engaging in efforts against HIV is explicitly incorporated in the aim of the health policy aspect of Switzerland's foreign policy.

[135] Federal Department of Home Affairs (FDHA) and Federal Department of Foreign Affairs (FDFA), Swiss Foreign Health Policy (GAP), "Aussenpolitische Zielvereinbarung im Bereich Gesundheit", 2006.

Task

1. Coordination
Switzerland is to coordinate its national HIV and STI programme with the endeavours of international cooperation in the field of HIV and STI and sexual and reproductive health

With the SDC taking the lead, Switzerland will make its contribution towards prevention of HIV and other STI and to improving sexual and reproductive health in developing and transitional countries as part of its action to reduce poverty and to strengthen international solidarity. In light of the health policy aspect of Switzerland's foreign policy, its national HIV and STI programme will play a complementary role in terms of international coordination and will aim for an approach that is consistent with international cooperation. The dialogue between the Swiss stakeholders in the country's national and international response to HIV and STI will be strengthened. The Swiss Federal Office of Public Health, the SDC and other federal offices will regularly coordinate their contributions and make sure that they actively involve each other at an early stage in consultations intended to result in new programmes and strategy developments. The Swiss National AIDS Commission (EKAF) and others will support this objective and ensure the involvement of non-governmental stakeholders in the exchange and learning process (civil society, NGOs, hospitals, research and so on). The Swiss stakeholders and the most important umbrella organisations with international activities will be familiarised with the SDC's remit, its HIV working strategy and the most important principles of international cooperation. The lessons learned from the national programme, the Swiss contribution to UNGASS and number six of the Millennium Development Goals will be made known nationally and internationally. To the extent to which it makes sense in the particular context and in dialogue with its partners, the SDC will give consideration to established expert opinions on the national HIV response, such as efforts to eradicate stigmatisation and discrimination of specific vulnerable groups (IDU, MSM, sex workers, mobile populations and so on) or the approaches of harm reduction[136] insofar as these are recognised as priorities in the cooperation countries.
Given increasing mobility within Europe, the development of the epidemics in the threshold countries of Eastern Europe is of particular interest and significance for Switzerland.

2. Cooperation:
Switzerland's national programme is a part of the European HIV and STI response

Switzerland's NPHS 2011–2017 is regarded as an exemplary model internationally, and Swiss HIV expertise is already in international demand. Good networking and cooperation with its European partners enhances the effectiveness of Switzerland's national programme and contributes to its quality assurance. The NPHS will be developed and implemented in close coordination with the relevant European bodies.

Switzerland will continue to adhere to international agreements in the field of HIV and other STI and to feed its skills and resources actively into the European and international dialogue in order to strengthen the European and international approaches and instruments. Switzerland will seek further cooperation with the European bodies and with WHO EURO in order to strengthen its national representation and its contributions to international bodies. Swiss guidelines are built on European recommendations and strategies, and Switzerland will continue to contribute to their development. Whereas Switzerland's international coordination is well established in the field of HIV, it still needs to promote and strengthen its control, surveillance and research for STI. Surveillance and the indicators used to monitor the NPHS will be adapted to European standards in order to generate comparable data.[137]

[136] See also: Kessler (2010) Expertensicht – die internationalen Bezüge des Nationalen HIV&STI Programms 2011–2017

[137] See also: Kessler (2010) Expertensicht – die internationalen Bezüge des Nationalen HIV&STI Programms 2011–2017

Milestones

1. Continuous exchange will be guaranteed in order to intensify the mutual provision of information and liaison between offices. The intention is that the interdepartmental working group on the health policy aspect of foreign policy (IdAG GAP) will receive reports on this activity.

2. The external evaluation of the National Programme on HIV and other Sexually Transmitted Infections 2011–2017 will also include an appraisal of the progress achieved towards greater consistency in Switzerland's national and international HIV and STI response (a component of the specifications). The criteria for the evaluation of this milestone are to be determined by the programme's principal stakeholders at the start of 2011.

   The programme includes additional milestones in support of the two aims mentioned above, for instance:
   Evidence (see also Support task Evidence): By the end of 2011 there is to be a concept, including a feasibility study, on the introduction of an effective third-generation surveillance system. Its indicators will be compatible with those of the European Union.

3. Switzerland (with the Swiss Federal Office of Public Health taking the lead) will organise a meeting of the relevant actors by the beginning of 2012, with the aim of intensifying exchange and cooperation with European networks in the field of migration, for instance "Aids&Mobility Europe".[138]

Competences

The Swiss Confederation will coordinate its national and international response to HIV and STI both with the international commitments it has entered into and with the actions of the competent international bodies.

The Swiss Confederation will incorporate HIV and STI in its efforts to harmonise the interventions against epidemics at a European level.

Since 2004, UNAIDS has supported the so-called principle of the "three ones",[139] which provides for the following:

1. One agreed AIDS action framework that provides the basis for coordinating the work of all the partners involved.

2. One national AIDS coordinating authority with a broad-based multisectoral mandate: EKAF has been commissioned by the Federal Council to advise the Council and in particular the FHOP on topical issues involving HIV. In this regard it functions as a higher independent body within the overall system.

3. One agreed country-level monitoring and evaluation system.

The Swiss Federal Office of Public Health will be responsible on behalf of Switzerland for international follow-up and monitoring activities (for example the Declaration of Commitment on HIV/AIDS adopted in 2001 by the United Nations General Assembly Special Session on HIV/AIDS (UNGASS)[140] and the Dublin Declaration on HIV/AIDS[141] of 2004). It will perform this task in cooperation with all other competent institutions.

The Swiss Federal Office of Public Health will cooperate as closely as possible with all the European bodies competent in this field (European Union, ECDC, WHO Europe, etc.) with a view to coordinating the European and Swiss responses to HIV and STI to the maximum extent possible.

[138] The main aim of Aids&Mobility Europe is to reduce the HIV vulnerability of migrant and mobile populations in Europe, through the development, implementation and promotion of appropriate policies and measures within a Europe-wide network. aids & mobility europe (2010)

[139] UNAIDS (2004) "Three Ones" key principles "Coordination of National Responses to HIV/AIDS".

[140] UNO (2001) Declaration of Commitment on HIV/AIDS

[141] Member States of the WHO European Region (2004) Dublin Declaration on Partnership to fight HIV/AIDS in Europe and Central Asia

The SDC will, in conformity with its remit, enter into both bilateral and multilateral commitments in terms of development cooperation and humanitarian aid to realise the sixth of the Millennium Development Goals[142] of the United Nations in countries of the south and in the transitional countries (of the east). It will represent Switzerland in the competent international institutions and furnish the financial aid offered by the state.

Research into sexual health and STI also helps to close gaps in knowledge at a global level. The efforts made in the field of research should aim to produce internationally comparable results, not least in areas which have not been sufficiently explored to date: e.g. behavioural and narrative research involving people with cultural links to two countries; research into the greater involvement of people living with HIV (GIPA); research into human rights and the criminalisation of HIV transmission; and research into human sexuality and its consequences for public health. Here Switzerland should actively publicise its experiences and best practice, making it accessible at an international level.

[142] United Nations (2000) United Nations Millennium Development Declaration

15 ANNEX

15.1 STAKEHOLDERS CONTRIBUTING TO THE DEVELOPMENT OF THE PROGRAMME

Swiss Confederation (including para-governmental bodies)

Federal Chancellery
Federal Customs Administration (FCA)
Federal Finance Administration (FFA)
Federal Office for Gender Equality (FOGE)
Federal Office for Professional Education and Technology (OPET)
Federal Office for Migration (FOM)
Federal Office of Justice (FOJ)
Federal Office of Personnel (FOPER)
Federal Social Insurance Office (FSIO)
Federal Statistical Office (FSO)
General Secretariat of Federal Department of Defence, Civil Protection and Sport (DDPS)
General Secretariat of Federal Department of Economic Affairs (FDEA)
General Secretariat of Federal Department of Finance (FDF)
General Secretariat of Federal Department of Foreign Affairs (FDFA)
General Secretariat of Federal Department of Home Affairs (FDHA)
General Secretariat of Federal Department of Justice and Police (FDJP)
General Secretariat of Federal Department of the Environment, Transport, Energy and Communications (DETEC)
State Secretariat for Economic Affairs (SECO)
State Secretariat for Education and Research (SER)
Swissmedic – Swiss Agency for Therapeutic Products
Swiss Agency for Development and Cooperation (SDC)
Swiss Federal Institute for Vocational Education and Training (SFIVET)
Swiss National AIDS Commission (EKAF)
Swiss price monitoring authority
The Federal Data Protection and Information Commissioner (FDPIC)

Cantons and intercantonal organisations

AIDS Commission of the Canton of Zurich
Bern University Hospital
Cantonal Doctor of Basel
Cantonal Doctor of Geneva
Cantonal Doctor of Lucerne (deputy)
Cantonal Doctor of Solothurn
Cantonal Doctor of Ticino (deputy)
Cantonal Hospital St. Gallen
Cantonal Institute of Microbiology, Ticino
Department of Finance and Health, Canton of Glarus
Department of Health Canton of Zurich, Cantonal Medical Service
Department of Health St. Gallen, Cantonal Medical Service
Department of Medical-Social Services of the City of Zurich
Department of Regional Affairs, Economic Affairs and Health (DARES), Geneva
Geneva University Hospitals
Institut Central des Hôpitaux Valaisans (Central Institute of Valais Hospitals)
Municipal health authority of the City of Zurich
Office of the Cantonal Doctor, Bern
Swiss Conference of Cantonal Ministers of Education (EDK)
Swiss Conference of Cantonal Ministers of Health (GDK)
University Hospital Basel
University Hospital of the Canton of Vaud
University Hospital Zurich
Zurich Cantonal School Health Care Department

Non-governmental organisations

AIDS Information Switzerland
Aids-Hilfe Aargau
Aids-Hilfe Basel-Stadt/Basel-Landschaft
Aids-Hilfe Bern
Aids-Hilfe Graubünden
Aids-Hilfe Lucerne
Aids-Hilfe Thurgau/Schaffhausen
Aids-Hilfe Upper Valais
Aids-Hilfe Zug
Aids-Infostelle Winterthur
Aidspfarramt Zürich (pastoral office)
Alpagai
Antenne Sida du Valais romand
ARTANES Association romande et tessinoise animatrices et animateurs en éducation sexuelle (association of sexual educationists)
Association Aspasie Geneva (support association for sex workers)
Association Dialogai
Association for Risk Reduction in Use of Drugs (ARUD) Zurich
Association for the Condom Quality Seal
Association Solidarité Femmes Africaines de Genève (ASFAG)
Beratungsstelle für Familienplanung, Sexualität, Schwangerschaft + Partnerschaft Graubünden
Centre Empreinte, Fribourg
Checkpoint Genf
Checkpoint Zürich
Centre Jurassien de Planning Familial
Fachstelle Behinderung und Sexualität

Fachzentrum eff-zett Zug, Fachstelle Sexual- und Schwangerschaftsberatung
Fachstelle für Aids- und Sexualfragen, St. Gallen
Fondation Agnodice
Fondation Profa
Gesundheit Schwyz, Section for Sexuality/AIDS
Groupe information sexuelle et prévention à la santé GIS, Neuchâtel
Groupe SIDA Jura
Homosexuelle Arbeitsgruppen beider Basel (HABS)
Imbarco Immediato, associazione gay lesbica Ticino
Isla Victoria (Zürcher Stadtmission)
Juragai
Lestime
LHIVE
Ligues de la santé, Waadt
Loge 70
LOS, Lesbenorganisation Schweiz
Medicus Mundi Switzerland
Medigay
Personnes Vivant Avec (Geneva)
Pink Cross
PLANeS (Swiss Foundation for Sexual and Reproductive Health)
Planning familial Biel
Planning familial et Information Sexuelle, Fribourg
Planning familial, Geneva
Planning familial, La Chaux-de-Fonds
Planning familial, Moutier
Planning familial, Neuenburg Radix Gesundheitsförderung
Santé PluriELLE
Swiss AIDS Federation
Swiss Medical Association (FMH)
Swiss Society for Dermatology and Venereology (SGDV)
Swiss Society for Gynaecology and Obstetrics (SGGG)
SEDES (association of sexual educationists of German-speaking Switzerland)
Sexualité et handicaps pluriels
SID'Action
SID'Actuel
Stiftung Aids und Kind (AIDS and Child Foundation)
Swiss Centre for International Health (SCIH)
Swiss Transgender Network
UBPRESS
Vogay
VEGAS (Swiss Association of Gay Businesses)
Walliser Dachverband der SIPE-Zentren (Valais umbrella association for sexuality info centres)
Zürcher Aids-Hilfe

For profit organisations
Interpharma
Janssen-Cilag AG
Life Science Communication
Merck Sharp + Dohme Chibret MSD

Research institutes
Gewerbliche und industrielle Berufsfachschule (commercial and technical college), Fribourg
Haute Ecole de Santé La Source (La Source College for Health Professionals), Lausanne
Institute for Medical Microbiology University Basel
Kompetenzzentrum Sexualpädagogik und Schule (centre of excellence for sexual education and school)/Central Switzerland Teacher Training College, PHZ Lucerne
Swiss HIV Cohort Study
University Institute of Social and Preventive Medicine, IUMSP, Lausanne
University of Applied Sciences Northwestern Switzerland
Unit for the Evaluation of Prevention Programmes, IUMSP Lausanne

International
World Bank, UNAIDS: AIDS Service Action Plan

15.2 OPERATIONALISATION OF THE NPHS BY THE VARIOUS PLAYERS: ALLOCATION OF ROLES

Federal Office of Public Health

Management of the National Programme for HIV and other Sexually Transmitted Infections: The FOPH is responsible for managing and coordinating the implementation of the NPHS 2011–2017, for setting priorities in terms of issues and for supervising projects according to its responsibilities. It invites stakeholders to implement their plans for the programme and to notify the FOPH and EKAF of these. In its leadership role, the FOPH is also responsible for quality assurance (interim reporting and evaluation) of the programme as well as for preparation of the follow-up programme. In addition, the FOPH is in charge of implementing the objectives falling within the Confederation's sphere of competence.

Coordination, cooperation: The FOPH works closely with government agencies, the cantonal authorities and with umbrella organisations and associations of NGOs. It is responsible for coordination with government agencies, avoiding duplication and ensuring the efficient use of resources. It exchanges information about the implementation of the present programme with the cantonal authorities. The FOPH also works with private umbrella organisations and associations to develop suitable activities and offers assistance with their implementation.

Information: The FOPH informs experts in epidemiology and people specialising in prevention about different aspects of HIV and STI using selected media (Bulletin[143], Spectra[144], SAN[145]).

Prevention: The FOPH supports the widespread provision of coherent information among the population.

Surveillance of HIV and other STI: The FOPH ensures epidemiological surveillance of HIV and STI relevant to public health, additionally collecting data for the purpose of second- and third-generation surveillance (see chapter on evidence).

Guidelines and recommendations: The FOPH cooperates with relevant scientific bodies (EKIF, EKAF, professional associations/Swiss Medical Association, other relevant actors) to draw up guidelines and recommendations relating to vaccination as well as the diagnosis, counselling and treatment of people with HIV and/or STI based on the latest national and international data. The FOPH also strives to ensure the development of standards for initial and further training in the prevention, diagnosis and treatment of HIV and STI.

Sexual health education: The cantons are responsible for cooperating with the Confederation to ensure that the prerequisites for adequate sexual health education are present throughout Switzerland.

↘*Knowledge management:* In its efforts, the FOPH adopts an evidence-based approach founded on notification, monitoring, evaluation and research. It is oriented towards models of good practice. It systematically safeguards such knowledge and communicates key findings at regular intervals. The Confederation coordinates the various platforms and forums available for HIV and STI knowledge management in Switzerland.

Product safety: Working in cooperation with Swissmedic, the Swiss Agency for Therapeutic Products, the FOPH is responsible for the accreditation of HIV test laboratories. Swissmedic ensures the safety of blood components and the market surveillance of HIV tests and condoms.

International coordination: The FOPH encourages cooperation with international bodies (UN, WHO, UNAIDS, ECDC) and the implementation of relevant stipulations and declarations in relation to prevention, counselling, diagnosis and treatment as well as equal treatment for people with HIV.

Tasks of the federal administration

The federal administration assists with the implementation of the NPHS 2011–2017. The individual federal agencies of Switzerland make their own contribution according to the tasks and responsibilities involved in the relevant objectives.

Cantons

Implementation of the National Programme on HIV and other Sexually Transmitted Infections: The cantonal authorities are responsible for the implementation and coordination of activities within their own canton. With the funding and controlling of local institutions (e.g. regional HIV/STI treatment centres or prevention and counselling services) they ensure that HIV- and STI-specific facilities of appropriate quality are available in the fields of prevention, counselling, diagnosis and treatment.

Coordination, cooperation: The cantons and Confederation work together on the issue of HIV and STI in terms of content, structure and finance, initiating (or maintaining) relevant coordination of activities. In the case of cantons whose expenditure for prevention of HIV and STI is not ad-

[143] BAG (ed.) (2011) Bulletin des Bundesamtes für Gesundheit

[144] BAG (ed.) (2011) Spectra – Gesundheitsförderung und Prävention

[145] Aids-Hilfe Schweiz (ed.) (2011) Swiss Aids News – SAN

equate for the epidemiological situation, the Confederation is mandated and obliged to draw attention to this disparity and to jointly seek solutions for this situation with the canton.

Sexual health education in schools: The cantonal authorities are responsible for the introduction and implementation of sexual health education in schools. They ensure age-appropriate integration of the subject in the curriculum and define quality criteria for sexual health education in schools in agreement with professionals from this field.

Contribution to notification: The cantonal authorities are responsible for reporting HIV and STI diagnoses and cases of AIDS in accordance with the Notification Ordinance.[146]

Professional initial and further training: The cantonal authorities are committed to ensure that the training standards defined nationwide for HIV and STI are implemented in the cantonal institutions.

Quality assurance: The medical profession monitors initial and further training of medical staff in cooperation with the Confederation, with the task of quality assurance is the responsibility of the cantons.

Educational institutions

Implementation of the National Programme for HIV and other Sexually Transmitted Infections: The educational institutions contribute to the implementation of the NPHS 2011–2017 by means of research and initial/further training at the conventional universities and the universities of applied sciences. In the school system, age-appropriate sexual health education is integrated in the curriculum.

Coordination, cooperation: Depending on the requirements, the educational institutions work with actors oriented towards practical and/or strategic application in terms of content, structure and finance.

Swiss National AIDS Commission (EKAF)

Implementation of the National Programme on HIV and other Sexually Transmitted Infections: EKAF offers assistance in both strategic and technical terms: It advises the Federal Council, the FOPH and the actors concerned about planning, milestones and specific issues involving the implementation of the programme and monitors compliance with the strategic guidelines.

Guidelines and recommendations: EKAF formulates and publicises guidelines and recommendations for counselling, diagnostics designed to support therapy and the treatment of people suffering from HIV and/or STI.

Dialogue with experts: EKAF maintains a continuous dialogue with experts from the fields of HIV and STI, so ensuring that it is aware of latest issues and developments.

Encouragement of political understanding: EKAF is committed to encouraging political understanding of HIV and STI issues.[147] It prepares relevant topics for policy decisions taken at a national level and is conscientious to ensure that the necessary scope of action is created here.

Federal Vaccination Commission (EKIF)

Guidelines and recommendations: EKIF helps to draw up guidelines and recommendations for vaccination programmes in cooperation with the FOPH and other relevant partners.

National NGOs (umbrella organisations and associations)

Implementation of the National Programme for HIV and other Sexually Transmitted Infections: The national NGOs ensure that professional information, prevention and counselling facilities are available in accordance with their mission and contractual responsibilities:

- **PLANeS**
  PLANeS is mainly responsible to attain of the objectives in axis of intervention 1.

- **Umbrella organisations and associations representing the interests of young people:** They contribute to attain the objectives in axis of intervention 1.

- **Umbrella organisations and associations representing the interests of lesbian, gay, bisexual and transgender individuals:** These contribute to attain the objectives in axes 1 and 2.

[146] Ordinance dated 13 January 1999 governing the notification of diseases transmissible between humans (SR 818.141.1)

[147] UNAIDS recommends that every country, in the framework of the so-called "Three Ones" principles, should maintain a coordinating authority with a broad-based mandate for HIV/AIDS. In Switzerland this role has to date been carried out by EKAF, which has been commissioned by the Federal Council to advise the FHOP and the Federal Council on topical issues involving HIV. As regards "Three Ones" see also: UNAIDS (2004) "Three Ones" key principles. "Coordination of National Responses to HIV/Aids" Guiding principles for national authorities and their partners

- **Swiss AIDS Federation**
  The Swiss AIDS Federation is mainly responsible for axis of intervention 2 (raising awareness, information, prevention and counselling) involving the following target groups: MSM, sex workers, migrants from countries with high prevalence, other vulnerable groups of migrants, IDU (to whom it offers support with addiction by raising awareness, information, prevention and counselling for IDU) as well as prison inmates.

- **Umbrella organisations and associations representing the interests of gay establishments:** They contribute to attain the objectives in axis 2.

- **Umbrella organisations and associations representing people affected by HIV:** They in particular contribute to the attain the objectives in axes 2 and 3.

Coordination and cooperation: Besides coordination and cooperation in the framework of their role as an umbrella organisation or association, the national NGOs also maintain contact with each other and cooperate with other actors according to the requirements for synergy.

Encouragement of political understanding and lobbying: The NGOs are committed to encouraging political understanding for the problem of HIV and STI at a national level and are involved in establishing a lobby for the issue of HIV and STI (including affected persons) as well as for sexual health.

Knowledge management: National NGOs contribute to systematically safeguarding knowledge about HIV and STI and regularly communicate key findings to the relevant platforms and forums provided in this regard.

Quality assurance: National NGOs cooperate with regional NGOs, cantons and municipal authorities to ensure that facilities for training and continuing education are offered to professionals specialising in prevention in the field of sexual health.

Cantonal, regional and local NGOs (members of umbrella organisations and associations):
Implementation of the National Programme on HIV and other Sexually Transmitted Infections: The cantonal, regional and local NGOs ensure that professional information, prevention and counselling facilities are available in accordance with their mission and contractual agreements. They also participate, as far as they are able, in tasks which, despite being subject to national control, are implemented at a cantonal, regional or local level.

Intracantonal and intercantonal coordination and cooperation: The regional and national NGOs coordinate their activities on an intracantonal and intercantonal basis to achieve synergy. They also make available, as far as they are able, their knowledge and expertise for projects and tasks undertaken by the umbrella organisations and associations and maintain an exchange of information.

Encouragement of political understanding and lobbying: The NGOs are committed to encouraging political understanding for the problem of HIV and STI at a regional level and are responsible for carrying out sensitisation in this regard.

Other NGOs
Implementation of the National Programme on HIV and other Sexually Transmitted Infections: Other NGOs working in the field of HIV and STI contribute to attain the NPHS's objectives in accordance with their individual mission.

Coordination and cooperation: The NGOs cooperate with other actors according to the requirements for synergy.

Regional HIV and STI centres
Implementation of the National Programme on HIV and other Sexually Transmitted Infections: The regional HIV and STI centres ensure compliance and implementation of the advisory, diagnostic and clinical standards of the NPHS 2011–2017 in their own geographical region and act as advisers to the FOPH in the framework of the working groups of the National AIDS Commission (EKAF).

Individual counselling and anonymous testing: Regional HIV centres maintain a counselling and information service for HIV and STI and may also offer HIV and/or STI testing.

Surveillance of epidemics/notification: The regional HIV centres assist the cantons and the FOPH to ensure compliance with the Notification Ordinance. In the framework of their clinical activities and the SHCS, they also send signals about new scientific findings.

Cooperation with the Swiss HIV Cohort Study (SHCS): In the framework of the Swiss HIV Cohort Study, the regional HIV centres collect clinical/epidemiological data for centralised analysis subject to the consent of the patients concerned. Such analyses back up the epidemiological data collected by the FOPH. In conjunction with the SHCS these centres offer a platform for clinical research into HIV and STI in Switzerland.

Guidelines and recommendations: Guidelines and recommendations for diagnostics, counselling and treatment are drawn up by representatives of the regional HIV centres in cooperation with the FOPH and other relevant partners. They are committed to ensuring distribution of these guidelines and compliance in their individual region.

Specialist centres and counselling services

Implementation of the National Programme on HIV and other Sexually Transmitted Infections: The specialist centres and counselling services ensure that professional information, prevention and counselling facilities are available in accordance with their mission and contractual responsibilities.

Intracantonal and intercantonal coordination and cooperation: The specialist centres and counselling services coordinate their work on an intracantonal and intercantonal basis according to the requirements for synergy.

Professional associations/Swiss Medical Association

Implementation of the National Programme on HIV and other Sexually Transmitted Infections: The professional associations and the Swiss Medical Association advise the Confederation on specialist issues and contribute their expertise to the formulation of guidelines and recommendations for the prevention, counselling, diagnosis and treatment of HIV and STI.

Quality assurance: The medical profession (in the guise of their professional associations) monitors initial and further training of medical staff in cooperation with the Confederation. The Swiss Medical Association works with the Confederation to ensure that sufficient medical specialists are available in the field of HIV and STI.

Medical HIV and STI specialists

Implementation of the National Programme on HIV and other Sexually Transmitted Infections: In their role as medical specialists for HIV and STI, such professionals also contribute towards the implementation of the NPHS 2011–2017. They are provided by the Confederation with suitable instruments for this purpose (guidelines and recommendations).

Guidelines and recommendations: Medical HIV and STI specialists contribute their expertise to the formulation of guidelines and recommendations for the prevention, counselling, diagnosis and treatment of HIV and STI.

Cooperation with the Swiss HIV Cohort Study (SHCS): In the framework of the Swiss HIV Cohort Study, the medical HIV and STI specialists collect clinical and epidemiological data for centralised analysis subject to the consent of the patients concerned. Such analyses back up the epidemiological data collected by the FOPH.

VCT centres and test centres:

Implementation of the National Programme on HIV and other Sexually Transmitted Infections: The VCT centres and test centres contribute to the implementation of the NPHS 2011–2017. The VCT centres comply with the FOPH's recommendations regarding VCT for HIV using HIV quick tests. They also act as a sensor for the FOPH and support the notification system. Such support is facilitated by use of the internet tool ↘BerDa.

Individual counselling and anonymous testing: The VCT centres maintain a counselling and information service for HIV and STI and may also offer HIV and/or STI testing.

Surveillance of epidemics/notification: The VCT centres and test centres assist the cantons and the FOPH in ensuring compliance with the Notification Ordinance.

Health insurers

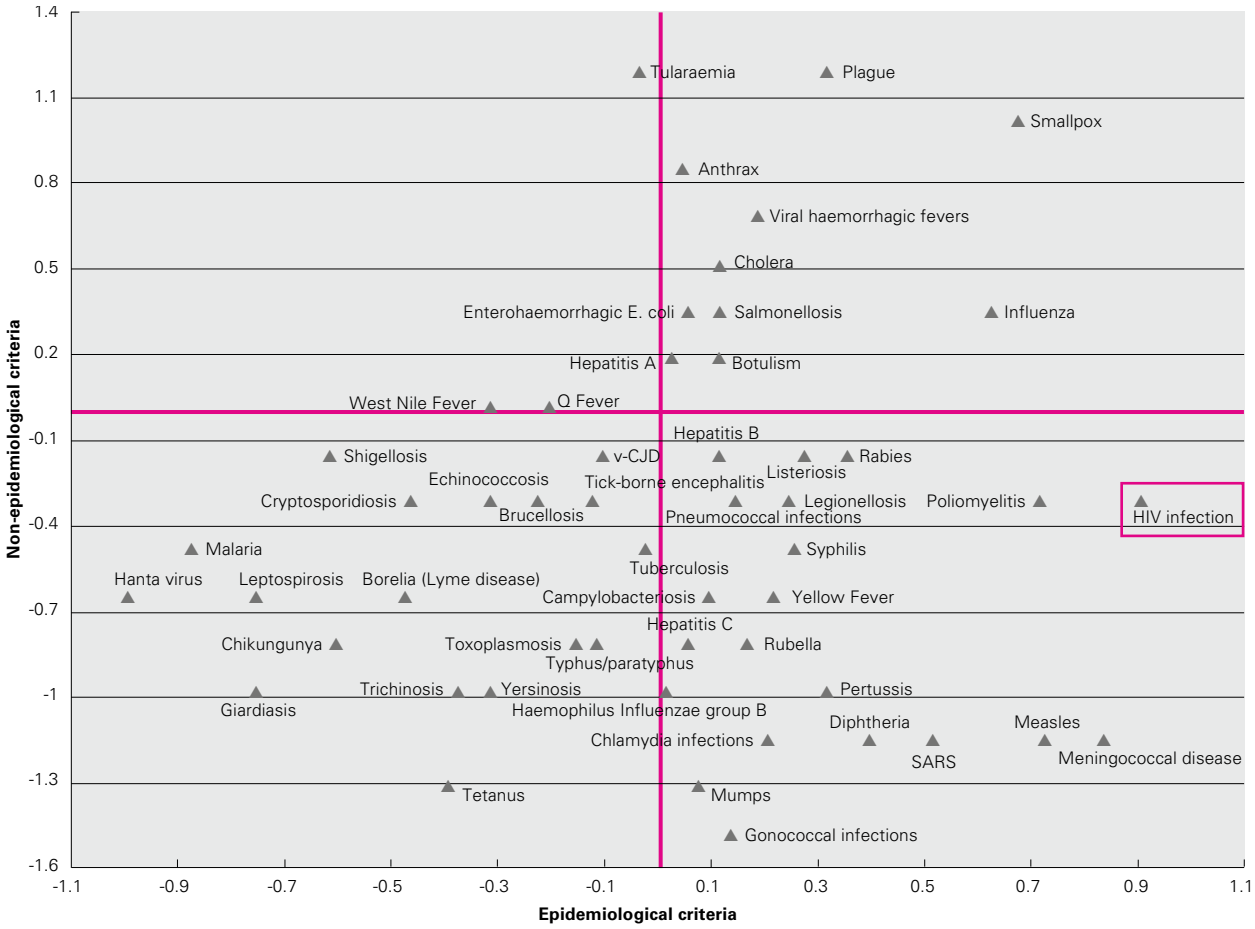
Implementation of the National Programme on HIV and other Sexually Transmitted Infections: The Confederation and health insurers work together on the issue of HIV and STI in terms of structure and finance.

All actors

They periodically plan the implementation of the programme and regularly coordinate their efforts in the interest of the NPHS using the coordination channels provided for this purpose.

15.3 IMPORTANCE OF PATHOGENS BASED ON EPIDEMIOLOGICAL AND NON-EPIDEMIOLOGICAL CRITERIA

The following figure shows the grouping of public health-relevant communicable diseases by the Priority Setting Tool, mentioned in chapter 3. (Database: CH 2005/2006; Source: FOPH)



15.4 OVERVIEW OF SEXUALLY TRANSMITTED INFECTIONS

STI	Symptoms	Complications	Prevalence/incidence	Mode of transmission
Chlamydia infections Bacteria *Chlamydia trachomatis*	70% of ♀ and 25% of ♂ with chlamydia generally only have minor symptoms or none at all. Otherwise: purulent discharge, burning sensation on urination, lower abdominal pain (♀), urethritis (♂). This clinical picture normally appears in ♂ 1–3 weeks following exposure and does not differ from that of gonorrhoea.	Without antibiotics 20–40% of infected women will develop pelvic inflammatory disease, possibly resulting in infertility or ectopic pregnancy. In ♂ (2%) epididymitis and other local complications may occur. In neonates: conjunctivitis, pneumonia.	3 to 10% of sexually active people depending on age bracket and population group. ♀ are twice as likely to be affected (70% vs. 30%) In ♀ 87% are aged between 15 to 34 years and in ♂ between 20 to 34 years; prevalence in heterosexual ♂ is three times that of MSM. 2008: marked increase in reported cases in ♀ aged between 20 to 24 years. Increased risk of infection in sexually active persons under 25 years of age.	Contact with mucous membranes (genital, anal, oral) and genital secretions; vertical transmission from mother to child during childbirth.
Gonorrhoea – Bacteria *Neisseria gonorrhoeae*	The first symptoms generally occur after 1 to 7 days following infection. In ♀ frequently asymptomatic. Otherwise: purulent discharge, burning sensation on urination, urethritis, reddening and irritation in anal region, conjunctivitis, non-specific symptoms in the throat.	If left untreated, gonorrhoea may cause infertility both in ♀ and ♂. Less frequent complications include inflammation of the joints, skin and heart. In neonates: conjunctivitis, damage to the cornea, blindness.	Approx. 800 new cases confirmed in Switzerland each year. 85% of cases involve ♂, with 75% falling in the 20 to 44 age bracket. 28% involve homosexual relationships and 48% heterosexuals. 37% occurred with casual contact and 29% in steady relationships. ♀: 70% are aged between 20 and 39 years (62% in a steady partnership and 16% in a casual relationship).	Contact with mucous membranes (genital, anal, oral) and genital secretions; vertical transmission. Transmission may extend over months without treatment.
Hepatitis A HAV	Incubation period is 5 to 50 days (on average 4 weeks). Symptoms: acute illness with fever, malaise, jaundice, loss of appetite and nausea. Children under the age of 6 have symptoms in only 30% of cases and often do not have jaundice. In older children and adults the infection generally causes symptoms, with the disease typically lasting several weeks (up to 6 months), and involving jaundice in 70% of cases. Spontaneous recovery normally occurs. The infection is never chronic and does not cause secondary damage.	Fulminant hepatitis (rare: <0.1%): often affects people with a pre-existing liver condition.	Prevalence/incidence Less than 200 acute cases of hepatitis A reported since 2001. Age group most frequently affected: people aged between 20 to 30 years of both sexes. ♂ affected more often than ♀ (reference to male-dominated risk groups: IDU, MSM).	Faecal-oral transmission following ingestion of contaminated food or drink or through touch. Transmission via the blood possible, but extremely rare.
Hepatitis B HBV	Incubation period between 1 and 6 months (average betw. 2 and 3 months). A third of adults may have the following symptoms: acute illness with fever, malaise, jaundice, loss of appetite and nausea. Infection very rarely produces symptoms in neonates, but becomes chronic in 70 to 90% of cases.	Risk of becoming chronic. 1/10–20 infected persons are unable to eliminate the virus and remain contagious their entire life, with the risk of major complications (progressive damage to the liver, cirrhosis, cancer).	Less than 5% of the population, with 5% of cases becoming chronic. The high-risk group consists of people who practise unprotected sex (both hetero and homosexuals). The number of new infections each year is put at 300 to 500.	Contact with blood, mucous membranes (genital, anal, oral) or genital secretions; vertical transmission, horizontal non-sexual transmission (close contact with infected person). 10 times more infectious than HIV.

	Prevention	Tests	Treatment	Vaccination	Costs (CHF)		Explanations
					Test*	Treatm.**	
	Condoms/Femidoms offer approx. 80% protection but not with oral sex.	Specimen collection (from infected area), urine test (PRC) and antigen test. To date not included in routine testing during pregnancy.	Frequently spontaneous recovery (♀: 80%, ♂: 50%). Antibiotic therapy: Azithromycin or doxycycline. Infection may last for months without treatment. Therapy is only successful if all sexual partners are treated.	No vaccine available. Intensive research underway into developing a vaccine.	♂: PCR 181.– ♀: PCR 95.–***	45.–	According to WHO the risk of ectopic pregnancy increases 6 to 10-fold in women who have had an infection of the upper genital tract. 40 to 50% of cases of ectopic pregnancy are attributable to an infection here.
	Condoms/Femidoms offer reliable protection (incl. when used during oral sex).	Specimen collection, urine test.	Treatment with antibiotic cefixime. Therapy is only successful if all sexual partners are treated.	No vaccine available.	♂: PCR 181.– ♀: PCR 95.–	15.–	
	HAV no longer exists in Switzerland. Nowadays, infection is only possible in countries with poor hygiene. Most important means of preventing transmission of hepatitis A: compliance with basic rules of hygiene: washing the hands, esp. after using the toilet, before preparing food and eating; no sharing of textiles in contact with the genital area (towels, bed linen etc.); laundry and kitchen utensils cleaned with hot water; separation of potentially contaminated raw produce from cooked food; vaccination recommended for certain situations or groups at risk.		The disease can be prevented in 85% of cases if vaccination takes place within 7 days after exposure (e.g. contact with an infected person).	Various recommendations for HAV vaccination (cf. FOPH vaccination programme 2010). In relation to National HIV/STI Programme: IDU, MSM, persons with contact to IDU or with persons from endemic regions, persons simultaneously infected with HIV, HBV and HCV. Administration of more effective combined HAV and HBV vaccine recommended for people not vaccinated against HBV.	♂: 35.–/45.–	–	
	Condoms/Femidoms reduce risk; Safer Use. Vaccination recommended for certain situations or groups at risk.	Blood test.	No treatment available for acute infection, with spontaneous recovery occurring in most patients. Chronic infection can be treated with antivirals such as lamivudine and interferon (limited success rate: 20–30%). Treatment keeps multiplication of virus under control.	Various recommendations for HBV vaccination (cf. FOPH vaccination programme 2010). In relation to National HIV/STI Programme: all adolescents aged between 11 and 15 years, people who often change sexual partners or come from endemic regions. 3 doses administered over 6 to 12 months.	♂: 35.–/45.– ♀: 20.–	Price varies from case to case (=HIV. approx. 30,000.–)	

* Tests and treatments may differ depending on the situation, with a corresponding variation in prices. Basic prices have been laid down for both tests and treatments by the FOPH. These prices do not include the fees charged by the medical profession (Tarmed) or the costs of monitoring (e.g. at the laboratory) [acc. to Dr. Markus Flepp]. Cost estimates were based on the prices applied by Checkpoint (VCT centre for MSM). This data was provided by Benedikt Zahno of Checkpoint Zürich and Dr. Pietro Vernazza.

** Ibid.

*** In the case of female patients, the prices given are the cost of laboratory analysis (an administrative charge of CHF 24.– must also be included for each patient). This data was provided by Dr. Lorenz Risch (specialist for laboratory medicine) at the request of Dr. Christiane Roth, Secretary-General of the Swiss Society of Gynaecology and Obstetrics (gynécologie Suisse).

STI	Symptoms	Complications	Prevalence/incidence	Mode of transmission
Hepatitis C HCV	Incubation period between 20 days and 6 months. Infection with hepatitis C rarely causes acute hepatitis (10–20%) and generally remains clinically quiescent (50% of people do not know they have been infected).	Chronic infection develops in over 50 to 80% of cases. 5 to 50% of people with a chronic infection will develop liver cirrhosis within 5 to 50 years with an increased risk of liver cancer.	60 to 80% of new cases are associated with injecting drug use. 60% are men, generally aged 25 to 29 years. Around 60 cases reported each year since 2003.	Contact with blood, anal sex (rare), vertical transmission.
Genital herpes – Virus (HSV-1 and HSV-2)	The disease is characterised by a burning, itching sensation due to blistering of mucosa. The most frequent type HSV-1 is generally limited to the mouth and lips. Type HSV-2 particularly affects the genitals. Infection remains asymptomatic in some 80% of persons infected with HSV-2. Recurrent episodes, with the first generally occurring 2 to 12 days after initial contact with HSV.	A serious primary infection in ♀ occurring during the first 12 weeks of pregnancy may cause miscarriage. Neonatal herpes is extremely uncommon in industrialised countries. Virus may cause meningitis or encephalitis in rare cases.	Some 20% of the population.	Contact with mucous membranes or infected skin, smear infection, vertical transmission; risk of infection during asymptomatic intervals. Genital transmission of HSV-1 possible.
Human papilloma virus (HPV, warts) – Virus *Human papilloma virus*	2/3 of infections are asymptomatic. Symptoms: changes to the skin (warts/condylomata) The average duration of a new HPV infection is 8 months. In 70% of cases the virus disappears within one year after infection and in 90% of cases within 2 years.	Each year some 5,000 women experience dysplasia of the cervix and 250 cervical cancer. One in 4 to 5 women will go on to develop dysplasia or cancer as a result of infection with HPV 16 or HPV 18. The HPV 16 and HPV 18 viruses are responsible for 70% of cases of cervical cancer (Such cases of cancer are virtually always due to HPV).	Some 15% of the population. It is estimated 70% to 80% of sexually active ♀ and ♂ contract HPV viruses in their lifetime. Estimated annual HPV infection rate in ♀: 2% (HPV 16/18: 1%) among people aged between 12 to 14 years; 14–16% (HPV 16/18: 7–9%) among people aged between 16 to 25 years; 8% (HPV 16/18: 2%) among people aged ≥ 50 years.	Contact with mucous membranes, infected skin, smear infection (rare), vertical transmission
Syphilis (lues, hard chancre) – Bacteria *Treponema pallidum*	Symptoms occur 10 days to 3 months after infection. Primary stage: indolent chancre at the entrance site of the bacteria (genitalia, mouth). Secondary stage: spread of infection in blood: swelling of lymph glands; changes in skin and mucosa. Latent phase: lengthy stage (lasting several months to years), asymptomatic, continuous spread to nervous system. Tertiary stage: damage to various organs, irreversible lesions.	Neonates: death during childbirth, congenital syphilis.	Prevalence/incidence 84% of cases involve ♂. 60% are aged 30 to 49. Majority are MSM (53.5% of ♂ associate the infection with a homosexual relationship), persons with multiple partners and in sex work. Some 670 cases reported in Switzerland each year.	Direct contact (not just genital) with syphilitic changes to skin, blood transfusions, vertical transmission.
Trichomoniasis – Protozoa *Trichomonas vaginalis*	No typical symptoms in half of ♀; generally asymptomatic in ♂. Symptoms: purulent discharge, burning sensation on urination, pruritus; pain on intercourse (♀). Often goes undiagnosed due to lack of acute symptoms.	Untreated infection can cause infertility in both ♀ and ♂. Atypical pelvic inflammatory disease may occur. Pregnant women: miscarriage, reduced birth weight and increased risk of endogenous dermatitis	At 5 million new cases/year worldwide this is the most common STI; especially likely to affect ♀ and young people.	Contact with genital secretions and other infectious fluids, smear infection, vertical transmission
Lymphogranuloma venereum (LGV) – Bacteria *Chlamydia trachomatis* (serotypes L1-L3)	Incubation period 2 to 60 days. Often asymptomatic. Symptoms: Primary stage: painless inflammation at the entrance site of the bacteria. Secondary stage: swelling of lymph glands with pain and fever; bleeding, purulent discharge, constipation and/or abscess and anal ulceration combined with fever.	If not treated in time, infection may cause severe lesions to the anus (scarring and cramps), requiring surgical intervention. In addition, distinctive swelling of glans and testicles.	Very rare in the general public, but increasing trend among MSM and HIV-positive MSM (assumptions, not confirmed by data).	Contact with mucous membranes (genital, anal, oral).

	Prevention	Tests	Treatment	Vaccination	Costs (CHF)		Explanations
					Test*	Treatm.**	
	Sterile injection equipment and strict hygiene measures.	Blood test.	Cure rate 50 to 90% with prompt antiviral treatment using ribavirin in combination with pegylated interferon.	No vaccine available	♂: 45.– ♀: 17.40	15'000.– bis 30'000.–	
	Condoms/Femidoms offer no protection from genital herpes due to transmission via the skin.	Specimen collection with injury, blood test.	It is only possible to treat symptoms. Continuous oral antiviral therapy with valacyclovir may reduce the frequency of recurrence and the duration of episodes.	No vaccine available	♂: blood test 105.– Swab 205.– ♀: PCR 180.– Culture 74.–	67.20	Co-infection type 1 and 2. According to the WHO 2006 to 2015 strategy paper on the prevention and control of STI, HSV-2 may be responsible for HIV infection in certain cases. For people who are HIV-negative, HSV-2 infection more than doubles the risk of HIV infection.
	Condoms/Femidoms reduce the risk. Vaccination recommended for girls.	Medical examination, poss. with vinegar test (acetic acid) and anoscopy/ colposcopy.	Surgical treatment and/or topical medication often administered long-term.	Preventive vaccination (of people not yet infected) against HPV 16 and 18, recommended for all girls aged 11–14. Should also be encouraged for boys. 3 doses administered over a period of 6 to 12 months.	♂: 205.–		The HPV vaccine can be administered at the same time as the hepatitis B vaccine. Age limit for vaccination: 26 years. This vaccination is no longer free from age 20. No charge planned for young women aged 15 to 19 until 2012.
	Condoms/Femidoms reduce the risk; rubber gloves during fisting (brachiovaginal/brachioproctic eroticism).	Specimen collection, blood test. Routine test in pregnancy.	Antibiotics benzathine penicillin G in the first two stages; secondary damage remains in tertiary stage (damage to organs).	No vaccine available.	♂: 60.– Rapid test 20.– ♀: 42.–	approx. 10.–	
	Condoms/Femidoms	Specimen collection and examination directly under microscope.	Treatment with antiparasitic medication, e.g. antibiotic metronidazole. Therapy is only successful if all sexual partners are treated.	Vaccine for active immunisation (no guarantee of success if already infected)	105.–		The parasite can survive and reproduce in a matter of hours (hands, hygiene articles, used swimming costumes). Thrives in damp and alkaline environments. Often occurs in conjunction with infection involving gonococci.
	Condoms/Femidoms, rubber gloves during fisting, rubber dams	Specimen collection, blood test.	Treatment with antibiotics doxycycline or erythromycin	No vaccine available	♂: 385.–	30.–	Frequent co-infection with HSV und HIV

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15.5 PROVISION OF SYRINGES HELPS MORE THAN JUST IDU

Swiss National Science Foundation

Bern, 06 May 2010

Spread of the AIDS pathogen, HIV, in Switzerland

For the first time, researchers for the Swiss HIV Cohort Study have reconstructed at molecular level how the AIDS pathogen, HIV, has spread in Switzerland over the last 30 years. The data shows that the provision of sterile syringes to IDU, which commenced in 1986, has also served to protect many people who are not IDU from the disease – a message that is especially important in countries where the provision of sterile syringes has not yet been introduced.

Since the emergence of the first cases in the early 1980s, a wave of infection has washed over Switzerland. Year upon year, several hundred more people become infected with the HI virus, which triggers the immune deficiency disease AIDS. Is this spread following some kind of pattern? Do these patterns differ between various transmission groups, such as IDU, MSM or heterosexuals?

Researchers funded by the Swiss National Science Foundation (SNF) pursued these questions using state-of-the-art molecular methods. In their study which has just been published in "The Journal of Infectious Diseases"[148], they concentrated on HIV-1 subtype B, which accounts for around 70% of all cases in Switzerland. They determined the HIV genotype for 5700 anonymised individuals who became infected with the pathogen between 1981 and 2007. Their idea was that the greater the similarity in the viruses of two patients, the greater the probability that they had been infected together. In cooperation with colleagues from the Swiss Federal Institute of Technology Zurich, the researchers thus determined what are known as chains of transmission, in which the virus is passed from one person to the next.

Two different transmission methods

The researchers found a total of 60 different transmission chains in which at least 10 people had become infected with HIV, but all these chains formed part of just one of two chain types – on the one hand, transmission chains mainly composed of addicts who inject heroin or other drugs into their veins, plus heterosexuals, and, on the other hand, the chain type in which the virus is predominantly spread by homosexual men. The chains with IDU and heterosexuals comprised an average of 114 patients; no fewer than 1051 people had been infected in the biggest transmission group. Study director Huldrych Günthard from Zurich University Hospital primarily ascribes this to the easier spread of HIV in the drugs scene at the start of the epidemic. "Through contaminated syringes shared by a couple of people who were infected to begin with, the virus quickly spread from the blood of one drug addict to the next", he says. In the case of homosexuals, on the other hand, where the virus is transmitted by sexual intercourse, it was spread through much smaller chains. Fewer partners became infected in the homosexual transmission chains (the average number was 29).

Key role of the drug district

"Interestingly enough, we did not find any transmission chains in which the virus was predominantly transmitted by heterosexuals", says Günthard. This means that the factors driving the epidemic's spread in Switzerland were clearly the infection chains amongst MSM and IDU on the one hand, and infections acquired abroad on the other, although the virus repeatedly switched from one group to the other. Every ninth HI virus in heterosexuals thus originated in the homosexual transmission chains. Whilst there are scarcely any infections between MSM and IDU, the infection of heterosexuals by IDU was very common, especially in the early 1980s. "The drug districts certainly played a key role", says Günthard.

The researchers' figures show, that infections between IDU and heterosexuals later decreased markedly. This is due above all to the epidemic amongst IDU being stemmed through the distribution of sterile syringes in return for used syringes, which was launched in 1986. This also led to fewer heterosexuals becoming infected with HIV. The syringe exchange programme thus protected society as a whole. According to Günthard, this is a message of international importance, because although syringe distribution programmes now exist in 77 countries around the world, they remain controversial in many countries and still have not been launched in Iceland, Turkey or Kosovo, for example.

[148] Kouyos et al. (2010) Molecular Epidemiology Reveals Long-Term Changes in HIV Type 1 Subtype B Transmission in Switzerland

15.6 SWISS NATIONAL AIDS COMMISSION'S OPINION ON SELECTED LEGAL QUESTIONS REGARDING PARTNER INFORMATION IN THE NPHS

I) Criminal and civil law aspects of HIV transmission:

1. On the basis of the settled case law of the Federal Supreme Court of Switzerland, any HIV-positive person who has unprotected sexual intercourse with an HIV-negative sexual partner is committing the offence of deliberate grievous bodily harm (Art. 122 of the Swiss Criminal Code) – if the HIV is transmitted – or of attempted grievous bodily harm if it is not. In addition, the HIV-positive partner is convicted of the spread or attempted spread of a dangerous human disease (Art. 231 of the Swiss Criminal Code). A violation of personal rights has also occurred under civil law, which can lead to a claim for compensation and amends by the victim.

2. On the basis of the settled case law of the Federal Supreme Court of Switzerland, the offence of (attempted) grievous bodily harm has not been committed if the HIV-positive person informs their sexual partner of the infection and the latter still agrees to unprotected sexual intercourse. An offence has, however, still been committed under the terms of Art. 231 of the Swiss Criminal Code, even if the HIV-negative partner has given his agreement.

3. On the basis of the settled case law of the Federal Supreme Court of Switzerland, anyone who does not actually know that they are HIV-positive, but has specific signs that they may indeed be infected by HIV and still has unprotected sexual intercourse, is committing an offence under the terms of Art. 122 and Art. 231 of the Swiss Criminal Code – (negligent bodily harm and the negligent spread of human diseases, see BGE 134 IV 193).

4. People who, despite knowing that they are infected with HIV, do not inform their sexual partner and yet *abide by the safer sex rules* of the Swiss Federal Office of Public Health cannot be convicted.

This therefore means that an HIV-positive person does not need to inform their sexual partner, in legal terms, if and insofar as the safer sex rules are observed. If the HIV-negative sexual partner is not informed by the HIV-positive sexual partner, this can (in the event of a criminal investigation) have consequences under criminal and civil law (if the victim takes the appropriate legal action).

So far, cases brought under criminal law or civil law have not yet considered the question as to whether a newly diagnosed HIV-positive person is obliged to inform partners from earlier unprotected sexual contacts of the HIV infection which may already have existed at that time. On the basis of the case law to date, it cannot be ruled out that one day HIV-positive people may be convicted for not having passed on this information.

II) Aspects of patient and data protection regulations:

1. The personal privacy and data protection acts and also patient confidentiality that is protected by Art. 321 of the Swiss Criminal Code prohibit medical personnel from passing patient information to third parties without the patient's consent or the presence of other justification.

2. If no consent has been given and if failure to inform the HIV-negative sexual partner results in a danger to the latter's health that cannot be averted in any other way, the doctor may have himself/herself released from the obligation to maintain patient confidentiality by the cantonal doctor and inform the HIV-negative sexual partner.

What are the implications of the above information for the NPHS programme?

Legal responsibility for providing information on one's HIV status prior to unprotected sexual intercourse fundamentally rests with the HIV-positive partner. The latter has to bear the consequences under criminal and civil law in the event of a failure to inform their partner.

Responsible behaviour additionally requires that an HIV-positive person inform sexual partners with whom he/she had unprotected sexual intercourse prior to the diagnosis.

Providing support for the patient in informing their current and (where relevant) former sexual partner(s) of their positive serostatus is doubtless permitted from the legal point of view, and is even essential with regard to the obligation of care towards the patient (information on the criminal consequences of not providing this information).

Swiss National AIDS Commission (EKAF), July 2010

15.7 EXTRACT FROM THE "SEXUAL HEALTH/STI RESEARCH: OVERVIEW AND DEVELOPMENT OPPORTUNITIES" REPORT

Recommendations on development of sexual health/STI research

For the promotion of research into sexual health/STI to be successfully intensified, it is not only important to submit specific research projects to the funding institutions, but at the same time to embed the topic and the corresponding need for research in the strategic fundamental principles of research development and to heighten the public's awareness thereof. This chapter contains corresponding recommendations and proposed measures, with a distinction being made between overriding and operational activities. The most important recommendations are summarised below.

Primary measures

The primary or strategic measures proposed by us create the foundation for and authorise the increased promotion of research in the field of sexual health/STI. The intention is that three strategic approaches should be followed:

- *Fundamental strategic documents:* First the subject of and the need for increased promotion of research into sexual health/STI should be integrated into the relevant fundamental strategic documents. Integration of the topic into these research strategies must also be given priority from the point of view of timing, as the corresponding periodic strategies at Federal level are currently being prepared.

- *Publicity efforts:* In the second stage, the awareness of specialists and a wider public should be raised through targeted publicity efforts regarding the need for research in the sexual health/STI field by means of articles in various forms of media and information events for specialist bodies.

- *Expansion of the EKAF mandate:* We recommend the expansion of the Swiss National AIDS Commission (EKAF) mandate to embrace a wider approach to sexual health/STI as another central measure. EKAF would have the expertise and the legitimacy for leadership in the field of sexual health/STI research. Even after what is known as the "normalisation process" in the field of HIV, there is still a need for an institution which can develop long-term outlooks in this field and follow the implementation thereof. We recommend a horizontal and a vertical widening of the EKAF mandate. Horizontal expansion would open the Commission's content to other STI and themes in the area of sexual health. Vertical expansion would change EKAF's range of duties. EKAF currently has two main remits – supporting and advising the FOPH on strategic and expert implementation of the National HIV Programme, and the review and evaluation of planning and milestones in the field of HIV. The strategic development of perspectives on research development in the field of sexual health/STI could be added as a new duty.

Level	Body	Measure	When	Lead	Remarks
		Primary measures			
Integrate sexual health/STI in research strategies	FOPH departmental research programme	Embedding of need for research in sexual health/STI field in departmental research programme 2012–2016	By mid 2010	Swiss Federal Office of Public Health (FOPH)	Embedding of sexual health/STI research requirements in FOPH's departmental research programme represents a central requirement for all other stages.
	Message on the development of education, research and innovation (ERI message)	Embedding need for research in the sexual health/STI field in ERI message 2012–2016	By end 2010	Swiss State Secretariat for Education and Research (SBF)	Embedding in the ERI message requires an appropriate reference in the departmental research programme and at the same time is contingent upon influence by the FOPH's directors.
	SNF mandate	Embedding of research requirements in sexual health/STI field in the SNF mandate 2012–2016.	By end 2011	Swiss State Secretariat for Education and Research (SBF)	Embedding the sexual health/STI research requirements in the SNF mandate represents a central requirement for the SNF's influence on project input to the cohort studies and in the event of any prioritisation of funding allocation as part of project development in sections 1–3.
	SNF multi-year programme 2012–2016	Embedding the sexual health/STI research requirements in the SNF multi-year programme 2012–2016.	By end 2011	SNF	The multi-year plan already strives for an increase in the competitiveness of social and psychological, as well as clinical and medical health research. Specific mention of sexual health research would be desirable.
Public	Special publications	Specialist article	2010	FOPH	These measures aim to increase public awareness of the need for research in the field of sexual health/STI.
	NZZ/Le temps	Layman's article	2010	FOPH	
	Radio/television	DOK or Puls contribution	2011	FOPH	
	Health policy parliamentary group	Information event with the health policy parliamentary group	2011	FOPH	Contact via chair of the parliamentary group
	Health and Social Security Committee (SGK)	Information as part of a suitable SGK topic.	2011	FOPH	Contact via Health and Social Security Committee Secretariat
	Swiss Academy of Medical Sciences (SAMW)	Information event within the scope of SAMW	2010	FOPH	Contact via General Secretariat
	Swiss Academy of Humanities and Social Sciences (SAGW)	Information event within the scope of SAGW	2011	FOPH	Contact via General Secretariat
Widening of Swiss National AIDS Commission mandate	Swiss National AIDS Commission (EKAF)	The Swiss National AIDS Commission (EKAF) expands its range of issues in the direction of other Sexually Transmitted Infections and increasingly assumes strategic leadership and guidance of research development in the field of sexual health and STI.	From legislature 2012	EKAF	As already mentioned in EKAF's annual report 2006, with effect from the 2012 legislature period EKAF is supposed to expand its mandate in the direction of other STI.

Level	Body	Measure	When	Lead	Remarks
		Primary measures			
Platform	SNF, tertiary education institutions	Support for the development or revival of an interdisciplinary research platform to act as a centre of research excellence.	Start of 2011	Federal Office of Public Health (FOPH)/ tertiary education institutions	A centre of excellence could be developed by reviving the Thun Conference and opening it up to other STI. It is essential that the SHCS be represented in this platform.
Monitoring, information	SNF, tertiary education institutions	The platform secretariat collates the research results and information in the field of sexual health and STI and prepares documentation for the attention of interested parties.	Start of 2011	Federal Office of Public Health (FOPH)/ tertiary education institutions	This centre of excellence should also be responsible for monitoring sexual health and STI research. By documenting and preparing the research results these will be more readily accessible for practical applications. The centre of excellence should make an up-to-date website and a half-yearly newsletter available to interested parties.
Simplification of access to SHCS	PaKliF, SHCS	Behavioural science issues (attitude to risk, preventative behaviour) should be investigated within the Swiss HIV Cohort Study.	2011	FOPH, PaKliF Expert Committee	An assessment by international experts of Swiss HIV policy (Rosenbrock et al., 2009) advised that social scientists and representatives of the groups concerned be integrated into the Swiss HIV Cohort Study's organisational structure. PaKliF, which is obliged by its rules and regulations to adopt an integrated approach, must take this decision. SHCS's collaboration with practice (FOPH, prevention agencies) must furthermore be improved, as this is the only way these institutions will also be able to use the Cohort Study's knowledge.
Seed money	Choice of development tool according to research project	Firming up of research issues Design of specific research plans Start-up financing by FOPH for preparation of project input	From 2010	FOPH/ Partner	Some departmental research funding will be made available to interested researchers to allow them to provide high-quality input into projects.
Departmental research	FOPH departmental research	Departmental research projects will increasingly be put out to tender to close the biggest gaps in the government's knowledge in the STI field.	From 2010	FOPH	It is necessary to define the knowledge which is regarded as urgently necessary to allow FOPH to work effectively and efficiently (e.g. it is necessary to know who has STI, and why, for effective prevention).
Target group information	Information letter	All institutions researching in the field of sexual health and STI are to be informed of the research development opportunities in this field.	From 2010	FOPH	

Recommended actions: Strategic and operational measures

(Haering et al. (2010) Forschung zu Sexual Health/STI: Übersicht und Möglichkeiten der Förderung. Final Report Attn: FOPH)

16 GLOSSARY

Axes of intervention	The NPHS groups the interventions and measures of the HIV and STI efforts into three axes. Each axis of intervention is targeted on particular population groups, and different goals will be attained in each axis. The bundling of the interventions into three axes makes it easier to structure the work with HIV and STI. First of all, it makes it easier to determine strategic goals. Secondly, it makes it possible to disentangle the HIV/STI system organisationally and thus to attribute the roles and responsibility in a clearer manner amongst the various actors. *Pages 7, **83** ff., **93** ff., 130*
Adherence	Technical term for a situation in which both patients and doctors correctly follow the therapeutic instructions, with the aim of attaining treatment success. Adherence is important in the context of anti-retroviral treatment of the HIV infection in order to guarantee that medicines are taken regularly and to avoid the development of resistances. Adherence is influenced positively, inter alia, by the support of the social environment, information and education. Negative influences may arise from mental crises (such as depressions) or the consumption of alcohol and narcotics. *Pages 8, 103, 104, 116*
AIDS	AIDS stands for Acquired Immune Deficiency Syndrome. AIDS is the late effect of an infection with HIV. Science divides the course of an HIV infection into various stages. The term AIDS is used to refer to the stage in which the immune system is severely deficient, and life-threatening AIDS-defined diseases occur, such as opportunistic infections (like pneumocystis pneumonia and toxoplasmosis), tumour diseases (like cervical carcinoma, Kaposi's sarcoma and malign lymphoma), severe general symptoms (like wasting syndrome, fever from an unclear source and neurological diseases). Following the introduction of the anti-retroviral combination therapies, the number of AIDS cases has declined since 1997 in those countries in which anti-retroviral medicines are accessible on an adequate scale.
Anamnesis	The history to date of a disease according to the patient's indications. Creating an anamnesis means establishing the patent's history to date in relation to his or her current troubles. Production of a careful anamnesis includes biological, psychological and social aspects. The individual items of information obtained in this way often permit conclusions to be drawn as regards risk factors and causal links (see also: sexual anamnesis). *Pages 29, 30, 63*
Anti-retroviral combination therapy (ART)	Anti-retroviral treatment (usually directed against HIV) involving several medicines that impede the propagation of viruses with different mechanisms of action or sites of attack. The aim of this treatment is to bring the viral load down below the detection limit. Pages 11, 23, 24 f., 27, 55, 59, 69
Behavioural prevention	Term for preventive strategies that have the aim of reducing individuals' high-risk practices by bringing about changes in certain patterns of behaviour. *Pages 7, 78*
Behavioural surveillance	Behavioural surveillance is comprised of the regular collection and appraisal of data that is relevant to prevention regarding the behaviour of people in certain population groups. The intensity and focus of behavioural surveillance is oriented towards which groups in a country are particularly affected by HIV and/or STI and to what extent. The surveillance of HIV- and STI-related protective and high-risk behaviour is a valuable complementary public-health instrument, because it makes it possible to monitor how the transmission risk of HIV and/or STI is distributed in the population as a whole and in vulnerable groups and how it is evolving in the course of time. *Pages 13, **43** ff., 60, 114 f.*

BerDa	An internet tool developed by the FOPH to guarantee a qualitatively high level of counselling in the VCT test centres in Switzerland. BerDa starts with the answers to a questionnaire and then automatically generates a risk profile of the test subject, which supplies the test-centre personnel with a series of recommendations that are relevant for the behaviour of the test subject and facilitate the appropriate structuring of counselling and treatment. BerDa also serves the purpose of the automatic capture of statistical data, which can be put to use for the monitoring and observation of various tendencies in Switzerland. Furthermore, it helps with quality assurance when quick tests are used. *Page 132*
Biological surveillance	Biological surveillance involves the collection and evaluation of data concerning the infection status of HIV as well as relevant STI and co-morbidities. The data is usually collected by means of screening either the population at large or defined groups of individuals. In Switzerland, biological surveillance is performed in connection with the screening of blood donors (for HIV, HBV, HCV and syphilis) and generally also of pregnant women (for HIV and syphilis) and of STI patients (for HIV). *Pages 8, 13, **23** ff., 60, 114*
Bisexuality	A term expressing the fact that there are people who feel drawn to both sexes (bisexual) in affective and sexual terms. *Pages 34 f., 39, 77, 85, 90, 130*
Checkpoint	Checkpoints are low-threshold health-care centres for MSM offering customised services to their specific target group, including comprehensive counselling in matters of HIV and other sexually transmitted infections (ranging from diagnosis with counselling beforehand and afterwards, via treatment, and going as far as vaccinations). The centres reflect a modern perception of integrated measures of prevention and harm reduction. At the time the programme was adopted, there was one checkpoint in Zurich and one in Geneva, and a further one was being planned for Lausanne. *Pages 65, 85, 101, 116, 127, 135*
Check-your-Lovelife tool (CYLL)	Check-your-Lovelife (CYLL) is a risk-evaluation tool. Anyone who has had unprotected sex can visit www.check-your-lovelife.ch to establish what risk they have subjected themselves to, whether an HIV test would be meaningful and, if so, where it can be carried out. *Pages 65 f., 96*
Co-infection	A co-infection is an infection by two pathogens at the same time. In a broader sense, these may also be infections contracted at different points in time but existing simultaneously. *Pages 102, 137*
Co-morbidity	Simultaneous presence of more than one disease, disorder or conspicuous characteristic. *Page 104*
Contextual prevention	Designation of a strategy for the avoidance of illnesses and other health impairments, aimed at creating a prevention-friendly climate with low-threshold access to information and prevention services so as to facilitate the use of individual protection and prevention measures. *Pages 7, 61, 85, 98 ff.*

Diagnosis

Recognition of a disease and naming it with the corresponding scientific term in accordance with an existing classification of diagnoses (the WHO's ICD 10 or, for instance, DSM IV from the American Psychiatric Association). Diagnoses are always working hypotheses as well. They are often provisional and sometimes they can only be made definitive in the course of time. Usually, it only makes sense to produce a diagnosis as a working hypothesis if a possible intervention or treatment can be derived from it.
Pages 7 f., 11, 18, 23, 26 ff., 42, 55 f. 59 f., 63 ff., 77 ff., 85, 93, 96, 101 ff., 109, 113 ff., 129 f., 132, 140

Disease management

Disease management is the structured, continuous and interdisciplinary care of chronically diseased groups of patients in accordance with scientifically recognised methods (generally in the form of treatment manuals). Active patient involvement is an essential component of the concept. In the spirit of a learning system, disease management includes the regular evaluation of the programmes. Disease management differs from case management in that it sets out to identify entire groups of patients with high and costly risks and to treat them according to the concept. In the context of the holistic treatment of the patient, more intensive use is also made of prevention and early-detection measures. It is intended to empower patients through training to learn to cope better with their illness and to work cooperatively with those treating them (compliance). Disease management requires an integrated system of care, without traditional demarcation lines, as well as comprehensive knowledge of prevention, diagnosis, treatment and the possible means for influencing a disease. Suitable incentives will be introduced for cooperative health-care providers to encourage adherence to the prescribed courses of treatment.
Pages 8, 104, 118

Discrimination

Discrimination is used in a broad sense to refer to all unlawful forms of disadvantageous treatment of social groups. The most evident possible grounds for discrimination are certain characteristics (gender, ethnicity, nationality, language, age, state of health, and so on). Discrimination can, however, also be based on less transparent characteristics (such as behaviour, social status, poor formal education, and so on).
*Pages 30, 60, 66, 77, 79, 85, 89 f., 94, 99, **109** ff., 122*

EKAF (Swiss National AIDS Commission) statement

Statement produced in a paper by the Swiss National AIDS Commission (EKAF in German), which was published in the medical journal "Schweizerische Ärztezeitung" on 30 January 2008. It stated: "the Swiss National AIDS Commission (EKAF), considering the query addressed to it by the Swiss Federal Office of Public Health's Special Committee on HIV/AIDS Clinics and Therapies and after taking note of the scientific facts and discussing the matter in depth, is of the view that a person infected with HIV, but no other STD, and undergoing anti-retroviral therapy (ART) with a completely suppressed viremia (referred to hereinafter as "effective ART"), is not sexually infectious, i.e. he or she does not pass on HIV through sexual contacts, provided the following conditions are met:

- the anti-retroviral therapy (ART) is scrupulously followed by the person affected with HIV and is verified by the doctor providing the treatment;
- the viral load (VL) has been below the detection level for at least six months (i.e. viremia has been suppressed);
- there are no infections with other Sexually Transmitted Infections."

Pages 59, 102

Empowerment

This term is used to designate strategies and activities that are suitable for increasing the degree of autonomy and self-determination in the life of individuals or communities and of making them capable of (once again) representing and shaping their own interests autonomously, under their own responsibility and in a self-determined manner. In this sense, empowerment refers to both the process of empowering oneself and to the provision of professional support for people in realising and making use of their creative attitude and resources.
*Pages **60** ff., 79, 90, 104, 111, 121*

Endemic disease

Technical term for communicable diseases whose distribution pattern is characterised by a consistent occurrence within a geographically limited territory or a particular population group.
Pages 84, 135

Epidemic

Technical term for communicable diseases whose distribution pattern is characterised by an increasing occurrence in a region, an extensive territory or a population group (concentrated epidemic).
Pages 7 f., 12 f., 23, 26 ff., 46, 55, 60, 65, 69, 73, 78 f., 83 ff., 89, 99, 110 ff., 114 f., 120 ff., 131 f., 139

Eradication

Technical term for the complete removal of pathogens from the body, tissue or organs. For a large number of infections, this can be achieved through the immune response or through treatment (with antibiotics or chemotherapeutical agents, for example). Attempts to date to eradicate HIV from the body, such as through anti-retroviral combination therapy, immunoactivation or gene therapeutic interventions have failed, since latent HIV that is present in virus reservoirs have not been reached.
Pages 7, 11

Evaluation

Evaluation is used especially as an instrument for judging the effectiveness of measures. Evaluations are targeted studies limited in time. Their aim is to identify the objective, concept, execution and impact of government actions, to measure these if possible and always to appraise to what extent they contribute to the welfare of the community. The purposes of evaluations are: (1) to account for actions by government, (2) to show where there is room for improvements and to trigger learning processes, (3) to provide findings for the design and adaptation of government measures and for planning them and (4) generally to disseminate the knowledge of government measures and/or extend the preconditions for actions by government to be successful. The most frequent appraisal criteria for the evaluation of measures by government are appropriateness, effectiveness and economic efficiency. It is possible for evaluation studies to also give consideration to monitoring data and surveillance results.
Pages 13, 32, 65, 79, 111, 115 ff., 123, 129, 141

Evidence

Scientific evidence is comprised of the knowledge gained through monitoring, evaluation, surveillance and research. Evidence-based measures are decided upon on the basis of this existing scientific information. Scientific evidence continuously provides inputs for the decisions to be taken on the control, further development and financing of interventions to match needs by the programme managers and the political decision makers in the field of public health. As far as the NPHS 2011–2017 is concerned, evidence is thus an essential instrument for the quality assurance and quality improvement of the programme and the full range of HIV & STI efforts.
*Pages 7 f., 13, 17, 45, 64, 79, 85, 94, 98, 102, 104, 112 f., **114** ff., 123, 129*

Gender Identity	Gender Identity describes the personal conviction of being a man or a woman, independent from the biological reality. *Pages 77, 89 f., 95*
Governance	Governance stands for a control or regulating system in the sense of the structures (organisational structure and process organisation) of a socio-political unit, such as the state, an administrative authority, a local government body or a private or public organisation. This expression has developed in the political setting as an alternative to the concept of "government" and is intended to express the fact that, within the socio-political unit concerned, it is not only the state ("first sector") that is responsible for control and regulation but also the private sector ("second sector") and the "third sector" (associations, clubs and lobbies). Expressed in more general terms, the concept of governance stands for all forms and mechanisms of coordination between actors with a greater or lesser degree of autonomy, whose actions are interdependent, i.e. can mutually impair or support each other. *Pages **112** f.*
Greater involvement of people living with HIV and AIDS (GIPA)	Greater involvement of people living with HIV and AIDS (GIPA) was decided on in the "Paris Declaration" of 1994 at the summit meeting of 42 states. It is a principle which states clearly that people with HIV and AIDS ought to have a decisive involvement in HIV related issues at all levels and in all programmes and institutions and ought to be empowered to assume that role if necessary. *Pages 79, 90, 111, 124*
Harm reduction	This term was coined in the field of acceptance-oriented work to describe an approach to (illegal) drugs, the aim of which is to avoid or reduce the risk of bodily, mental and social harm being caused by the use of drugs. The term encompasses information about narcotics and individual substances, and the mental and physical processes triggered by them, knowledge about risk management (such as avoiding overdoses) and the lowest-risk-possible methods of consuming them (such as safer use). *Pages 56, 100, 122*
Heterosexuality	Heterosexuality is a sexual orientation or identity in which love, romance and sexual desire are felt exclusively or primarily for persons of the other gender. *Pages 18, 23 ff., 34 ff., 48 f., 55, 61, 64, 79, 85, 90, 134, 139*
HIV	Abbreviation for Human Immunodeficiency Virus. A lentivirus belonging to the family of retroviruses. HIV-1 was identified as the pathogen causing AIDS in 1983 (and was initially known by the names of LAV-1, lymphadenopathy-associated virus, ARV, AIDS-related virus or HTLV-III). A second type of virus, HIV-2, has also been known since about 1986. Both virus types are distributed throughout the world, but HIV-1 occurs very much more frequently than HIV-2, which has been shown to exist almost exclusively in parts of western Africa. HIV-1 is subdivided into three groups: HIV-1 M (main group), HIV-1 N (non-M, non-O) and HIV-1 O (outlier). More than 90% of all infections are caused by viruses belonging to the HIV-1 M group, in which it is possible to distinguish at least ten subtypes (A to K). The commonest subtypes are B (especially in North and South America as well as Europe), A and D (especially in Africa) and C (especially in southern Africa and Asia).
Homophobia	Homophobia essentially denotes a social aversion to homosexuals, or hostility or an irrational fear (since there is no factual justification for it) of homosexual individuals and their lifestyles. In the social sciences, homophobia is included under the concept of "group-focused enmity" along with phenomena such as racism, xenophobia or sexism. *Page 30*

Homosexuality

Homosexuality is a sexual orientation or identity in which love, romance and sexual desire are felt exclusively or predominantly for persons of one's own gender. Homosexual women are also called lesbians and homosexual men gays. The adjective homosexual is also applied to sexual acts between persons of the same sex who are not lesbians or gays.
Pages 30, 34 ff., 47, 52, 55, 85, 90, 127, 134, 136, 139

Intersexuality

In the case of intersexuality, it is impossible to definitively determine the gender of a child at birth, since the child's internal and external gender characteristics do not correspond with each other. Individuals having a female external appearance, for instance, are genetically male (XY chromosomes), with testicles present instead of fallopian tubes. In turn, children declared to be boys on the basis of their genitals, display a female set of chromosomes (XX) and the corresponding reproductive organs. The term intersexuality is used in these cases – which are only two examples of a wide range of intersexual forms. Atypical genitals frequently point to intersexuality: these can range from an over-sized clitoris, via a penis-like clitoris through to a micropenis.
Page 90

Incidence

From the Latin "incidere": Incidence is the term used for the number of new cases or occurrences (of a disease, disorder or infection) within a defined population during a defined period of time.
Pages 11, 17, 32, 38, 42, 115, 134, 136

Isis-Info

Isis-info.ch is a Swiss website that provides information on all the offers available nationwide from the counselling units appointed by the cantons in the fields of pregnancy, family planning, sexuality and AIDS support. It is thus the information platform of the Swiss counselling units in the area of sexual and reproductive health (SRH).
Page 95

Knowledge management

Knowledge management is the term applied to the totality of strategies and processes for leveraging and developing knowledge at various levels inside the institution. Knowledge management does not refer so much to the contents of the knowledge but rather to the shaping of the general setting, structures, processes and methods. In practice, there are two different directions that knowledge management can take: "management of knowledge" and "management for knowledge". The first of these concentrates on handling existing knowledge. Management for knowledge, on the other hand, is oriented towards the dynamic, implicit and equivocal quality of knowledge and focuses on the relevant general environmental conditions and the ground rules for using and developing knowledge.
Pages 129, 131

LOVE LIFE campaign

Since 2005, the FOPH and the Swiss AIDS Federation have been using the LOVE LIFE STOP AIDS campaign (formerly STOP AIDS) to inform everyone living in Switzerland about HIV on a regular basis. The campaign is an important element in the FOPH's nationwide AIDS-prevention strategy. It is intended to put the population in a position to protect itself against HIV infections.
Pages 11, 85, 94

Managed care

A steering system in health care. Managed care refers to a concept for medical care intended to guarantee a holistic health-care system controlled from a single source and across the demarcation lines between all the care sectors. Its aim is to arrange the health-care procedures efficiently and effectively. Its central elements are the quality assurance of the care and the share in budgetary responsibility of the provider of the managed care.
Page 104

Microbicides	Microbicides are chemical substances that kill off microbes. One of the uses to which microbicides can be put is to prevent infection with HIV or an STI during sexual intercourse. *Page 19*
MSM (men who have sex with men)	This term includes not only men who have a homosexual identity and who only have sex with men, but also men with bisexual and heterosexual orientations who sometimes practise homosexual sex. *Pages 23, 25 ff., 45 ff., 55 f., 64 f., 79, 83, 85, 99, 114 ff., 122, 131, 134 ff.*
Obligation of notification	In Switzerland, laboratories are required to report HIV, AIDS and other sexually transmittable diseases (hepatitis B and C, gonorrhoea, syphilis and chlamydia infections), and doctors must also report these, with the exception of chlamydia. In the context of the notification obligation, it is not only biological parameters regarding the diagnosis that are collected but also socio-demographic data and indications regarding the suspected exposure. *Pages 23, 32, 42, 115 f.*
Partner information	Term used for the passing on of information about the medical findings, the health or sero status of a person to their partner (male or female), which may be done by the person affected themselves or by third parties (such as doctors). *Pages 8, 59 f., 85, 90, 94, 97, 101 ff.*
Post-exposure prophylaxis (PEP)	Technical term for secondary prevention measures following suspected or known exposure to a disease-causing pathogen, with the aim of preventing an infection or a disease. In the case of HIV-PEP with exposure at work or otherwise (such as sexual exposure), it is recommended to start immediately with an anti-retroviral combination therapy (within 24 hours if at all possible and certainly not later than 72 hours). In the case of a syringe wound, that wound should also be washed out and cleaned. In the case of oral exposure (oral-genital sexual contacts with ejaculation), a mouth rinse should also be performed. If possible, and once the person who might have constituted an infection risk has been counselled and given their consent, it might make sense to perform a quick test to determine their sero status and to appraise their infection risk. As a general rule, PEP is performed for 28 days. Starting PEP as soon as possible may reduce the risk of an HIV infection. *Page 101*
Prevalence	Prevalence states how many persons within a given group (population) of a defined size are infected with a particular pathogen or are ill with a particular disease. Prevalence is not the same as incidence, in that it counts not only the newly diagnosed cases at the time of the study, but also persons who are already ill (or infected). *Pages 7 f., 17, 27, 30, 32, 42, 46, 55, 59 f., 63 ff, 78, 83 ff., 98, 100, 114 ff., 121, 131, 134, 136*
Prevention	General term for all the measures that contribute to reducing the occurrence, spread and negative effects of diseases or health disorders. Preventive measures include medical, psychological and educational interventions, environmental monitoring, legislative measures, lobbying, and campaigns in the mass media. "Behavioural prevention" is targeted directly on individuals, whereas "contextual prevention" is targeted primarily on organisational structures (society, government, legislation and settings). These are understood as an intervening variable between preventive intervention and individual behaviour.

Primary infection

First-time infection with a pathogen. In the case of HIV, the virus generally spreads rapidly throughout the body after three to ten days (sometimes taking up to three months) and establishes itself definitively. This phase is often experienced with symptoms similar to influenza: high temperatures, swollen lymph nodes, sore throat, etc. During the primary infection, the virus load in the blood and sperm is strongly increased, which means that the sufferer is highly infectious.
Pages 17, 23, 28, 63 f., 99, 136

Provider-initiated counselling and testing (PICT)

This concept complements that of VCT (voluntary counselling and testing), in which the initiative to undergo an HIV test comes from the client. The essential difference between these two approaches is that in the case of PICT it is a doctor who proposes the test to the person consulting them (usually for other reasons). As a fundamental rule, both procedures must satisfy the criteria of the "three Cs": consent (i.e. no test without express consent granted voluntarily), confidentiality (the test and its result are not accessible to third parties) and counselling (both before and after the test).
*Pages **63** ff., 97, 101*

Public health

The WHO definition of 1998 states that "public health is a social and political concept aimed at improving health, prolonging life and improving the quality of life among whole populations through health promotion, disease prevention and other forms of health intervention."
*Pages 7 f., 13, **17** ff., 46, 59, 63, 79, 112 f., 116 ff., 129, 133*

Reproductive health

The definition contained in the Programme of Action adopted at the United Nations' International Conference on Population and Development (ICPD) held in Cairo in 1994 states that "reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so."
Pages 77, 97, 122

Research

Research denotes the search for new knowledge based on specific methods. A distinction is drawn here between fundamental research and applied research. While the former sets out to extend scientific knowledge without a particular purpose in mind, applied research endeavours to create specific knowledge that is of direct practical relevance. Surveillance constitutes a particular form of applied research.
*Pages 11, 19, 69, 79, 111, 115 f., **117** ff., 122, 124, 128, 129 ff., 135, 141 ff.*

Safer sex

A term that came into being in the 1980s for practices that are very unlikely to lead to the transmission of HIV (and, in part, of other sexually transmitted infections too). This term expresses the idea that it is possible to reduce risk but that the exclusion of all risk (safe sex) is only realistic in exceptional cases (such as practising nothing other than masturbation). The safer-sex rules can be summed up as: no penetration without wearing a condom and no seminal fluid to get in either the blood or the mouth. In the event of itching, a discharge or pain in the genital region, a doctor should be consulted.
*Pages 7, 12, 17, 38, 64, **66,** 78, 85, 90, 94, 102, 140*

Screening

Screening makes it possible to detect conspicuous characteristics or risk factors through simple tests, examinations or other procedures, which can be performed quickly on a fairly large scale. Screening ought not to be a replacement for diagnosis. Individuals with positive or suspicious findings must be referred to the health-care institutions for diagnosis and treatment.
Selective screening is targeted on a selected group assumed to have a higher risk for a particular disease or disorder.
Pages 36, 60, 63, 65, 97

Sentinel notification system ("Sentinella" in Switzerland)

Switzerland's Sentinella notification system is used to collect epidemiological data, to monitor transmitted and other acute illnesses and to conduct research in primary-care medicine. A number of European countries have had Sentinel notification systems of this type for several years now, including Great Britain, France, the Netherlands, Belgium, Germany, Italy, Portugal and Spain. In Switzerland, the "Sentinella" network was set up in 1986, following trials in a regional pilot project, for purposes of monitoring frequently transmitted diseases. Since then, the range of topics covered has been extended to include non-infectious diseases too. Alongside specific registers, such as those kept of cases of cancer, Sentinella is thus the only instrument in Switzerland which gives insight into illnesses occurring throughout the entire population that are not subject to notification, plus the primary care given by general practitioners.
Pages 42, 114, 116

Second-generation surveillance system

Second-generation surveillance (SGS) is a form of surveillance in which biological data and notifications of new HIV and STI diagnoses are combined with behavioural data (such as sexual, preventive or high-risk behaviour). This data is collected and evaluated regularly. SGS makes it possible not only to estimate the severity of a public-health problem but also to analyse its causes and to forecast the future course of an epidemic.
Page 129

Sero-different (sero-discordant)

Sero-different (older term: sero-discordant) describes different findings in the examination of the serum of couples, for instance evidence of HIV antibodies in only one partner.
Page 47

Sero status

This is the status of the blood serum (liquid component of the blood), where two conditions can occur: individuals are designated sero-positive if it has proved possible to find antibodies against a specific antigen, if the findings are negative, then the individual is sero-negative. There are limits on the process for detecting antibodies, which are based on two time factors: on the one hand, the infected organism must have already started forming antibodies and, on the other hand, the antibodies must be available in a sufficient concentration.
Pages 46, 59, 140

Sexual anamnesis

The sexual anamnesis is that part of the anamnesis that systematically records the symptoms and the background of sexual symptoms and disorders.
Pages 64, 97

Sexual health education

Sexual health education provides (young) people with fundamental knowledge and with the capability, skills and values that they require to experience their sexuality in physical, mental and also emotional terms.
Pages 52, 56, 69, 77, 85, 90, 95, 111, 130

Sexual health

Sexual health describes a state (or also framework conditions) in human development in which sexuality can be lived subjectively, pleasurably and without harm for others.
The WHO's target definition of the concept of "sexual health" is as follows: "a state of physical, emotional, mental and social well-being related to sexuality; not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be protected, respected and fulfilled" (WHO 2002).
Pages 7 f., 12, 59 ff., 66, 73, 77 f., 85, 89, 94 f., 97, 101, 109 f., 112, 116 ff., 124, 131, 141 ff.

Sexual orientation	This term expresses the fact that there are people who are drawn in affective and sexual terms to the other gender (heterosexual), the same gender (homosexual) or both (bisexual). *Pages 77, 89 f., 95*
SHCS, Swiss HIV cohort study	The Swiss HIV cohort study has created a broad cohort of HIV patients (both male and female) and thereby made it possible to build up a representative data pool, which is open to all interested researchers (carrying out bio-medical and clinical research). As an interdisciplinary, cooperative network, the SHCS covers all aspects of disease-oriented and patient-oriented research. *Pages 11, 47, 55, 69, 110, 115 f., 118 f., 131 f., 140, 142 f.*
Stakeholder	Stakeholders are: ■ individuals or groups of individuals or organisations, ■ actively participating in the project or affected by the course of the project or its outcome ■ and, possibly, able to influence the course of the project or its outcome. *Pages 7, 12 f., 112 f., 119, **127** f., 129*
STI (sexually transmitted infection)	A term introduced by the World Health Organisation for infections that can be transmitted by sexual contacts (regardless of whether or not such contacts actually lead to a disease).
Stigmatisation	The term "stigma" refers to a bodily, mental, character-based or social characteristic of a person that is ascribed to him or her by others. The stigma triggers rejection, anxiety or apprehension amongst other people and denigrates the person to whom it is ascribed. *Pages 60 f., 65, 79, 95, 99, **109** ff., 122*
Supplementary notification	Epidemiological monitoring (the notification system) is aimed at permitting health problems to be recognised at an early stage so that the necessary measures for efforts against infectious diseases can be initiated on time. For a number of pathogens, the initial notification does not yet cover all the epidemiological requirements. Additional details are required for the specific infection in question, such as regarding vaccination status and exposure. The cantonal doctor obtains this "supplementary notification" from the doctor who has submitted the notification or is providing follow-up treatment. These supplementary details allow the necessary measures to be implemented. The cantonal doctor forwards the supplementary notification to the FOPH. *Pages 29, 31 f., 34, 36, 115 f.*
Surveillance	Surveillance describes the regular and/or continuous and systematic collection of epidemiological and other data (with comparable indicators) and its evaluation in accordance with relevant criteria (for example age, gender, transmission route, etc.) for the consistent observation of an epidemic. In the case of HIV and STI, this includes, amongst other data, newly diagnosed HIV and STI infections as well as data on AIDS cases and AIDS-attributed deaths. Surveillance is thus an important instrument for a country to cope with the challenges it faces in the field of public health. In Switzerland, laboratories must report HIV, AIDS, gonorrhoea, syphilis infections and chlamydia infections, and doctors must similarly report these infections (with the exception of chlamydia). In the context of the notification obligation, it is not only biological parameters regarding the diagnosis that are collected but also socio-demographic data and indications regarding the suspected exposure. *Pages 13, 17, 84, 114 ff., 122, 129*
Symptom	A sign. The technical medical term for a sign caused by a disease. *Pages 17, 23, 34, 36, 38, 40, 63 ff., 78, 117, 134, 136*

Target group	Group of individuals (with comparable characteristics) which is to be addressed in a targeted manner about something or which is to be reached via something. *Pages 7 f., 11, 55 f., 60, 62, 65, 69, 79, 83 ff., 89 f., 93, 97 ff., 101, 116, 131, 143*
Third-generation surveillance system	Third-generation surveillance (TGS) is the name given to a comprehensive surveillance system, which includes biological and epidemiological surveillance along with behavioural surveillance, but goes further still in that individual prevention measures and the care services on offer are subjected to monitoring with a view to establishing their effectiveness. This monitoring also includes a cost/benefit analysis. The aim of third-generation surveillance is to arrive at a situation in which the preventive measures are rendered comparable as regards their benefits and costs and can thus be assigned priorities. This gives the decision makers the necessary inputs for allocating the scarce resources optimally to the individual preventive measures. In this way, third-generation surveillance provides an important instrument for quality assurance and for assessing the effectiveness of prevention. *Pages 8, 60, 114 ff., 129*
Transgender Identity	Feeling of belonging to the other sex, often linked to a desire for a sex change. *Pages 85, 90, 130*
Viral load	Quantity of viruses in the blood, indicated as a natural or logarithmic number of the virus copies per millilitre. In the case of an acute HIV infection, a very high viral load occurs at the beginning, which then wanes, but increases again later, as the immune deficiency deteriorates once more. Individual fluctuations and temporary increases (such as during infections or after protective vaccinations) are possible. A higher viral load corresponds to a higher risk of disease progression. *Pages 17, 23, 59, 85, 102, 104*
Voluntary counselling and testing (VCT)	Voluntary counselling and testing (VCT) is the term given to an internationally validated HIV prevention intervention on individuals, whom it is hoped to bring to a reduction in the risks of transmitting HIV through improved protective behaviour to be achieved through a uniformly structured combination of HIV counselling and testing. VCT guarantees confidentiality to clients. An HIV test is performed solely if the client has given their voluntary informed consent to it. *Pages **63** ff., 97, 101 113, 132*

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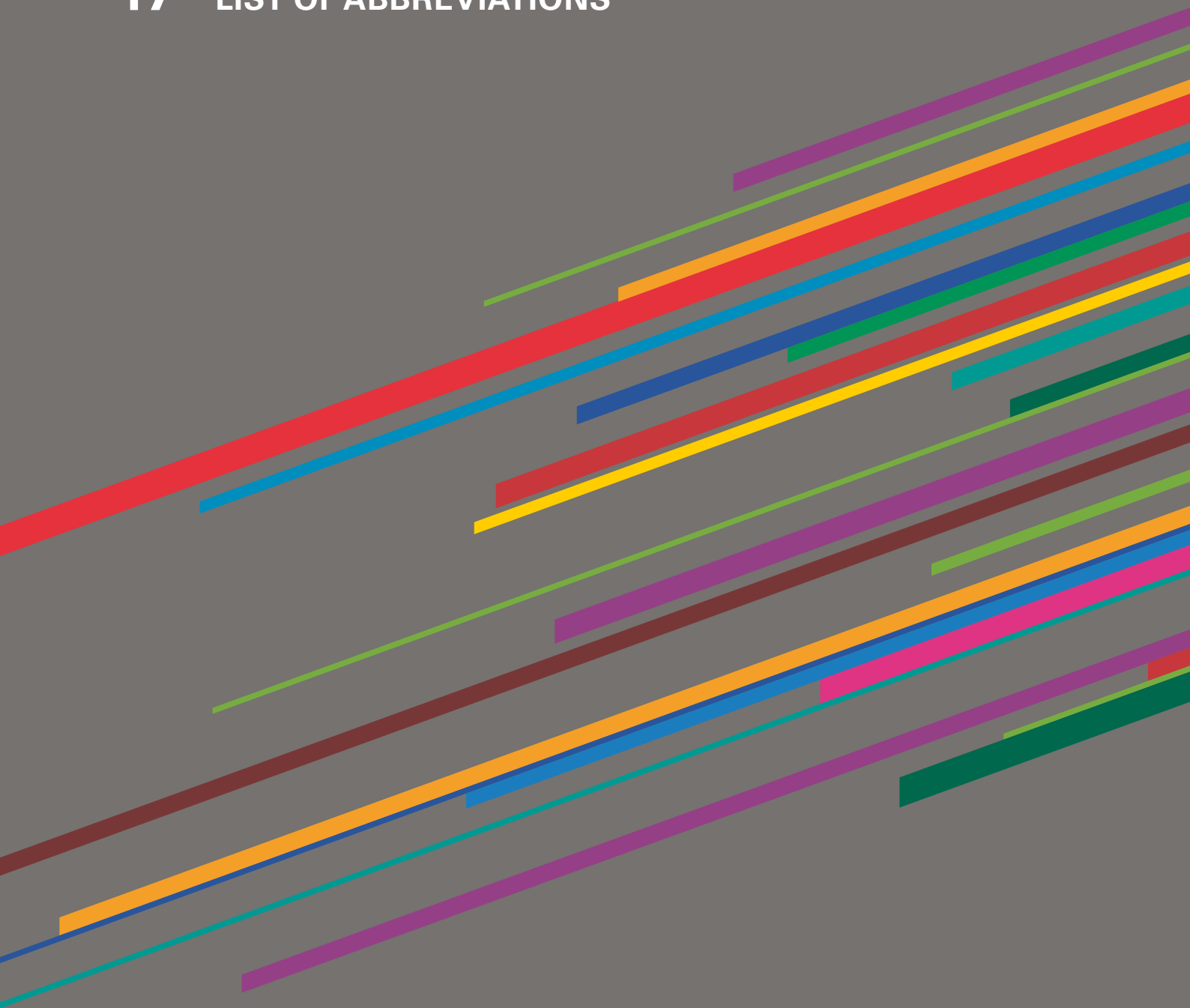
17 LIST OF ABBREVIATIONS



AIDS	Acquired immune deficiency syndrome
ART	Antiretroviral therapy
BerDa	Counselling guidelines and data processing system for voluntary counselling and testing centres
BIG	Bekämpfung von Infektionskrankheiten im Gefängnis (Combating Infectious Diseases in Prison)
CYLL	Check Your Lovelife
ECDC	European Centre for Disease Prevention and Control
EKAF	Eidgenössische Kommission für Aidsfragen (Swiss National AIDS Commission)
EKIF	Eidgenössische Komission für Impffragen (Swiss Federal Vaccination Commission)
FDFA	Federal Department of Foreign Affairs (Eidgenössisches Departement für auswärtige Angelegenheiten)
FDHA	Federal Department of Home Affairs (Eidgenössisches Departement des Innern)
FOM	Federal Office for Migration (Bundesamt für Migration)
FOPH	Federal Office of Public Health
GAP	Gesundheitsaussenpolitik (foreign health policy)
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of People Living with HIV/AIDS
HIV	Human immunodeficiency virus
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HPV	Human Papilloma virus
HSV	Herpes genitalis
IDU	Injecting Drug User
ILO	International Labour Organisation
IPPF	International Planned Parenthood Federation
LGBT	Lesbian, Gay, Bisexual & Transgender
LGV	Lymphogranuloma venerum
MSM	Men who have sex with men
NGO	Non-governmental oganisation
NHAP	Swiss National HIV/AIDS Programme
NPHS	Swiss National Programme on HIV and other Sexually Transmitted Infections
NPO	Non-profit organisation
PEP	Post-exposure prophylaxis
PHZ	Pädagogische Hochschule Zentralschweiz – Luzern (Central Switzerland Teacher Training College – Lucerne)
PICT	Provider Induced Counselling and Testing
PLANeS	Schweizerische Stiftung für sexuelle und reproduktive Gesundheit (Swiss Foundation for Sexual and Reproductive Health)
PrEP	Pre-exposure prophylaxis
SADC	Swiss Agency for Development and Cooperation (Direktion für Entwicklung und Zusammenarbeit)
SAN	Swiss AIDS News
SCIH	Swiss Centre for International Health
SGDV	Schweizerische Gesellschaft für Dermatologie und Venerologie (Swiss Society for Dermatology and Venerology)
SGGG	Schweizerische Gesellschaft für Gynäkologie und Geburtshilfe (Swiss Society for Gynaecology and Obstetrics)
SGS	Second Generation Surveillance System
SHCS	Swiss HIV Cohort Study
SNF	Schweizerischer Nationalfonds (Swiss National Science Foundation)
STI	Sexually transmitted infections
TGS	Third Generation Surveillance

UEPP/IUMSP	Unit for the Evaluation of Prevention Programmes/University Institute of Social and Preventive Medicine, Lausanne (Unité d'évaluation de programmes de prévention/Institut universitaire de médecine sociale et préventive, Lausanne)
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on AIDS
VCT	Voluntary Counselling and Testing
VEGAS	Verein Gaybetriebe Schweiz (Swiss Association of Gay Businesses)
WHO	World Health Organisation

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