Early Testing Promotion

The Swiss Experience in Scaling up VCT

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With a population of 7.5 millions inhabitants, Switzerland knows a concentrated HIV epidemic with a high incidence of diagnosis. The Swiss situation is comparable to Portugal with an HIV incidence of 100 cases per million inhabitants. The people mainly concerned with HIV infections are gay men and other men who have sex with men, migrants from Sub-Saharan Africa and injecting drug users. The prevalence in the general population stands at less than 0.1%. The global number of people living with HIV in Switzerland is estimated between 20'000 and 25'000. Finally, more than 300'000 HIV tests are carried out every year, and about 50% of the population has taken an HIV test once in their lives. Unfortunately, it is often not the people concerned who mostly apply for HIV testing. These tests are generally done by practitioners, who miss, most of the time, to give any proper pre- and post-test counselling. Therefore, the Federal Office of Public Health wants to scale up VCT.

Why scale up VCT?

Switzerland also experiences late presenters. AIDS cases occur for two reasons. The first reason is usually people who are not aware of their infection and receive simultaneously a positive an HIV test and a AIDS diagnosis. The second reason is treatment failure. Heterosexuals and migrants, who tend to reach health services with difficulties, are mainly cases of late presenters. AIDS cases among gay men are more often due to treatment failure.

As mentioned, the number of HIV test performed each year in Switzerland is very high. Most of them are done by general practitioners (GPs); and too many of them without proper counselling. Therefore, the Federal Office of Public Health does not want more testing but better counselling and testing. Testing itself has no impact on changing behaviour yet counselling does. There is, indeed, no "natural" behaviour change after knowing one's HIV status. There is strong evidence that behaviour change can occur without HIV testing. And there is also strong evidence that behaviour can remain unchanged after learning one's positive status. Behaviour changes are then linked to education and proper counselling and not to testing itself. In that respect, approaches such as "universal testing", or "opt-out-strategies" or "screening", are not perceived as suitably methods compared to New Public Health approaches.

In addition, promotion of testing must only be targeted, in a concentrated epidemic, to the vulnerable and high prevalence groups. VCT among people with low risk and low prevalence is a waste of time and money.

How to scale up VCT?

The promotion of VCT can be done in two ways.

1. People at risk can be motivated to seek VCT.
2. General practitioners (GPs) are educated to induce counselling and testing to their patients at risk. Such approach is called "provider induced counselling and testing" (PICT).

In order for people to know if an HIV test makes sense or not, the Federal Office of Public Health has developed on the Internet a risk assessment tool called www.check-your-lovelife.ch. After answering 10 questions, the user receives his or her risk evaluation, and a list of VCT centres in his or her area if counselling and testing is needed. Different VCT centres have been created to receive specific populations such as the Checkpoint centres in Geneva and Zurich for gay men.

Furthermore, another tool has been created by the Federal Office of Public Health to assure quality counselling and testing within the VCT centres. This tool is called BerDa. Likewise the assessment tool Check-your-lovelife.ch, a questionnaire has to be answered by the client. On the basis of his or her answers, BerDa administers the correct use of rapid test, and the confirmation procedure in case of reactive rapid test. BerDa enables also the collection of anonymous data, which are delivered to the Federal Office of Public Health.

PICT is promoted by educating GPs in Switzerland to recognize signs, such as STI, TB, hepatitis, and especially mononucleosis, that could imply an HIV infection, and to offer in these cases VCT to their patients. Too many doctors miss effectively cases because of their prejudices. For example, they might know the patient and cannot believe that he or she could be unfaithful or a sex tourist. The question if a test for such patient should be "opt-out" or opt-in" is wrong. There is no reason for GPs not to talk with their patients about his or her possible risky behaviour and his or her willingness to consent to an HIV test after adequate counselling. GPs are informed through the Federal Office of Public Health's publication.

What about people diagnosed positive?

The whole process of doing VCT right makes sense if we also insure a good follow-up for those diagnosed HIV positive. It is crucial that people diagnosed positive receive counselling and can attend peer education together with their partners. It is important that they begin their treatment at the right clinical time and when they are ready and willing to adhere seriously to their treatment.

How can you find out if scaling up VCT did work?

VCT worked if there is less late presenters with CD4 below 200 and if there are less AIDS cases.

Finally, scaling up VCT by promoting VCT and provider induced counselling and testing (PICT) makes sense if:

- one consents to New Public Health as ground of HIV prevention strategy;
- one can offer access to treatment;
- one can assure good quality of counselling, (rapid)testing and treatment.