Research and Practice of Health Promotion

Quality Assurance in AIDS Prevention

Volume 3

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The Federal Centre for Health Education (FCHE) is a government agency, based in Cologne, responsible to the Federal Ministry of Health. Its remit is to design and implement measures aimed at maintaining and promoting health.

It develops campaign concepts and strategies, produces summaries of media and methods, cooperates with a variety of workers and agencies in the health education field, and carries out education measures both for the population as a whole and covering selected topics for specific target groups.

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These studies and assessments, along with the results of specialist meetings, are published by the FCHE in its specialist booklet series on "Research and Practice of Health Promotion". This is to be seen as a forum for scientific discussion. The aim of the series – like the existing series on sex education and family planning – is to further extend the dialogue between theory and practice.

Research and Practice of Health Promotion
Volume 3

Quality Assurance in AIDS Prevention

Report of the Expert Conference from 13 to 15 November 1995 in Cologne

A conference in cooperation with the

World Health Organization
Regional Office for Europe
Copenhagen

Federal Centre of Health Education (FCHE)
Cologne, 1999

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Tel.: +49(0)221/89 92–0
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E-Mail: international@bzga.de

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Preface

The Federal Centre for Health Education (FCHE) held an international expert conference on the subject of "Quality Assurance in AIDS Prevention" from 13 to 15 November 1995 in cooperation with the World Health Organization, Regional Office for Europe (WHO/EURO), whose financial support made this possible. The aims of the event were to exchange experiences from ten years of AIDS prevention and to discuss future concepts for the quality assurance of prevention work, especially against the background of ever decreasing financial resources.

To this end, representatives of national AIDS prevention programmes from eight European countries were invited. These were, on the one hand, countries who have many years of experience in AIDS prevention and, on the other hand, countries who are currently just starting to develop comprehensive and complex AIDS prevention strategies.

Overall, the international exchange of experience provided important impulses for the respective national prevention work. We consider this subject to be very important for our work and intend to continue the expert exchange of experience in the future.

Against the background of the intensive and fruitful discussions in the context of the event, I would like to thank the WHO/EURO and the Federal Ministry of Health for their professional and financial support of the expert conference. Furthermore, I would also like to extend my thanks to the participants who made the successful work of the conference possible through their commitment.

Cologne, January 1999

Dr. Elisabeth Pott
Director of the Federal
Centre for Health Education

Outline of the Conference

Titel of the project:	Expert conference "Quality Assurance in AIDS Prevention"
Goals:	• Exchange on essential learning experiences of one decade of AIDS prevention • Concepts and activities of quality assurance optimisation of the national AIDS prevention • Measures (resp. measures combinations) which secure in future sustainable effects of AIDS prevention • Scientific research as element of quality assurance
Conference dates:	13 to 15 November 1995
Participants:	Coordinators of the national AIDS-Prevention programmes from Belgium, Estonia, France, Letvia, Lithuania, The Netherlands, Switzerland and Germany
Project planning and realisation:	Gerhard Christiansen, Dr. Dr. Wolfgang Müller, Helene Reemann, Jürgen Töppich Federal Centre for Health Education (FCHE) Ostmerheimer Straße 220 D-51109 Cologne Tel.: +49-(0)2 21/89 92-0 Fax: +49-(0)2 21/89 92-300
Facilitator:	Hans Saan, NIGZ (NL)
Editors:	Thomas Hafer, Cologne Jürgen Töppich, FCHE
Sponsor:	Federal Centre for Health Education (FCHE) Ostmerheimer Straße 220 D-51109 Cologne Tel.: +49-(0)2 21 / 89 92-0 Fax: +49-(0)2 21 / 89 92-300 in cooperation with the WHO, Regional Office for Europe (WHO/EURO), Copenhagen
Project management and coordination:	Helene Reemann, FCHE

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Introduction

1. Introduction

10 Years of AIDS Prevention

Ten years of AIDS prevention in the Federal Republic of Germany and in other European countries have shown that broad-based education using the mass media, target group specific and personal offers is successful. AIDS prevention, also as an international joint task, has contributed to the fact that the HIV epidemic has been able to be largely restricted in Europe.

As the national coordinators of the AIDS prevention programmes from Belgium, Estonia, France, Latvia, Lithuania, the Netherlands and Switzerland report, many European countries have gradually developed comprehensive national programmes, beginning in around the mid-1980s. Under the pressure of alarming predictions about the further spread of the disease, action was usually taken rapidly and decisively.

To date, all the countries represented have been pursuing the same essential goals with their very different campaigns:

- Prevention of new infections
- Prevention of discrimination against those affected
- Establishment of an optimum system for the medical and psychosocial counselling and support of infected and sick persons.

The effects of AIDS prevention

Changes in protective behaviour, a high level of information of the general population and the relatively low spread of HIV are signs of the success of these efforts. In this context, a European comparison made it clear that only a complex system of intensive education efforts, which addresses the population as a whole and different target groups through a variety of media and measures, can result in the successes listed.

In Germany, the Federal Centre for Health Education has carried out annual representative surveys among the population on the knowledge of, attitude to and behaviour as regards AIDS since 1987. However, against the background of shrinking financial resources, the current results of this study from 1994 show signs of retrogressive tendencies in the scope of preventive measures and in protective behaviour for the first time.

Ensuring of effective prevention work

In view of this situation, the following question arises: How can the successes of AIDS prevention be ensured or further expanded in the future?

The international exchange of experience showed that, despite the specific framework conditions of each country, the following elements have to be indispensable components of effektive prevention work in all countries:

- A broad offer of education measures for the entire population must form the basis for target group related media and counselling offers.
- Prevention strategies should be developed even more strongly on a scientific basis in future, and less on the basis of opinions and ingrained habits of thought.
- The work must be continuously pursued, as it involves long-term social learning processes in very intimate personal spheres of complex interaction.
- Constant scientific monitoring of the prevention campaigns of a country and consideration of the results in the further development of work.
- Close cooperation of government and non-government agencies, and the agreement of all important social groups on the contents and goals of prevention are necessary.

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Aims and Results of the Expert Conference

The Federal Centre for Health Education (FCHE), Cologne, held an international expert conference on the subject of "Quality Assurance in AIDS Prevention" from 13 to 15, November 1995 in cooperation with the World Health Organization, Regional Office for Europe (WHO/EURO), Copenhagen.

2.1. Background and Goals of the Event

Ten years of AIDS prevention and current epidemiological situation

Since the mid-1980s, most European countries have developed AIDS prevention programmes. Differences in the structure and strategy of the individual national programmes arose in some areas owing to the different framework conditions. Despite this, AIDS prevention has the same essential aims in all European countries, i.e.:
The prevention of new infections and of discrimination against sick and infected persons, as well as the establishment of systems for the pyschosocial and medical support of those affected.

Today, these prevention programmes are showing clearly successful results. A high level of information among the general population and, in particular, among those groups primarily affected, as well as changes in protective behaviour, have contributed to the relatively low spread of HIV and AIDS in Europe in comparison with other continents.

However, the epidemiological situation as regards the spread of HIV in Europe clearly illustrates that AIDS continues to be one of the most pressing problems of health policy, despite the marked success of the existing prevention programmes. According to information of WHO 2,000 new HIV infections (Dr. Johannes Hallauer, WHO/EURO 1995) and 70 cases of AIDS are diagnosed every day in Europe. In general, an increase in cases of heterosexual transmission can be observed. There has been a striking increase in new infections through the use of intravenous (i.v.) drugs, e.g. in Southwestern regions such as Spain, France and Italy, as well as a rapid increase of i.v. drug use in Eastern Europe. The likewise marked increase in the number of cases of sexually transmitted diseases in Eastern Europe, where figures have climbed to around ten times those previously usual since 1988, indicate a large and growing potential for future infections. Further infection risks are arising owing to growing mobility within Europe – the result of the social transformation – emphasizing the necessity of continued prevention.

The permanent establishment of national and international AIDS prevention is becoming a central challenge to prevent increasing financial burdens in addition to human suffering.

Scarce resources

However, in view of the economic situation in Europe, the achievements of health promotion programmes as a whole are being put to the acid test, and this also includes AIDS prevention.
Questions as to efficacy, efficiency and quality assurance are thus becoming the focus of the assessment and evaluation. The critical discussion of the experiences gained from a decade of AIDS prevention is the main basis for the evaluation and planning of future programmes.

Despite the different framework conditions, developments and experiences, it is important to carry out this discussion at an international level in order to utilise the manifold experiences and examine which elements have proved successful and could also be viable in future.

Goals of the expert conference

The goals of the conference thus consisted of taking stock of European AIDS prevention on the basis of the following leading questions:

- What has been done and against what national backdrop?
- What has been evaluated and how?
- What has proved successful in the different national programmes?
- What has proved to be in need of changing?

Building on this, another goal was the elaboration of general recommendations as regards essential elements and aspects of the quality management of future AIDS prevention.

The participants

In line with the aforementioned goals, the participants were a group of 26 decision makers who play a leading role in the conception, steering and further development of the AIDS prevention programmes at national level. The number of participants was limited intended to permit particularly intensive and result-oriented work and who are authorized to officially represent the national AIDS prevention programme.

Experts from European countries with a comparable epidemiological situation and similar history of AIDS prevention and epidemiology, such as Belgium, France, Germany, the Netherlands and Switzerland, participated. Furthermore, participants from Estonia, Latvia and Lithuania whose national AIDS programmes are in the initial stages.

2.2. Concept and Programme of the Event

The conference began with welcoming addresses by the Federal Centre for Health Education (Dr. Elisabeth Pott), the Federal Ministry of Health (Dorle Miesala-Edel) and the World Health Organization/Regional Office for Europe (Dr. Johannes Hallauer), as well as an introduction to the subject by the moderator (Hans Saan, NIGZ), who represented concept and structure of the event.

In order to give every participant the opportunity to present the AIDS prevention of his/her country in detail and at the same time leave enough time for joint analysis and discussion, the following programme was developed:

- In the run-up to the conference, the participants were asked to describe their national AIDS prevention programme on the basis of standard questions (see Appendix I).
- A working group at the Federal Centre for Health Education assessed the Country Papers submitted and summarized the results in a matrix (see Appendix I). The aim of this assessment was to gain an initial overview of common aspects and differences of national AIDS prevention strategies and to identify unanswered questions. This assessment was available to the participants and was supplemented and modified by them in the course of the conference.
  The unanswered questions and discernible focuses revealed by this assessment formed the questioning of the experts by the moderator at the beginning of the conference. In combination with brief presentations, this provided the expert input.
- On this basis, two working groups compiled qualification demands on an "optimum" prevention programme the following day. The aim was to identify those elements which have proved successful in the framework of national programmes and which should therefore be an element of future prevention.
  In this context, one working group focused on:
  - Prevention offers for young people and the general population and
  - Prevention offers for the groups primarily affected.
- The results of the working groups were presented and discussed in a plenary session on the third day.
  A small exhibition of concepts and media from the various AIDS prevention programmes provided an opportunity to intensify impressions of the participating countries.

The jointly elaborated conclusions of the conference are thematically summarized below. It is important to emphasize that these recommendations and the quality features of AIDS prevention thus formulated – implicitly or explicitly – are supported by many years of experience of the experts with national responsibility and/or by research data. They build a valid basis for future programmes.

2.3. Aspects of Quality Assurance – Results and Conclusions

Basic elements of AIDS prevention

The following basic elements were jointly identified as necessary for an effective and rational AIDS prevention.

Acceptance of lifestyles and self-responsibility as principles
"Respect lifestyles" – or, as one participant put it: "Make sure you keep people alive the way they want and don't make them live the way you want them to" – was unanimously formulated as a effective principle for AIDS prevention at the conference. In accordance with the lifestyle concept of the WHO, specific and accepting offers should be made for different target groups, such as homosexuals, intravenous drug users, prostitutes, etc. This – and the principle of self-responsibility – are central prerequisites for effective AIDS prevention.

Social consensus on goals and messages
Achieving social consensus on these principles and the resultant fundamental goals and messages of prevention is of particular importance for the long-term efficacy and efficiency of prevention work in a country. An effort should be made to achieve social unanimity on the fact that , for example, the call for compulsory state measures (as opposed to a strategy of self-responsibility) is ineffective. In the initial phase, it is important to establish how the subject of "condoms use", which is absolutely essential to prevention, can be brought up, and it should be ensured that current legislation corresponds to prevention work which accepts lifestyles and is based on self-responsibility.

No panic-mongering strategies
AIDS education by means of panic-mongering and shock does not have the desired preventive effect. It is more effective to give information on the dangers while simultaneously illustrating possibilities for protection.

The HIV test is not an instrument of prevention
The HIV antibody test is not an instrument of prevention in itself. Carrying out the test without the consent of the person being tested and without offering counselling is to be regarded as malpractice in prevention.

Consideration of other sexually transmitted diseases (STDs), health risks and diseases associated with HIV infections
The sexual transmission among intravenous drug users should also be considered, as should the danger of other STDs and possible combinations of various risks (such as unprotected sex, alcohol and other narcotics).

Broad-based design and coherence

Coherence of the goals and messages

A national programme for AIDS prevention should be designed to be both comprehensive and differentiated at the same time. Preventive measures on three levels are indispensable:

- General population
- Target groups
- Individual counselling and communication

Offers for the general population can include television spots, brochures, posters, advertisements, etc. Central telephone counselling (hotlines), as well as local counselling offers, exist in many European countries as individual counselling.
One of the crucial prerequisites for effective prevention work in this context is that the various offers form a coherent whole, discernibly and verifiably representing the same philosophy and the same messages.

Mass media campaigns must build upon the consensus between the main actors of a society (e.g. politics, scientific community, churches, self-help).
All target groups should be integrated (implicitely and explicitely) in mass media measures (inclusion strategy).

Addressing of specific target groups

Target groups can be defined on the basis of risks and/or in terms of access to them via specific communication channels. AIDS prevention is therefore constantly confronted with the necessity of finding adequate access to the target groups. For example, younger and older youths react differently to interventions and must thus be reached with different interventions. Another example are the various and rapidly changing youth scenes, such as techno, punk, scat, etc.
Women are one of the groups in which the rate of new infections in rising. Women-oriented measures must therefore also be considered in prevention.
In addition to conducting target group surveys, it is also recommendable to include members of target groups in the conception of offers from the outset. Specific inside knowledge, regarding the language, the need or special sensibilities, for example, can thus be used and the acceptance of the offers increased considerably.
The target groups of AIDS prevention defined on the basis of specific risks are, above all, the so-called primarily affected groups. The corresponding working group compiled the following list on this subject:

Groups primarily affected by HIV

- Men who have sex with men. This means homosexuals, bisexuals and male prostitutes, as well as men who regard themselves as heterosexuals but occasionally have sex with men.

– Intravenous drug users,
  including men and women, homosexuals, bisexuals and heterosexuals.
– People from regions with a high spread of HIV (e.g. Central Africa),
  including all sexual groups, but mainly heterosexuals.
– In some countries, other groups are also taken into special consideration, e.g. sailors and people with STDs in Lithuania.

Communicative access to men with homosexual activities but no homosexual identity

One of the most important learning experiences from recent years is how to get communicative access to men with homosexual activities but without homosexual identity. It is the recommended that these men, in particular, be reached via mass media campaigns, as these men can generally only be reached by media for a male public. A target group strategy which is exclusively oriented to this group is bound to fail due to the non-identifiability of the target persons. Successful examples of posters were discussed whose visual message includes men having sex with both women and men. Pre-tests of posters or advertisements in this area are important.

Continuity and concentration

Continuous information

The continuity of information and prevention offers, as well as the presence of the subject of AIDS in the general mass media, is necessary in order to expand and maintain preventive effects. A continuous "background noise" of simple and basic information on AIDS additionally prevents forgetting. Experiences and evaluation results show that a decline of this "background noise" can lead directly to a decrease in the attention of society in general and indirectly to a decline in protective behaviour.

Continuous structures

The same demand for continuity must be placed on the structures of AIDS work. This includes institutions for counselling, testing, psychosocial, nursing and medical care, as well as the various elements of prevention work, of course. Institutions which have already been established and accepted by people may not be thoughtlessly dissolved in times of declining resources. This must be taken into consideration from the start when establishing structures. In any case, the continuous maintenance of such structures is always cheaper than having to re-establish them. The qualification of prevention workers is also an important aspect of structure quality.

Concentration on essential contents and messages

In addition, concentration on central aspects is also necessary to ensure the maximum success of prevention work. In print- and audio-visual media, as well as events and personal talks, specific emphasis on points which are really important and relevant for per-

sonal protection is better than a comprehensive discussion of a host of sometimes marginal aspects of the subject. Experience has shown that texts which seem too long and detailed, at first glance, are hardly ever read. Not only is 100% completeness bound to fail, it could also disrupt those effects of prevention which are actually possible.

Coordination

Systematic coordination as the foundation of the entire national programme

The coordination of the various elements of a national AIDS prevention programme is one of the most important aspects altogether. The clarity of the structures and of the steering and communication mechanisms is the real foundation on which the building of a differentiated campaign can be footed. Without such a foundation, an effective system of prevention offers which is coherent in its internal structure, messages and philosophy cannot be realised. And finally, if based on such a foundation, a campaign can best maintain its stability, continuity and thus efficacy, even under changing conditions and during times of declining financial resources.

Different solutions in various European countries

The countries represented at the conference have sometimes found completely different solutions to this problem, the advantages and disadvantages of which were discussed. While the structures prevailing in Switzerland and Germany tend to be fairly constant in the long term, processes of change are taking place in other countries. The principle of decentralization is currently of great importance in politics in general in France, which was characterised by marked centralism for a long time. In terms of AIDS policy, this means that the Ministry of Health is in future to pay annual budgets to the Departement governments, which will use the budgets themselves for their own activities and by awarding funds to independent sponsors. The remaining task of the Ministry is thus the control of the supreme overall strategy and research.

The policy in the Netherlands is of similar orientation. Efforts are also being undertaken there to equip the local level with independent competences in the area of prevention practice, and thus in the area of fund allocation, and to give the national level a more supplementary and supporting role. On the other hand, there is a simultaneous tendency towards centralization at a national level in the area of strategy development and evaluation, particularly in the Netherlands. This is due to the realization that "umbrella organizations" are of great importance for organizations which work decentrally and which are oriented towards target groups. They offer the latter scientific knowledge and, in particular, instruction and assistance for practical situations (e.g. further training).

The Netherlands Minister of Health has transferred the responsibility for central steering to the AIDS Fund as a non-governmental organization. Strategy, fund-raising (see below), fund allocation and research are unified under one roof. However, the Minister ul-

timately remains the person responsible for national AIDS prevention, in that she checks the programme of the AIDS Fund every year.

The situation in Belgium is the opposite of that in France in certain respects. Here, the competences in politics, especially in health policy, are distributed unevenly and largely independently in a decentral manner. Belgium is made up of the regions Flanders, Wallonia, the German-speaking area and Brussels. While matters concerning the medical care of sick persons fall into the government's sphere of responsibility, the activities of prevention fall within regional competence. For reasons of effectiveness, particular efforts are being undertaken in this context to achieve a common approach in the area of strategy. In Flanders, for example, the central coordinating instrument is a regular project report. Every institution which receives public funds must submit a detailed report every six months, in which the activities, strategies and methods, the determinable results, contacts with cooperating institutions and with the target groups, and, above all, any occurring problems and possible solutions are presented. Submission and acceptance of this report is required to permit the allocation of further funds by the Flemish government. Other special methods are described in the Country Papers in the Appendix to this report. In general, the following realisations apply:

(1) The tasks of the national, regional and local levels should be recognised as being different and should be cooperatively (but unequivocally!) clarified, instead of playing competences off against each other.
(2) Networks of cooperating institutions and persons are of great importance.
(3) As structures cannot be changed quickly, they should be accepted in order to make the best of them.

Coordination and cooperation at various levels play an important role in every conceivable national AIDS prevention programme.

Central coordinating institution
The task of a central prevention institution must be, above all, the coordination of the campaign participants (in the narrower sense) and of the campaign measures. For example, it issues invitations to working groups and mutual consultations. But it also stimulates, supports and controls. It is responsible for the coherent, scientifically justified and constantly reviewed and optimised overall strategy and concept of the campaign. In addition, it also has the task of providing politicians who decide on the allocation of public funds with optimum information and of preparing decisions concerning prevention policy. In order to carry out this task properly, it requires the acceptance of the participants, which it has to gain by means of expert competence.

Integration of other institutions and persons working in prevention
Gaining cooperation partners and integrating them in an overall coordination process is another important task.

Possible cooperation partners (individuals and organizations) who could act as mediators/multipliers and allies should be adequately selected and integrated in a suitable manner. Their possibilities for action, as well as their needs and expectations, must be clarified in a fair and open way. Mutual satisfaction is crucial in cooperations.
A specimen list of possible cooperation partners was compiled by one of the working groups: journalists, artists, parental associations, sexual counselling centres, youth groups, sports organizations, associations of target groups, youth workers, hotels, restaurants, clubs, bars, cafés, chemists, airports, railway stations, underground stations, petrol stations, religious groups, etc.

Training
The professional cooperation partners have to be well-prepared for their role and their task in the fight against AIDS. Amongst other things, corresponding training and education programmes for students of relevant occupational groups, such as psychologists, educators, social workers, etc., and the constant further training of prevention professionals are required to this end.

Cooperation with journalists
Cooperation with journalists was a special case discussed at the conference. False information, scandalisation and trivialisation are some of the bad experiences reported from many countries. On the other hand, prevention institutions in almost all countries have also had very good experiences. In Estonia, for example, more than 4,000 informative newspaper articles on the subject of AIDS have been published free of charge in recent years. Prerequisites for good cooperation are fairness and clear definition of mutual interests. In this context, the prevention institutions involved should remember that it is not the task or primary interest of journalists to carry out AIDS prevention work. Seminars for journalists, providing detailed information on the correct content and strategies of AIDS education, can promote cooperation.

Cross-border cooperation
International cooperation is necessary in the area of prevention offers for migrants. Working meetings to exchange experiences, strategies and problems, as well as to develop joint, cross-border projects, are important.
Examples include prevention projects in border regions, such as on the German-Czech border and the German-Polish border.

Coordination of governmental and non-governmental organizations: "Integrated separation"
The coordination of governmental organizations (GOs) and non-governmental organizations (NGOs) was discussed in detail at the conference. Possible methods were illustrated using the example of the different structures in Germany and France.
In Germany, an official agreement between the Federal Centre for Health Education (FCHE) as a GO and Deutsche AIDS-Hilfe (DAH) as an NGO as regards the allocation of

tasks and funds has existed since the mid-80s. The FCHE carries out AIDS prevention work for the general population, while it delegates the prevention work for the primarily affected groups, above all homosexuals and junkies, to the DAH and supports it with the necessary funds. The DAH National Office receives approx. 90 % of its funds from governmental funds via the FCHE in this way. However, it must also be remembered that private donations and sponsoring play a considerable role in the area of the two AIDS foundations at a national level and in the field of the local AIDS-Hilfe organizations.

On the one hand, the FCHE has a certain influence on the work of the DAH via the allocation of funds. On the other hand, the DAH is granted general independence as regards concepts and prevention strategies. This is ultimately the basis for its acceptance among the target groups. Homosexuals and junkies can experience the DAH as an institution which represents their interests and which works with them in a self-help-oriented and solidary manner. One major effect of this regulated cooperation is the generally cooperative and accepting appearance of both organizations in the public debate.

In France, there is no similar official contract at the national level between the Division Sida, Direction Générale de la Santé (AIDS Division of the Directorate-General for Health) as a GO and Aides as an NGO. However, the Ministry voluntarily consults Aides workers, e.g. when developing material for gays. Despite this, there are differences of opinion be-tween Aides and the Ministry in some areas. However, it should be noted that the integration of GO and NGO at the Departement level is very successful. The allocation of funds is also regulated differently. Aides may not receive more than a maximum of 49 % of its total funds from public funds. This necessitates the acquisition of donations on a large scale. On the one hand, the fund-raising activities of Aides illustrate and promote the responsibility of society and the economy for the social consequences of AIDS. On the other hand, the system obviously also impedes the possibilities for regular work.

A consensual formulation of the goal of GO/NGO coordination was found with the key term "Integrated Separation", which describes very different processes. This is obviously only possible in the respective country-specific style.

Scientific research as an element of quality assurance

Quality management measures should be an integral element of the strategy right from the start. Scientific survey play an important role in this context.
The following demands on a system of scientific quality assurance in AIDS prevention were compiled by one working group:

Epidemiological review studies as a starting point and steering instrument
Epidemiological review studies as regards HIV and venereal diseases in the respective country should be an important basis for conceptions. In addition, it is also very impor-

tant to scientifically observe potentially risky modes of behaviour in society even before cases of infection become apparent, in order to take preventive action in time.

Evaluations as a steering instrument
All recommendations relating to prevention strategy should fundamentally be made on the basis of empirical data.

While intuition and normative approaches world wide played a relatively major role in the early phases of HIV prevention, empirical evaluation results and reliable systematised experience should guide today practice.

Another important step of quality assurance to be carried out as early as in the conception phase is the setting of fundamentally evaluable goals.

Practice documentation is important
In the context of the implementation of prevention measures, many systematic result checks can be carried out by the practitioners themselves without having to commission external scientific institutions. For example, important pointers for the steering and assessment of a measure can be gained simply by counting the persons reached, stating the subjects discussed and the questions which were frequently asked, etc.

Significance of evaluation for politically sensitive projects
The results of evaluations are particularly important in politically explosive and sensitive fields. An example of this is the Swiss report of the issue of disposable syringe kits to prison inmates in a pilot project solely for the purpose of researching the results. Here, evaluation has the function of empirically assessing a politically controversial subject.

Evaluation as a way of success monotoring
The evaluation of the success of a national AIDS prevention programme comprises the examination of:

- the effect of individual media and measures,
- the current form and development of knowledge, attitudes, behaviour,
- the development of the infection figures (HIV and STDs),
- the relation between campaign activities and effects.

Pre-tests for mass media offers
Warnings against overestimating mass media pre-tests were formulated by Switzerland. The impressions which a poster evokes when looked at in a conscious, concentrated manner in a pre-test are, for example, often very different to the impression gained when hurrying past. On the other hand, such pre-tests can be of great importance if the content and form of education is controversial at the decision-making level. A clear formulation of goals and the choice of a suitable method is always necessary.

Pilot projects
In addition to continuous concomitant research (monitoring, media evaluations, etc.), pilot projects can be a good idea and effective if special action is required, gaps in knowledge are to be closed and/or experience gathered in a new field of prevention.

As for evaluation in general, the following approach is advisable:
– starting with the available scientific knowledge (planning of measures),
– gathering practical experience with the prevention measures,
– scientific evaluation (process evaluation),
– modification of the measure if necessary,
– evaluation of the effects of the measure.

Communication and feedback
Scientific results from concomitant studies and basic research in the field of psychology, sociology, pedagogics etc., can only be effectively used for optimization of the programmes if there is a regulated process of communication and feedback with practitioners.

The most important exchanges are between:
– research projects,
– researchers and programme developers,
– the persons who implement evaluation programmes.

Also direct feedback to the ultimate addressees can be a good idea.

Examples of feedback mechanisms in the European countries
A number of examples of this feedback process were presented and discussed at the conference. In Germany, not only is constant concomitant research the basis for further planning of nationwide education measures by the FCHE, but a Bund-Länder Commission also meets regularly, where the various results of the evaluation of national AIDS prevention are presented and their significance for AIDS prevention activities at the Federal level discussed.

In Belgium, this function is assumed by the above-mentioned regular project report by the persons responsible for the project and by the checking of project applications according to a clear catalogue of quality criteria.

In Switzerland, a synthesis report on the programme and results of national AIDS prevention is compiled every two years by the University of Lausanne which is commissioned with evaluation. In the meantime, the constant presence of members of the evaluation team during programme conception steps ensures that the research results are taken into consideration in the updating of the programme, the media and the measures. A poster on the increase in the use of condoms in Switzerland between 1986 and 1994 was presented as an example of the communication of prevention results to the ultimate addressees.

In the Netherlands, the so-called AIDS Fund has the tasks of being particularly closely involved in the shaping of the communication process between different organizations due to its position as a superior institution. The summary of the programme strategy, fundraising, allocation of funds to third parties and the planning and implementation of research, as well as the policy on integration of AIDS work in more general contexts, such as sex education, family planning etc., under one roof.

One example for dealing with criticism from the population was reported by the Netherlands. A parental association had criticised the failure to mention the option of faithfulness as a protection option in newly developed youth material. This parental association was thus requested to draw up a page on this subject themselves which was incorporated in the material. This resulted in high acceptance and the association was subsequently actively involved in the distribution of the material.

3

National AIDS Prevention in Europe (Country Papers)

3.1. The National AIDS Campaign in Belgium

Anne-Lies Vanmechelen, Flemish AIDS Coordination Centre, Antwerp

Essential framework conditions of AIDS prevention

Structural characteristics

Belgium – a federal state

Belgium, subdivided into ten provinces, has recently been transformed into a federal state of communities and regions. The communities correspond to the three major language groups in Belgium, namely the Flemish, French and German-speakers. Alongside the communities, there are three geographical regions, namely the Flemish, Brussels and Walloon regions. This reorganization of the Belgian state has also been the occasion for a far-reaching devolution of power. Nowadays, the federal authorities are responsible for foreign policy, defence, the judicial system, etc., whereas the communities and regions have assumed responsibility for matters such as transport, education, scientific policy and culture. AIDS prevention is a matter of health care and public health, and as such the community governments are responsible. The devolution of power following federalization means that there is no single national AIDS programme in Belgium. The communities have their own AIDS budgets and pursue their own specific policies on AIDS.

Flanders – a project-oriented approach to AIDS

In Flanders, the problem of AIDS is typically approached on a project-oriented basis. This means that any work aimed at specific target groups (men with homosexual contacts, young persons, multipliers, persons infected with HIV/AIDS, prostitutes, and intravenous drug users) is subsidized for a period of no more than three years. New funding must be applied for upon expiry of such a period. It is always a matter of waiting to see how much money will be made available and the particular priorities of the current government. AIDS policies of this kind make it exceptionally difficult to make any organized and planned approach to dealing with the problem in the longer term. These conditions also mean that the people employed in AIDS projects have little job security, which is bad for morale and has a demotivating effect, particularly when unemployment is high. Funding of AIDS research is likewise allocated on a project basis. A federal research programme was started in 1991, but will come to an end in 1995. So far, no initiatives have been undertaken to extend the project, and the future of AIDS research in Belgium remains uncertain.

Epidemiology

On 30 June 1995, 9,527 persons in Belgium were known to be infected with HIV (two-thirds men, one-third women). Of these, 1,931 had developed full-blown AIDS (54% Bel-

gians). Between 1987 and 1993, an average of about 71 new HIV infections were being registered every month, in other words about two to three a day. By early 1994, this average had fallen to 64 new diagnoses a month, or about two a day. It remains to be seen whether the falling trend of the last eighteen months will continue in the longer term.

The nationality of 6,267 seropositive persons is known. 2,800 of them are Belgian (about 45 %). The majority of the non-Belgians (about 75 %) are from Sub-Saharan Africa.

Transmission among Belgian people takes place differently than among the non-Belgians. Of those Belgians in whom the probable transmission route is known, slightly more than half were infected via homosexual contact. About 30 % were infected after heterosexual contact, and about 6 % via intravenous drug use. The majority of the non-Belgian seropositives have been infected via heterosexual contact (about 71 %), 12 % via homosexual contact and 8 % via intravenous drug use.

Important sponsors
Individual aids projects receive funding from the Minister of Health Care and Prevention Policy. Scientific research projects are subsidized by the relevant Flemish and Federal Ministries. In 1995, for example, BF 70 million (about $ 2.3 million) were released for AIDS projects in Flanders (for both prevention and care as well as counselling for HIV and AIDS patients). In the period from 1991 to 1995, BF 400 million (about $ 13.3 million) was made available for AIDS research in Belgium.

Joint projects with other countries
There is an awareness in Flanders that certain of the surrounding countries can bring greater (resources and) experience to bear on the AIDS problem. For this reason all project leaders maintain functional links with AIDS organizations in the Netherlands, France, Germany and the U.K., to mention but a few. This helps us to learn from the successes and mistakes of workers in other countries. The Vlaams AIDS-Coordinaat IPAC (the IPAC Flemish AIDS Coordination Centre) also makes use of foreign expertise, e.g. for the design of a new AIDS folder, a solidarity campaign, the development of a documentation centre. Furthermore, IPAC is involved in two European projects, namely the Self-Care Manual Project and the European Flying Condom Project.

The elements of national AIDS prevention

Historical changes

1992: An Aids policy for Flanders
The year 1992 was a turning point for the approach to the AIDS problem in Flanders, as distinct from the other "community states" of Belgium. AIDS was declared a health priority in the policy declaration of the Flemish government. The Flemish community

government designated a single minister with full responsibility for AIDS and he was given the task of coordinating AIDS programmes. Since 1992, this minister has implemented several media campaigns, increased subsidies for field work and launched initiatives aimed at improving policy structure. Resources for AIDS projects are now entered separately in health promotion budgets. The decision to extend the period of recognition for AIDS projects to three years (formerly 6 months) has resulted in improved continuity.

In December 1992, the Minister for Employment and Industrial Affairs published a policy paper entitled "AIDS in Flanders", in which the policy objectives for an overall approach to the AIDS problem were set. AIDS themes are coordinated by the IPAC Flemish AIDS Coordinating Centre within the association known as the Vlaams Instituut voor Gezondsheidpromotie (VIG – Flemish Institute for Health Promotion).

To say that there is now a globalized approach to AIDS in Flanders would be excessively optimistic. If an integrated policy is to be achieved, several pressing problems must first be overcome. These include the fact that decision-making authority is highly fragmented at all levels (municipal, provincial, community, federal, European, etc.); the difficulties associated with frank discussions of matters relating to sexuality and safer sex, the (in)visibility of the AIDS problem, the opaqueness of structures and advisory bodies, and the piecemeal approach to AIDS.

1993: A strategic plan for Flanders

Towards the end of 1993, thirty or so organizations active in the AIDS sector met at the request of the minister to work out long and short-term plans for an integrated and effective campaign against AIDS in Flanders. This strategic plan, referred to as the "Campaign against AIDS in Flanders", is used as a guideline to measures adopted in the AIDS field. The strategic plan relies on three principles: emancipation, motivation and integration.

Emancipation

The emancipation movement assumes the right of self-determination of each individual and stimulates personal autonomy through a series of structural and individual measures. The right to pursue a personal lifestyle implies the duty to respect and tolerate other lifestyles. The right of self-determination and the responsibilities arising from the same for the individual and for others, is therefore a point of departure in both general and sex education. In concrete terms, this means that a choice must be made for an approach which respects the values, standards, lifestyle, and sexual orientation of the people who are being approached.

Motivation

The history of the war against sexually transmitted disease shows that coercive measures have little or no effect. However, a knowledge of the risks alone is often insufficient to per-

suade people to modify their behaviour. For this reason, sex educators must also make use of motivating techniques, such as peer group education and counselling.

The general public and the target groups can only be persuaded to change their behaviour and show greater solidarity, if they are made aware that AIDS is a problem of general concern and not one affecting only marginal groups. Every action must therefore take this into account.

Integration
AIDS is a disease which forces society and the individual to confront taboo subjects. If we are to facilitate discussion of the disease and the risks, if we are to build confidence and emphasize each individual's personal responsibility, both seropositives and people with AIDS must become visible in our society. If this is to be achieved, they have to be included in every aspect of society. Only then it will be reasonable to expect seropositives and people with AIDS to shoulder their responsibilities vis-à-vis themselves and others.

Solidarity between infected and non-infected persons must therefore be encouraged at all levels of society. AIDS is our problem, not just a problem of other people. Consequently, we must try to root the problem of AIDS in the wider sphere of building social skills and sex education, as, in the longer term, this will give rise to an automatic sexual hygiene, and make it easier to discuss the balance of power in relationships and recognize the equal validity of the various sexual orientations.

The mission of the strategic plan is:

TO MINIMISE THE IMPACT OF AIDS IN FLANDERS

It uses three fundamental strategies to achieve this objective:

1. Minimisation of the number of new infections in Flanders
The central task here is educating and informing the population as a whole. This includes using the mass media to approach the general public, adopting selected information channels for specific target groups, and exploiting person-to-person contacts. The central objective here is to sustain the awareness of the problems among the population as a whole and bring about a change in the behaviour of all those persons who, regardless of the reasons, are either occasionally or frequently exposed to the risk of infection or risk infecting others. In this connection, structural measures are required, apart from actions aimed at target groups. This means that the availability of protective agents – good-quality condoms, sterile needles/hypodermics, uninfected blood – must be secured or safeguarded for the various target groups and furthermore, that a considerable amount of legislative work must be carried out, including steps to prevent discrimination and improve the regulations on condoms.

2. Optimization of the care, reception and counselling of HIV-infected persons and their environment in Flanders

In the years to come, just as much attention must be given to caring for infected and ill persons and their environment as to the prevention of new infections.

If the psychosocial reception and care of HIV-infected persons is to have a broad social base, the general public must feel greater solidarity with infected and ill persons. Every effort must be made, using various educational and informative programmes, to prevent infected persons from being discriminated against and becoming socially isolated. HIV-infected persons must also be individually encouraged to continue taking part in all aspects of social life. Furthermore, the environment must be given maximum support. The role of volunteers in supporting infected and ill persons – including the buddy system – must be reinforced.

Psychosocial and medical care must also be further developed in the profession health care sector. One aspect is that training facilities will have to be provided for everybody involved in the professional reception, care and counselling of infected and ill persons. Elsewhere restructuring work is called for, which aims at lowering the entry thresholds of the services offered to various groups. In this connection, a choice will have to be made for a combination of reception centres integrated into existing structures, and a number of first-line reception centres for specific groups (e.g. prostitutes, homosexual men).

3. Implementation of a global approach to the AIDS problem in Flanders

A fragmented or short-sighted approach to AIDS can only result in wasting both time and energy. For this reason, a clearly stated all-in approach is favoured.

The primary requirement here is the unequivocal commitment of the political world, accompanied by clearly enunciated policies. After all, AIDS is not the problem of just a few marginal groups, but of the entire population. In the long term, the only way to contain the disease is to facilitate the discussion of taboo subjects, such as various forms of sexuality, disease and death, as well as problems such as anxiety, guilt and discrimination. In the much shorter term, work must go ahead on creating a legal framework and stimulating solidarity of the general population with infected and ill persons in Flanders and the world in general.

An integrated approach can, however, only be implemented, if there are improvements in the organization and coordination of actions, and if everybody is prepared to close the gap between scientific workers and other workers and cooperation is built up across the borders of the various ethical and religious factions in our society.

Specific target groups for AIDS prevention

The general public

There is no media strategy implemented at federal government level in Belgium. The communities are responsible for their own media campaigns. In Flanders, the first mass-media campaign dealing with AIDS was implemented in 1987. It made use of leaflets dis-

tributed door-to-door and a TV-spot. The first campaign aimed at the general public which explicitly mentioned condoms was launched in 1992. Most campaigns are organized by the relevant ministry in conjunction with the AIDS Telephone service.

Homosexual males
Men who have homosexual contacts are an extremely important target group in Flanders. A little over half of all Belgians seropositives were infected via homosexual contact. Consequently, much work in Flanders is specifically directed at this group. The prevention message and preventive materials are distributed in homosexual bars and at cruising spots by visiting workers. The most recent condom campaign in the mass media made explicit reference to the latter target group.

Young persons
Social Skills and Sex Education (SSSE) for young persons is not a compulsory item on the Flemish curriculum. Each school is free to decide whether it should be taught or not. This means that some schools offer their pupils an extensive package of SSSE, while others virtually ignore the subject. There is a number of organizations which help schools and teachers provide SSSE. However, it has proved difficult to win general acceptance for SSSE, particularly in catholic schools (the majority). For this reason, the SSSE and AIDS prevention effort in Flanders is being increasingly directed at youth in non-school contexts. There are three such projects, which seek contact with young people in youth centres, via youth organizations and at pop concerts.

Intravenous drug users
The number of persons in Belgium infected with HIV as a result of injecting drugs is limited. This, however, does not mean that prevention is unimportant. After all, we have seen that, in other West European countries, drugs have been an important route for HIV transmission. For this reason, a number of organizations are now working among drug users to try and encourage them to use clean "works" and practice safer sex. The two paradigms used are the harm reduction model and peer group education. At present, there are no officially sanctioned needle exchange programmes in Flanders, despite the fact that a trial project in Antwerp produced positive results.

Prostitutes
HIV prevalence among commercial sex workers in Flanders is on the low side. Condom use among both male and female prostitutes tends to be the rule, rather than the exception. Even so, caution is advised. Organizations in Antwerp, Gent, and shortly in Ostend propagate the prevention message and distribute material via low-threshold advisory centres where commercial sex workers can obtain psychosocial and medical help.

Non-Belgians
The number of non-Belgians in Belgium's seropositive population is very high. Most of the non-Belgians come from Sub-Saharan Africa. Consequently, the strategic plan has

earmarked this as a priority group. So far, very little attention has been given to this group in Flanders. Only recently, a project started to work out a plan to reach this specific population.

People with HIV and AIDS
This group is clearly of fundamental importance in preventing the spread of HIV. For this reason, when the strategic plan was updated at the end of 1994, spreading the prevention message among people with HIV and AIDS was designated an additional objective. This group is reached by organizations which cater to the needs of and counsel people with HIV and AIDS, as well as by the AIDS referral centres.

Evaluation and quality assurance

Process evaluation of Flemish AIDS projects
The 15 AIDS projects – aimed at various target groups – funded by the Flemish Ministry for Health Care and Prevention Policy must prepare an interim report every six months and submit it to the IPAC Flemish AIDS Coordination Centre.

The preparation of this report is a moment of critical self-examination for every project leader. It contains a report on the current state of affairs as viewed in the light of the planned objectives. It provides a summary of the results, the methods used and the way in which the target group is involved in activities, and on cooperation with other organizations.
Apart from this, the report may describe difficulties which have been encountered and point to where there is a need for external support. This allows the progress of project to be closely followed.
The report in this form is also a good basis for process evaluation. As the project leaders are well aware of the importance of evaluation, this process evaluation is generally extremely thorough.

True impact evaluations are less common. This is not merely because it is extremely difficult in many cases to carry out pre- and posttests, and thus limit the effect of disturbing variables, but also because this kind of study is expensive and time-consuming. Indeed we know of impact evaluations in other areas of healthcare which proved to be more expensive than the project itself, and were concluded long after the project under evaluation had come to a final end.

Cooperation with scientific workers

There is a growing trend in the Flemish AIDS field to call on the assistance of scientific workers at various stages of the project in order to make corrections if this should be

necessary. Moreover, before any AIDS project can expect funding, an examination is made of whether the project is strategically useful and whether the proposed method has an adequate scientific basis. In effect, every project actually launched has already undergone a thorough quality check.
The IPAC Flemish AIDS Coordination Centre has long argued forcefully in favour of closing the gap between fieldwork and scientific workers. Here the hope is to arrive at a situation where scientific research is done in relation to the needs of the field and where the fieldwork is corrected on the basis of the findings of this research.

Trends in risk behaviour in a number of key target groups

Males with homosexual contacts

During recent years the homosexual population appears to have adapted its behaviour to take account of AIDS. A survey of the sexual behaviour of Flemish homosexual men carried out in 1993 yielded 533 useful personal interviews with Flemish homosexuals from both within and outside the structures of the homosexual subculture.[1] The results of this survey were compared with those obtained from a comparable survey carried out in 1989 among 379 males with homosexual contacts. In general it appears that the AIDS epidemic is now viewed as being more part of everyday life than in 1989. People accept AIDS as a fact of life and are less interested in obtaining information about the disease. Males now also assert that they take more care than in the past to practise safer sex. Although there is a certain degree of acceptance, AIDS is certainly not viewed as banal. AIDS has been integrated into the worldview of the homosexual male, but has meant that he has to bear a greater psychosocial burden.

Changes in the sexual behaviour of homosexuals are difficult to summarize. The number of partners and the degree of acquaintance with the partner (totally unknown, some knowledge of the partner, friend but not a permanent relationship) appear not to have changed. The percentage of men who do not practise anal sex or claim always to practise protected anal sex has risen very slightly, from 70.1% in 1989 to 73.9% in 1993. The number of men who have never had anal sex does, however, appear to have risen significantly. Nevertheless, 26% of these men are still not using condoms or only using condoms inconsistently during anal sex. It is thus a matter of defining this population more precisely. The researchers write that the intensive prevention campaign aimed at the entire group of homosexual males should not be ignored. "Numerous factors may result in men switching from safe to unsafe sex, whether sporadically or constantly."

Young persons

Young persons are a target group for several reasons: they experiment with sex and often have different (sequential), "steady" partners; young people make only moderate use of

[1] Vincke, J, (1993): Mannen met mannen. Universiteit Gent.

condoms, and tend to use them less as they grow older; whereas 4% of young persons have experienced sex with a same-sex partner. Both young persons between 14 and 16 years old and young adults have so far had an average of 2.4 partners.[2]

As they grow older, they have just as many partners but tend to make less use of condoms. Whereas 59% of young persons use a condom for the first coitus, this falls among the 14–16 age group to 43% for the most recent coitus, and to only 28% for the 17–21 age group. When we compare these figures with those for a 1989 survey, we see that condom use among young persons has risen in recent years. Young persons are now slightly more aware of AIDS and indicate that they are more prepared to modify their sexual behaviour than the young persons of 1989. This appears to indicate that young persons are influenced by prevention campaigns and that they have become somewhat more aware since 1989. Analysis of earlier awareness campaigns in schools confirms this. However, repeated efforts are necessary in order to promote awareness as each new generation of young persons becomes sexually active.

Furthermore, it appears that young persons do not always know how they should use a condom. A study indicates that the vast majority of condom users under 25 years of age are convinced that they know how to use a condom.[3] Even so, it turned out again and again that half of them thought the condom had to be first unrolled to check it for leaks, that the penis did not have to be withdrawn before the erection had subsided and that oil or vaseline were acceptable lubricants for use in combination with condoms.

Intravenous drug users

The Ministry of Justice and the various agencies providing care estimate that there are between 10,000 and 20,000 users of illegal drugs in Belgium. At the present time there are about 300 known seropositive intravenous drug users in Belgium. Comparative surveys in Antwerp in 1990 (n = 199) and in 1992 (n = 217) indicate that the percentage of seropositives among intravenous drug users has remained virtually constant.[4] In 1990, 4.5% of the sample was seropositive, in 1992 this figure was 4.6%. This is low compared to other European countries.

Over half of all users continue to share needles, although there has been a slight fall in needle sharing since 1990. Users often share needles because they are "difficult to get hold of". Pharmacists are apparently less prepared to sell needles than in the past. Moreover a more pronounced police presence on the streets has tended to discourage users from carrying their "works" round with them. As a result of a sustained effort health workers have succeeded in winning acceptance for the use of bleach when cleaning needles. Almost half of the users sharing needles, report that they now clean needles in a safe way.

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[2] Buysse, A./Van Oost, P. (1993): Relopvattingen en rolverwachtingen bij 17- tot 21-jarigen ten aanzien van condoomgebruik, initiatifnemen en mondigheid bij seksuel contact. Universiteit Gent.

[3] Van Hove, E. (1993): Seksuele gedragingen en attitudes ten overstaan von het hiv-risico. Universitaire Instelling, Antwerpen.

[4] Todts, S. (1993): HIV risk behaviour in injecting drug users. vzw Maatschappelijke en Geneeskundige Research.

The sexual behaviour of the interviewees has altered less perceptibly, although a number reported that they had intercourse with fewer partners and used a condom more frequently with casual partners. "Dislike of condoms" (heterosexual males) and "I get paid more" (prostitutes) are still the main reasons for not using a condom. The most alarming developing is the growing popularity of cocaine and snowball (a mixture of cocaine and heroine). In Spain, this form of drug use was seen as one of the main causes of the explosive growth of HIV transmission among intravenous drug users.

Prostitutes

The number of persons working as (male or female) prostitutes in Flanders is estimated at 10,000 on the basis of comparisons with surrounding countries. The actual population is of course dynamic with several thousand entrants and leavers every year.

The prevalence of HIV in this group continues to be low. In 1988–1989, a survey in Gent found 1 HIV seropositive in a population of 123 respondents, while in 1992 a survey revealed no infections in a population of 97.[5] In 1988 1 HIV seropositive was found in a population of 83 respondents. Hepatitis B was experienced by 16 % in the 1988–1989 period and by 10% in 1992. Condom use during their professional activities (as reported by the respondents) rose from 86% in 1988–89 to 94% in 1992. However, only 11% used condoms in their private lives. If we were to assume that 10% of contacts during the course of professional activities took place without the use of a condom, that there are roughly 1,000 persons active in commercial sex in Gent, and that each has between 10 and 20 contacts per week, there are between 1,000 and 2,000 unprotected contacts with prostitutes every week in Gent. If this estimate is extrapolated to all of Flanders, we arrive at a figure of between 10,000 and 20,000. Vaginal sex is the most commonly used technique. Anal sex tends to be exceptional (77.7% report never using this technique at all). Despite their importance, lubricants are not always used. Sometimes the incorrect lubricant is used, namely an oil-based one, which can affect the rubber of the condom and result in the tearing of the material.

STD patients in Belgium

Patients with a sexually transmitted disease (STD) are useful indicators for determining whether or how fast HIV is being transmitted among people with several sex partners. For this reason, since 1988, there has been a network in which the seroprevalence of HIV infection among STD patients can be monitored. The doctors participating in the study include general practitioners, gynaecologists, urologists, dermatologists, trainee physicians, and physicians working in family planning clinics and hospital STD clinics. The identity of the patient is never revealed.

[5] Mak, R. (1993): HBV vaccinatie project prostitutie. Universiteit Gent.

A total of 1,810 patients were recorded by 69 physicians.[6] Overall, 2.8% was HIV-seropositive. HIV infection was encountered 3 times more frequently in men than in women. The majority of seropositives was found among men with homosexual or bisexual contacts (21.6% were seropositive), followed by men born or resident in countries where HIV infection is endemic (11.7% seropositive). No seropositives were found among the prostitutes. Two seropositives were found among heterosexual patients not belonging to risk groups, and a further 6 seropositives were found among the 126 patients about whom no further information was available. Twenty of the forty seropositives were already aware that they were seropositive before they came for treatment for a new STD episode! In the course of 4 years, no trend whatsoever could be discerned, either among the men with homosexual and bisexual contacts or among the heterosexual non-drug users, for whom the average seroprevalence was 1.1%.

All studies indicate that the Flemish population is slowly adapting to the infection risk. The prevention efforts appear to have some impact and every effort must be made to continue them in the years to come.

[6] Delercq, E. /Strooband, A. (1993): Surveillance of the HIV seroprevalence among patients with sexually transmitted diseases in Belgium. Instituut voor Hygiëne en Epidemiologie, Brussel.

3.2. HIV/AIDS Prevention in Estonia

Ludmilla Priimägi, Institute of Preventive Medicine, Tallinn

Management and Funding of HIV Prevention

In 1987, the Republican House of Health Education started several projects for HIV prevention in Estonia. This institution was abolished in 1989 and the projects were turned over to NGO – the Estonian "Anti-AIDS" Association, established in 1990 to unite people dealing voluntarily with HIV prevention. Paid workers for HIV prevention were employed in 1993 as a Health Education Group of the AIDS Centre. The Group works in close collaboration with the "Anti-AIDS" Association. In September 1993, the government of Estonia provided the first US$ 11,500 specifically for HIV prevention.

Up to that time, HIV prevention has been carried out voluntarily with the help of local sponsors. Leaning on this support, a series of booklets and leaflets about HIV/AIDS were published applying to women, young people, tourists, sailors, sportsmen and homosexuals as well as to the general population.
In 1994, US$ 16,000 from the state budget were allotted for prevention. US$ 20,000 were received from the Open Estonia Foundation and US$ 30,000 from Euro/WHO. In 1995, US$ 26,000 from the state budget were allotted for prevention and US$ 14,000 were received from the WHO.
Thanks to improved funding, it was possible to issue new books, booklets, posters etc. of good quality, to carry out seminars and other educational work.

The elements of the national AIDS prevention programme

The goal of the programme is to influence people to behave safely as regards HIV/AIDS/STDs by imparting knowledge and skills, as well as by changing attitudes.
Besides work with the general population, special groups are also targeted: young people (incl. 12–15 year-olds), tourists, homosexuals, sex workers, sailors, etc.

Main communication strategies:
Issuing and distributing IEC materials for different target groups. Separate materials are issued concerning safe sex, condom use and STDs, as well as T-shirts, calendars and postcards. Lots of printed materials, condoms, stickers, T-shirts and videoclips were obtained from other countries as humanitarian aid to distribution in Estonia. Videoclips, both domestic and foreign, are shown on TV. Annex 1 lists the IEC materials issued or received since the beginning of 1994.

Carrying out campaigns related to sexual health. "Flying condom" summer campaigns were carried out in 1994 and 1995 as a part of the "Europe against AIDS" campaign. Booklets with comics, as well as posters, were received and distributed on youth events, in hotels, by taxi companies, etc.; some booklets were supplied with comics in Estonian. Campaigns relating to World AIDS Day and International Candlelight Memorial Day are arranged every year. The "Flying Condom" summer campaign was carried out in Estonia in 1994 and 1995 as a part of the "Europe against AIDS" campaign. In 1994, 10,000 booklets with comics in 9 languages and 100 posters were received for that purpose. 5,000 booklets were supplied with comics in Estonian. In 1995, 50,000 booklets with comics were received, 20,000 of them with comics in Estonian. These comics were mostly distributed at youth events, in hotels, by taxi companies, etc., and were very popular among young people. The "Flying condom" videoclip was shown on TV during both summers. These campaigns were also reflected in the mass media. Annes 3 lists events relating to WAD '94, Annes 4 events relating to International Candlelight Memorial Day '95 and Annex 5 events for WAD '95.

Work with mass media: Publishing interviews, articles and broadcasts about sexuality and health as well as advertising our information. There is a good contact with journalists – they are quite interested to deal with matters of sexuality health. During last 3 years, there was about 400 articles in newspapers and magazines about sexuality health matters. Publishing this kind of information in mass media is free of charge.

Direct work with different groups of population (especially young people). Discussions in schools and the army are arranged regularly. Two competitions for posters and a competition for written works were organized for schoolchildren, as well as different events to reach young people in out-of-school settings: rock concerts, discos, shows, summer camps, etc. Some other concerts have been organized for young people, such as two concerts in Town Hall Square in Tallinn. All these activities were accompanied by condom promotion and distribution, and the showing of video materials. Material about HIV/AIDS was also distributed at major "Rock Summer" festivals in 1993, 1994 and 1995. A play, "Are there any tigers in Congo?" by Bengt Ahlfors and Johan Bargum, was staged in the "Old Town Studio" theatre. With the support of "Anti-AIDS", this play, devoted to the problem of HIV/AIDS, was performed more than 150 times before about 20,000 people at schools and clubs throughout Estonia. There is sex education in the school curricula, but in the most schools there are no teachers ready to talk about sexual matters.

Training of professionals involved in health education (health teachers, medical workers in schools, etc.). In the countries, there are contacts (voluntary workers, mostly health teachers and physicians) to take care of HIV prevention on-the-spot. The association publishes a bimonthly newspaper "Anti-AIDS News" für specialists. There have been 13 issues since December 1993, with a circulation of 1,500 copies each. Seminars arranged in 1994 and 1995 are listed in Annex 2. 3 seminars were arranged in collaboration with the WHO in 1994 and 1 seminar in 1995.

Peer education is considered to be of great importance. With this in mind, special training has been provided for groups of students, senior pupils and homosexuals.

Individual counselling and testing. Anonymous and free of charge it's available in anonymous counselling centres in Tallinn, Tartu and Narva. These centres also provide telephone counselling. There are also some paid institutions in Tallinn and Tartu.

Evaluation

Up to the present, there has been insufficient evaluation of the Estonian National AIDS Programme. However, the following studies have been carried out.
In the frameworks of WHO Cross-National Survey Programme *Health Behaviour in School-age Children*, anonymous interviews of 7th and 9th grade schoolchildren were conducted in 1993. The interview carried out in the capital and in the towns represented the level of knowledge of HIV and STDs of mostly urban adolescents and their reported sexual behaviour. A total of 2,019 questionnaires were usable for analysis.

An anonymous questionnaire was distributed in four high schools in Tallinn in December 1992 and March 1993. Answers were given by 210 students aged between 15–18. The questionnaire included 38 questions, 24 of which concerned epidemiology and the prevention of HIV, while 11 questions concerned the personal attitude of students to the problem; 3 questions concerned the sex life of the students and the main sources of information about AIDS.

The *Prevention of HIV/AIDS in Estonia; External Programme Review* was carried out by the WHO on 22–30 April 1995. The Report of the External Review was sent to the Minister of Social Affairs on 26 July 1995.

At present, preparations are in progress for carrying out a survey of the population, using prevention indicators proposed by the WHO. The results of the study will be very important for planning future activities.

Future planning

Besides continuing the present activities, it is necessary to develop activities in the following directions:

Outreach work for marginalized groups – drug users, sex workers, homosexuals. There are plans to start a needle and syringe exchange programme for intravenous drug users. For planning, we shall need the results of the planned survey of the population using prevention indicators.

Annex 1: IEC materials issued since the beginning of 1994

1) Manual for physicians about HIV/AIDS (in Estonian, 3,000 copies)
2) Paperback (46 pages) about HIV/AIDS for the general population (in Estonian, 16,000 copies)
3) Folder about HIV/AIDS and its prevention (three issues, a total of 41,000 copies in Estonian and 17,000 in Russian)
4) Wall calendar for 1994 (1,000 copies)
5) Poster with guiding principles of UN about HIV/AIDS (2,000 copies, in Estonian on one and in Russian on the other side)
6) Small poster with Life, Manifesto of Mother Teresa (15,000 copies in Estonian and 5,000 in Russian)
7) Postcard Right to hope (2,300 copies in Estonian and 300 in English)
8) Poster Safe sex (4,000 copies)
9) Domestic videoclip to promote condom use Condoms protect you
10) Collection of videoclips from other countries for use in schools
11) Pocket calendar for 1995 (10,000 copies)
12) Poster Keep yourself from the kiss of death (4,000 copies)
13) Illustrated guide about safe sex for men having sex with men (3,000 copies in Estonian and 2,000 in Russian)
14) Paperback Talking to teenagers about HIV/AIDS. Guide for parents. (Translated from English, 8,000 copies in Estonian and 4,000 in Russian)
15) Booklet about STDs (2 issues – 15,700 and 16,000 copies – in Estonian and 11,200 in Russian)
16) Booklet AIDS and you for youths 12–15 years old (18,000 copies in Estonian and 12,000 in Russian)
17) Booklet advertising the Estonian Health Care Museum, with information about anonymous AIDS counselling centres (5,000 copies in 3 languages: Estonian, English, Russian)
18) Folder about safe sex and condom use (20,000 copies in Estonian, Russian version in press)
19) Supplement (20,000 copies in Estonian) to Condom passports (booklets with comics in 9 languages, received from Europe against AIDS.)
20) Christmas card May your Christmas be safe! in Estonian, Russian and English (2,000 copies.)
21) Pocket calendar for 1996 (10,000 copies)

In addition to this, 3,200 copies of a folder about HIV/AIDS were received from Finland and 3,240 paperback copies about HIV/AIDS/STD from Sweden, both in Russian.

Annex 2: Seminars arranged during 1994 and 1995

1) For contacts of the counties (1 day)
2) For school nurses about HIV/AIDS/STD (1 day in Estonian and 1 day in Russian)
3) HIV/AIDS Group Education Workshop, arranged in collaboration with the WHO (3 days)
4) For school physicians about HIV/AIDS (1 day in Estonian and 1 day in Russian)
5) About HIV prevention in Sweden, with guest speaker from the Swedish Red Cross, for contacts of the counties, as well as for health teachers (1 day)
6) About STD management, in collaboration with the WHO, for STD policy-makers (2 days) and venerologists (3 days)
7) About IEC materials development, in collaboration with the WHO (4 days)
8) About STD/HIV/AIDS for prison workers (1 day)
9) For students of Medical School, Pedagogical School and Pedagogical University, as part of the Conference of HIV + People (1 day)
10) NGO Management and Project Development seminar in collaboration with the WHO (3 days)
11) Repeated seminar for teachers and medical personnel, dealing with health education in schools (1 day in Estonian and 1 day in Russian)

Annex 3: Main events relating to WAD '94:

1) There was a special issue of the Estonian Anti-AIDS News newsletter
2) Posters (in Estonian on one side and Russian on the other) with guiding principles on HIV/AIDS were exhibited on news-stands in Tallinn for a week
3) In the mass-media, there were several articles and interviews, relating to the WAD. Lots of newspapers, radio and TV channels mentioned the WAD.
4) 100 T-Shirts were designed with the text Safe Pleasures and a picture of condom
5) There was a seminar for heads of schools about STDs and HIV/AIDS
6) On 30 November, there was a show for young people, consisting of a rock-concert, a poster exhibition and the showing of videoclips; members of Anti-AIDS explained the basics of safe sex
7) On 30 November, an Australian documentary entitled Suzy's Story was shown on TV and afterwards, there was a temporary AIDS Hotline
8) On 1 December, a short film was shown about an Estonian artist who devoted one of his works of art to a friend who died of AIDS
9) On 1 December every visitor to a theatre in Estonia was given not only a programme, but also brief printed information about the day
10) On 1 December, there was a concert, relating to WAD in a popular concert hall in Tallinn
11) There were also discos in Tallinn and in smaller towns of Estonia, where participants were provided with information materials and condoms

Several of these events were arranged in collaboration with the main importeur of condoms, *Nordic Sales Group Ltd*

Annex 4: Main events relating to the International Candlelight Memorial '95

1) Programmes about HIV/AIDS, STDs and sexuality were shown on Estonian TV on 4, 8, and 18 May. Specialists working in the field of prevention, testing and treatment were interviewed, as well as STD patients and HIV-positive people
2) An American movie *Our Sons* was on TV on 21 May
3) Videoclips on the topic of HIV/AIDS were shown on TV in the course of the week prior to 21 May
4) There was a special issue of the "Anti-AIDS News" newsletter
5) A Youth Rock Festival took place in the Nõmme Cultural Center on 19 May, with posters, stickers and booklets about HIV/AIDS as well as condoms available
6) IEC materials and condoms were also available on the concert of the Estonian ensemble *Nancy* in the *Piraat* club on 20 May
7) On 19 May, there was a Spring Festival in Glehni castle. The prices of the lottery included 10 T-shirts with the text *STOP AIDS*
8) A Poster on the topic of AIDS was printed on the front page of one Tallinn's newspapers
9) Tallinn Boys Choir presented classical music in Niguliste Church on 21 May
10) A concert for people engaged in HIV prevention and HIV-positive people took place in the Old Town Hall on 21 May
11) People who died of AIDS were remembered in divine services on 21 May
12) Posters with the UN's guiding principles on HIV/AIDS (separately in Estonian and in Russian) were exhibited on the streets of Tallinn on 17–24 May

Annex 5: Main events relating to WAD '95

1) During the two weeks prior to 1 December, three videoclips were shown on Estonian state TV. Two of them were produced in Estonia and one came from *Flying condom* with Elton John speaking
2) On 1 December, there was a discussion on Estonian TV on the topic of WAD '95 – Shared Rights, Shared Responsibilities, with the participation of HIV+ persons.
3) On the radio, TV and in newspapers, there were several articles and interviews with people active in HIV Prevention in Estonia.
4) There was a special issue of the Anti-AIDS News newsletter separately in Estonian and Russian. The newsletter is for professionals (teachers, journalists, medical personnel etc.).

5) During the week prior to WAD, there were Anti-AIDS days in the largest universities: on 28 November at Tartu University, on 29 November at the Agricultural Academy, on 30 November at the Technical University and on 1 December at the Pedagogical University. IEC materials were distributed and advice on condom use given in the lobbies of all the listed universities. Anti-AIDS videoclips were shown at the Agricultural Academy and the Technical University.
6) On 1 December, there was a *Tolerance Night* in the club of the Agriculture Academy.
7) On 1 December, there was an Anti-AIDS Day in Tallinn 58th Secondary School, with showing of a video film, distribution of IEC materials, sharing knowledge with teenagers and telephone hotline.
8) On 1 December, there was an Anti-AIDS Day in the old city of Tallinn, with distribution of IEC materials and condoms and with participation of the Finnish AIDS Support Centre.
9) Condoms and IEC materials were distributed at an alternative music concert in Tallinn, Music Academy on 17 November.
10) Condoms and IEC materials were distributed in several youth shows and discos in Tallinn and other towns in Estonia.
11) On 6 December, the Tallinn Pedagogical College showed videoclips and offered counselling by both peers and a doctor, with IEC materials and condoms also being available.
12) At the Tallinn Medical School, an Anti-AIDS Day was organized by teachers of the school.
13) On 1 December, there was an Anti-AIDS night at a gay bar in Tartu.
14) There was a *Bel canto* concert for people active in the fields of HIV/AIDS.

3.3. The National AIDS Campaign in France

Pierre-Christian Soccoja, Direction Générale de la Santé, Paris

Essential framework conditions for HIV/AIDS prevention

What structural characteristics of the health system in your country have an important impact on AIDS preventions?
At the institutional level, the prevention activities are carried out by the AIDS Division of the French Ministry of Health.

In December 1993, a new structure was created to reinforce the fight against AIDS: *the Interministerial Commission for the Fight against AIDS* under the presidency of the Prime Minister. The interministerial delegate is the current Director of Health, Pr. Jean-François Girard. The mission of this commission is mainly to integrate prevention of HIV/AIDS in the public institutions and various ministries.
Beyond the bilateral agreements that existed between the AIDS Division and public institutions, one can clearly see the value of engaging in a collective thought process with all interested parties on different areas of the fight against HIV/AIDS.

In 1995, in a global context of *deconcentration*, the AIDS division will need to articulate the different levels of its commitments (local, regional, national) in a more efficient manner.

The elaboration of prevention policy and its evaluation remain the responsibility of the AIDS division, as do testing policy and international policy. At the local level (Directions Départementales des Affaires Sanitaires et Sociales), the "DDASS" are in charge of the organization and implementation of the prevention policies in close collaboration with NGO's in the metropolitan territory and in the overseas "départments".

Who are the most important sponsors of AIDS prevention?

The most important sponsors of AIDS prevention is the *State*:

in 1993	170 million FF ($ 34 M)
in 1994	300 million FF ($ 60 M)
in 1995	308 million FF ($ 61 M)

Are there any major lines of conflict which influence AIDS prevention?
Major lines of conflict exist between certain NGO's and the administration. But they do not really influence AIDS prevention. For the information campaigns NGO's are consul-

ted during the elaborating phase. They give their opinions, advice and critical remarks. Other lines of conflicts exist between the administration and some political parties, but they remain underground and it is very difficult to appreciate how they influence AIDS prevention.

Are there any joint projects with other countries?
Several joint projects with other countries have been implemented, specially through the European "Europe against AIDS" programm (summer information campaign, comparison of evaluation or monitoring on AIDS prevention) and the Paris AIDS Summit in December 1994.

The elements of national AIDS prevention

How would you describe national AIDS prevention in your country?

Goals:
- Maintain a good level of information about HIV/AIDS among the general population;
- Strengthen and diversify prevention efforts with regard to people who are most at risk;
- Train health educators;
- Promote a better access to treatment and psychosocial assistance for people living with HIV/AIDS.

Target groups:
- People living with HIV/AIDS
- Homosexuals
- Intravenous drug users
- Sex workers
- Heterosexuals with multiple partners
- People originating from endemic areas

Messages: "AIDS, a public health priority"

Communication strategies:
- The communication campaign must be open to all types of risky behaviour. The content of these messages should include the respect for an individual's lifestyle choice.
- It must give the opportunity to recognise risky situations and must give the means to protect oneself against these risks.
- Everybody should be concerned by the campaign and the campaign should "talk" to everybody. This means messages for the general public, but also targeted messages/national campaigns vs. local campaigns and community-based actions.

– The campaign must be visible through TV network, radio, press, etc. but also on a regular basis in time.

Have there been any major historical changes and, if so, for what reasons?
In 1994, following a decision of the Montagnier Report, the Agence Francaise de Lutte contre le Sida, the pivot of AIDS prevention for 4 years, disappeared. Its missions were taken over by the AIDS division of the Ministry of Health, in order to link prevention to outpatient care, to improve coordination with the other public institutions and to implement the "deconcentration".

Evaluation and quality assurance

What elements of national AIDS prevention are evaluated empirically and since when?

There are three national surveys of KAPB (Knowledge, Attitude, Practice, Behaviour):

– among the general population every 2 years (1990, 1992, 1994),
– among the teenagers in 1995,
– among homosexuals every year from 93 to 95 and now every 2 years,
– among intravenous drug users, one in 1990 and one 1995.

The communication campaigns are tested before and after they are released.

Under the responsibility of the Direction Générale de la Santé, and with the collaboration of the Agence Nationale de Recherche sur le Sida (ANRS) and the Direction des Hôpitaux, a group of experts have created a committee called Sida prospective 2010. This committee aims to lead a prospective reflection on the situation of AIDS in France in the coming years. It examines exploratory scenarios to determine the evolution of a phenomenon according to its environment in terms of high probability for strategic scenarios by simultating alternative responds and exploring their impact.

This committee has produced a document summarizing knowledge and expertise on AIDS (epidemiology, research, social and economic issues and the psychosocial dimension).

What are the main experiences derived from evaluation?
– There is a relatively high level of knowledge, and this it is even on the rise in certain categories of the population, the youngest and the oldest in the most underprivileged sections of society.
– There is an overall increase in declared condom use among the youngest (18 to 25 years old) and a stagnation or a small increase among the people over 30.

– Diversification in the ways of dealing with the risks can be observed.
– Tolerance and non-exclusion behaviour towards people living with HIV are maintained, although strong opposition remains on specific topics, such as testing policy and targeted messages in the general media.
– Minority groups among young homosexuals and marginalised intravenous drug users are still displaying risky behaviour.

What further quality assurance considerations and activities have been standard practice to date, based on the national AIDS prevention in your country?

– Expert group to follow the condom market.
– Expert group working on the accessibility of syringes for intravenous drug users.
– Steering committee on communication with NGO's, researchers and members of the administration.
– Experts meeting between the ANRS and the Direction Générale de la Santé (DGS).

3.4. AIDS Prevention and Quality Assurance in Germany

Wolfgang Müller, Jürgen Töppich,
Federal Centre for Health Education, Cologne

General Conditions for AIDS Prevention

Special structural features of the health system in Germany with a significant impact on AIDS prevention

– *Public health service:* The nationwide network of the public health service, particularly the health offices working on a local basis in the municipalities, was involved in the fight against Aids from the outset as provider of counselling and outreach prevention work. Within the scope of the "Health office pilot project", an "Aids specialist" was engaged at each of the then total of 309 health offices in the old Federal Länder, starting in 1988, in order to deal with HIV test counselling, scholastic and extramural prevention work and other related tasks. In some cases, streetworkers were also affiliated to the health offices.

– *Federal structure:* The Federal Länder are fundamentally responsible for preventive health care and health care in Germany. Primary Aids prevention, as well as secondary/tertiary prevention activities, were started in almost all the Federal Länder as of 1987 – partially with the support of the Federal Government in the form of a host of pilot projects for psychosocial support, social stations, women, children, drug addicts, etc.

  Since 1985, the Federal Centre for Health Education, acting on behalf of the Federal Government, has been staging the nationwide primary Aids prevention campaign aimed at the general public in close coordination with the Federal Länder.

– *Aids-Hilfe network:* The Aids-Hilfe groups, which arose from the self-help movement, have been active since 1983/84 in the field of prevention, self-help for the affected, and support of persons infected with HIV and suffering from AIDS. Today there are such groups in a total of 130 towns (old and new Federal Länder). Since 1986, their umbrella organization (Deutsche Aids-Hilfe – DAH) has been commissioned with prevention in the main groups affected and at risk, acting as an NGO and sharing this work with the FCHE. The local Aids-Hilfe groups generally cooperate closely with the local health offices, the help network for drug addicts and resident practising doctors and nursing services.

Main sponsors of Aids prevention and their spheres of responsibility in this context

– *Federal Ministry of Health (BMG):* Supervision of the FCHE and the AIDS Centre of the Robert Koch Institute, AIDS policy; legislation; allocation of funds for prevention.

– *Federal Centre for Health Education (FCHE)*: AIDS prevention for the general public, including specific target groups, coordination and cooperation between the Federal Government and the Federal Länder, WHO Cooperation Centre, EU project sponsor, promotion of Deutsche Aids-Hilfe.

– *Länder(federal states):* Public health service, regional prevention campaigns, promotion of local/regional institutions; close and consistent cooperation between the Federal Government and the Federal Länder.

– *Deutsche Aids-Hilfe (DAH):* Primary/secondary/tertiary prevention for the main groups affected and at risk, in close cooperation with regional/local Aids-Hilfe groups as their central association (NGO).

– *Municipal health offices:* HIV testing/counselling; STD counselling and control; outreach prevention work on the subject of AIDS; health promotion and networking.

Main financial and human resources of national Aids prevention

The financial and human resources made available for primary prevention on the national level can be named here, the figures being collective totals for the BMG, FCHE and DAH:

1985 approx. DM 5 million (2.5 million ECUs)
1986 approx. DM 2 million (1 million ECUs)
1987 approx. DM 48 million (24 million ECUs)
1988 approx. DM 41 million (20.5 million ECUs)
1989 approx. DM 42 million (21 million ECUs)
1990 approx. DM 32 million (16 million ECUs)
1991 approx. DM 28 million (14 million ECUs)
1992 approx. DM 27 million (13.5 million ECUs)
1993 approx. DM 25 million (12.5 million ECUs)
1994 approx. DM 20 million (10 million ECUs)
1995 approx. DM 20 million (10 million ECUs)

The costs of the national telephone counselling service (AIDS Hotline) set up at the Federal Centre for Health Education are not included in the above figures.

Since 1987, the share attributable to the DAH as an NGO has risen steadily, now amounting to 37.5 % of the overall total.

The following figures indicate the human resources of the institutions:

FCHE: From 0 in 1986 to approx. 8 to 9 jobs today

DAH: Expansion to 34.5 jobs promoted by the Federal Government since 1987

DAH and FCHE work on the basis of the division of labour and closely coordinate the contents of their activities.

Important lines of conflict with an effect on AIDS prevention today or in the past

– In the first few years, there was a severe conflict – which has largely been settled on the basis of a consensus since then – over the basic concepts of AIDS prevention: the "Search and containment strategy" versus the "Societal learning strategy", based on the principle of voluntary participation and anonymity. The installation of cross-party parliamentary (Committee of Enquiry of the German Bundestag) and non-parliamentary (National AIDS Advisory Council) committees of experts resulted in the decision in favour of the long-term societal learning strategy as the effective form of AIDS prevention.

– The explicit propagation of condoms aroused resistance, especially in the initial years, among individuals and institutions who saw themselves coming into conflict with their fundamental moral convictions. The fact that the main route of transmission is unprotected sexual intercourse among non-monogamous groups of the population led to the development of extensive tolerance of the propagation of condoms.

– The initially marked distance maintained between NGOs and state sponsors of AIDS prevention, which made cooperation difficult and ruled out the exploitation of synergistic effects, has developed into far more pragmatic mutual recognition in the course of the 90s. There is still some disagreement as regards drug policy, the scope of state promotion and the degree of influence exerted by the state on the media and the activities of the NGOs via its financial promotion. On the whole, however, it is true to say that the government-organised and non-government partners adopt a cooperative attitude based on the division of labour in their actions in the field of AIDS prevention

– The decline in resources (both human and financial) for AIDS prevention in all regions of Germany and at all levels (local, regional, national, and the GO/NGO sector), together with the increasing number of persons with HIV and AIDS requiring support,

is increasingly leading to "redistribution battles" for the scarce funds and a growing burden on full-time employees. In the NGO sector, primary prevention is occasionally losing its priority over support and care activities in this context.

Joint projects with other countries

– Both the FCHE and the BMG, as well as the DAH, are involved in an international network of information and joint concept elaboration (via the WHO, EU, through congresses, expert meetings and institutional exchanges of experience, etc.).

– In addition, there are (in individual cases) binational projects of the FCHE, particularly with other German-speaking countries (mainly Switzerland). This generally involves the adoption of brochures or AV media.

– The "Europe against AIDS" programme, which has been active since 1994, has realised a project for young people on their travels (Flying Condom Project) which the FCHE has also adopted since 1995, along with nationally operating youth organizations (German Youth Hostel Association, German Junior Red Cross, youth travel agencies), and propagated using nationally modified media.

– Since 1988, the FCHE has been staging European AIDS Consultations and Expert Meetings on central aspects of the AIDS problem within the frameworks of its cooperation with the WHO.

The Elements of national AIDS prevention

Goals

The goals of the AIDS education campaign are

1) to achieve and stabilise a high level of information among the public concerning infection risks, non-risks and protection options,

2) to promote protection motivation and protective behaviour in risk situations, and

3) to create a social climate which opposes the stigmatisation and isolation of persons with HIV and AIDS.

The continued transmission of the HI virus (i.e. new infections) is to be prevented and the integration of those affected promoted by achieving lasting changes in these variables.

Target groups

Attention focuses on different target groups in relation to the objectives:

– High level of information (basic knowledge about AIDS)
  – General public
– Protection motivation/protective behaviour
  – Young people and non-monogamous groups in the population
– Integration of those affected
  – General public

Groups with a higher infection risk to which state institutions have only limited access (e.g. homosexuals, intravenous drug addicts) are primarily addressed via the DAH (division of labour).

Messages

The main motto (logo) of the campaign is "Don't give AIDS a chance". It integrates the following messages: "AIDS is a disease beyond medical control. It's largely up to you whether you get infected with HIV, as the main transmission routes are unprotected sexual intercourse and intravenous drug use. Therefore

– inform yourself,
– protect yourself and your partner (by using condoms in sexual risk situations!),
– don't isolate affected persons, isolate the virus."

Communication strategy

In order to achieve prevention effects which remain stable in the long term, education campaigns must succeed in establishing and maintaining a permanent process of communication.

The media and measures used in a campaign not only have the task of propagating messages and information, but must also create the possibility of recapitulating on knowledge, correcting it or deepening it. And success must be attained in starting or maintaining processes of interpersonal communication on the subject of the campaign, so that behavioural directions can develop and behavioural patterns be changed or consolidated in discussions with persons of confidence, opinion-leaders, partners, friends or professional counsellors (two-step flow of communication).

In order to initiate and sustain this kind of learning process in society, the Federal Centre for Health Education has developed a campaign comprising three inter-related sets of measures – mass media offers, telephone counselling and personal communication activities (see Chart 1).

In addition, there are media which offer more in-depth information, dealing with and implementing the central messages in a target group-related manner in order to promote knowledge, motivation, attitudes and willingness to engage in interpersonal communication.

Structure of the Aids education campaign		
Campaign segment	**Communication goal**	**Media/Measures**
Mass-media campaign	Propagation of basic messages and information through widely used mass media	TV spots Cinema spots Advertisements Posters
Telephone counselling	Reply to current questions for information and reducing anxiety/ Support of behavioural security	Publication in the mass media Counselling on all Aids-related subjects
Personal communication campaign	Creation of offers with interpersonal (bilateral) communication on behavioural motivation and change	Events Discussion groups Counselling sessions Training courses Workshops
▼ Learning process through use of different media ▼		▼ Learning process through initiation and stimulation of interpersonal communication ▼
	▼ **Goals** Information about Aids Protection motivation and protective behaviour Integration of those affected	

Chart 1

The fact that several, different media are put at the disposal of the individual is the prerequisite for learning processes in which the information can be compared and a person's own knowledge corrected, recapitulated, expanded and consolidated.

As activities in the media are incapable of providing an answer to every question, and thus generally give rise to additional questions, supplementary options for obtaining information and engaging in discussions are developed and offered on the basis of personal communication. The aim of this is to guarantee possibilities for targeted feedback to the campaign in the form of personal communication, in addition to the everyday interpersonal communication taking place in parallel with the media communication. Thus, a further learning process is initiated with the aim of supporting a change in attitudes and behaviour in the direction of the above-mentioned campaign goals.

Have there been any major historical changes?
The initial forecasts of a rapid and massive spread of the HIV infection have proven to be wrong. We consider this to be attributable to a preventive effort in the whole of society which can be regarded as unique in comparison with previous campaigns.
Since it became clear that AIDS can currently be regarded as largely contained, there has been a steady decline in the total funds available for prevention.
We fear that the effects and success of prevention achieved in the short term could destroy their own financial basis – the prerequisite for lasting learning processes. This is the "prevention trap".

There are already the first signs of declining effectiveness.

Evaluation and quality assurance

Evaluation approach

The Federal Centre for Health Education has been accompanying the AIDS education campaign with various evaluation studies since 1987.
On the one hand, individual elements of the campaign are examined in order to establish the extent to which they achieve specific (sub-)goals.

Evaluation studies of this kind are available for

1) individual media,
2) the telephone counselling service, and
3) the personal communication campaign.

A summary of all studies conducted to date can be found in the "Documentation of completed studies of the FCHE", which is updated annually.

The effect of the campaign activities as a whole as regards the goals of HIV and AIDS prevention is examined in the general public and sub-groups of relevance for prevention with the aid of a monitoring study accompanying the campaign.
Representative surveys are conducted each year in order to record changes in knowledge, attitude and behaviour, the results also being published annually by the Federal Centre for Health Education under the title "Public Awareness of AIDS in the Federal Republic of Germany" (available in German).
In addition, specific repeat surveys geared to the special living situation of homosexual men are conducted on behalf of the FCHE and published regularly by the Deutsche Aids-Hilfe. The latest report by Michael Bochow was published under the title "Gay sex and the threat of AIDS – Reactions of male homosexuals in Eastern and Western Germany", Aids-Forum DAH, Vol. XVI, Berlin 1994 (available in German).

The contents of the questions asked in the "Public Awareness of AIDS" study are derived from the main objectives of the campaign. The following individual aspects are examined:

- To what extent is use made of the various media of the AIDS education campaign, how extensive is the reach of the campaign as a whole, do the intended interpersonal communication processes develop, is use made of additional communication options?
- To what extent is a high level of information concerning AIDS established and maintained among the public?
- To what extent is self-determined and responsible behaviour promoted as protection against AIDS?
- To what extent is a social climate opposed to the isolation of people with HIV and AIDS developed?

Main experiences gained from evaluation in relation to the campaign as a whole

Basing the campaign on a communication strategy made it possible to reach the entire population with offers (media/measures) – there are no signs of differences in levels of education.

- A high level of basic information was achieved and maintained very rapidly – in all educational strata.
- The social climate vis-à-vis persons with HIV and AIDS has been improved.
- Protection motivation and protective behaviour (use of condoms) have increased steadily and are continuing to grow in those groups of the population which are exposed to a potentially higher risk of infection – again, regardless of the level of education.
- The repeated analyses performed within the frameworks of the study concerning the connection between the utilisation of communication offers and the impact on the target variables indicate that effects are attributable to the education activities. This applies to the level of information, attitudes towards persons with HIV and AIDS, as well as to protective behaviour when making new sexual contacts.
- In 1994 it became very apparent that ever fewer people are coming into contact with the individual media and measures.
- Together with the marked decline in interpersonal communication, this downward trend in the density of information options has far-reaching consequences for the communication processes of the AIDS education campaign: societal learning processes are becoming less likely.
- A declining trend in protective behaviour is becoming apparent among the younger age groups.

  Among the group of 16 to 45-year-old singles, there has been a drop in the percentage who have used condoms at all in the recent past, as well as in the frequency of their use. There is an even more striking decrease in the regular use of condoms among the young generation of 16 to 20-year-olds.

As it proved possible to demonstrate that protective behaviour when making new sexual contacts is dependent on the intensity with which information and communication offers are used, this also means that the two downward trends – declining communication density and declining use of condoms among the younger age groups – are not independent of each other. Thus, a further decrease in the opportunities for information and communication increases the probability of a long-term decline in preventive behaviour on the whole.

Main experiences gained from evaluation in relation to individual media/measures

– Ways of addressing target groups on "taboo" subjects (sexuality) were examined within the framework of evaluation studies. The results could be used as a basis for developing guidelines for the contents of media and measures (planning criteria).

Additional activities customary to date in quality assurance

Cooperation with other countries:

– In relation to the campaign as a whole: refer to the objectives of this event
– Evaluation: standardisation of indicators for measuring effects (EU activities)

Feedback from other experts

– Discussion of measures with experts/evaluators (consultation, written expertises)

Target groups

– Involvement of representatives of the target groups in the elaboration of media/materials
– Target group-related testing of media (e.g. audiovisual media, brochures)

Future and prospective planning

Which concrete measures or combinations of measures are considered to be indispensable in the future and in the long term?

1) Measures in widely-used mass media continue to be indispensable if the high level of basic knowledge concerning HIV and AIDS is to be safeguarded both among the public as a whole, and among the younger age groups, in particular. This also makes it possible to achieve a kind of continuous "background noise" which triggers recollection and makes it clear that AIDS still exists as a risk.
   Campaign media suitable for achieving these effects are, in particular, TV spots, cinema spots, advertisements and poster campaigns.
2) Brochure offers geared to specific target groups and offering an opportunity to deal with the subject of AIDS more intensively can also still be regarded as a central element of the communication concept.
3) In addition to mass media activities, measures based on personal communication are also important in order to establish, maintain and consolidate learning processes.
   Above all, multipliers must be addressed in order to promote AIDS prevention in individual towns, regions or institutions (continuing education/training).
4) Cooperation with other institutions and individuals in order to consolidate prevention work and increase public attention for the subject of AIDS (among other things: development of media events, linking to/joint organization of events attracting public attention, sponsoring).

Which goals and quality requirements are essential in this context?

Goals

The main goals continue to be
– the prevention of new infections, and
– the integration of people with HIV and AIDS.

Thus, safeguarding a high level of information (also among the younger generations), the promotion of condom usage in situations with a potential risk of infection (target group: young people and non-monogamous groups of the population) and measures aimed at creating a social climate opposed to the isolation of affected persons (target group: general public) will continue to be the most important tasks of the AIDS education campaign in the future.

Quality requirements

– Safeguarding of time-proven elements (justification by way of evaluation results, etc.).

– Planning and justification of additional measures relating to the communication strategy concept (no extra, isolated measures).
– Consideration of the empirically determined design criteria when developing media/measures.
– Cooperation/division of labour with partners on the basis of joint concepts (including sponsoring).
– Promotion and evaluation of innovative prevention approaches (e.g. integration of the subject in soap operas, peer education, etc.).
– Parallel evaluation of the campaign and individual activities.
– Exchange of experience with national and international cooperation partners/experts.

Which strategies for goal achievement and quality assurance should be used to ensure this?

The activities proposed previously would have to be embedded in the following structural model for quality assurance (see chart 2).
It is a discourse model in which representatives of the scientific community, prevention institutions, politics and cooperation institutions/organizations are involved.
The participants in the discourse should present and justify their ideas as regards the goals, contents, methods and expected results, in order to arrive at concepts and programmes supported by all involved.
The prevention institutions would then be responsible for the actual implementation of the programmes.
The scientific community plays a decisive role during the implementation and effectiveness control phase. It can be summed up in the keywords "quality assurance" and "effectiveness control".
Their results form the basis for assessments within the framework of a renewed discussion process involving all those taking part in the discourse.
The results of this evaluation process would then be used for drawing conclusions as regards the further planning and implementation of prevention, as well as for further research work.
In other words, the process then starts over again.
From the prospective point of view, we consider it essential to increase the institutionalisation of a "quality assurance system" of this kind, so that AIDS prevention can be freed from its dependence on financial, content-related and political cycles and be further developed on the basis of professional standards.

The tasks of the mass media part of the campaign are as follows: to use various, coordinated, widely-used media to propagate essential messages and basic information concerning infection risks and protection options, as well as a knowledge of risk-free situations, this being particularly important for life with people with HIV and AIDS.

Chart 2

Structural model for the planning and evaluation of prevention campaigns

Epidemiological situation in the Federal Republic of Germany as of 31. 12. 1994

HIV infections

Total number (estimated) of persons infected since the start of the epidemic:	50,000–60,000
Breakdown according to *sex:*	
Men:	80–85%
Women:	15–20%
Children under 13 years of age:	Roughly 500 (1%)
Number of *new infections* per year:	2,000–3,000
Routes of infection important today:	
Homosexual contacts between men:	65%
Intravenous drug abuse:	15%
Heterosexual contacts:	10%
Persons from pattern II countries:	10%
Vertical transmission (mother–child):	< 1%
Blood transfusions and blood products:	< 1%
Haemophilia:	0%

Regional distribution:
55% of all persons with HIV live in the large cities of Frankfurt am Main, Munich, Berlin (West), Düsseldorf, Cologne and Hamburg. 44% of all those with HIV live outside the above cities in the old Federal Länder. A few hundred HIV infections (1%) have been diagnosed in the new Federal Länder to date.

Trends:
The great majority of new infections continues to occur via homosexual contacts between men. The rate of new infections among intravenous drug addicts seems more likely to be on the decline. In contrast, the number of infections transmitted through heterosexual contacts will rise. The most important sources of infection are contacts with members of the primary risk groups. There have so far only been very rare reports of independent chains of infection among heterosexuals.

The number of HIV infections in the new Federal Länder is increasing – albeit on a low level. In the old Federal Länder, there will be no fundamental change in the regional distribution observed to date, which matches the regional distribution of the groups displaying high-risk behaviour.

AIDS cases

Completeness of recording:	> 85%
Total number of reports since 1982:	12,379
Of those, reported as dead:	7,522
Breakdown according to *sex:*	
Men:	90%
Women:	10%
Children under 13 years of age:	98 (0.8%)
Number of *new cases* per year:	About 2,000
Routes of infection (cases diagnosed in 1994):	
Homosexual contacts between men:	65%
Intravenous drug abuse:	4%
Heterosexual contacts:	8%
Patients from endemic regions (Pattern II):	3%
Haemophilia:	2%
Blood transfusions and blood products:	2%
Vertical transmission (mother–child):	< 1%
No data:	6%

Regional distribution:
57% of all persons with AIDS live in the large cities of Frankfurt am Main, Munich, Berlin (West), Cologne, Düsseldorf and Hamburg. 42 % of all those with AIDS live outside the above cities in the old Federal Länder. To date, 126 (1.0 %) of the diagnosed AIDS cases originated from the new Federal Länder.

Trends:
There will be no fundamental change in the annual number of new AIDS cases diagnosed in the next few years. No major changes in the distribution of the cases according to the infection risk can be expected in the short term. Shifts in the spectrum of initial manifestations of the immunodeficiency and increasing survival times are to be expected as a result of improved therapeutic options.

Source:
Robert-Koch-Institut, Bundesinstitut für Infektionskrankheiten und nicht übertragbare Krankheiten, RKI-Hefte 6/1995

3.5. The National AIDS Campaign in Latvia

Andris Ferdats, Melita Sanka, National AIDS Centre, Riga

Essential development steps and framework conditions for AIDS prevention

Development and current situation of the HIV/AIDS epidemic in Latvia

Systematic surveillance of the HIV/AIDS epidemic in Latvia was started in 1987, the first case of AIDS being diagnosed in 1990.

Since 1987 and up to October 1995, 43 HIV-infected individuals have been recorded. Of those, nine AIDS cases have been identified, of which three have died. The majority (31 or 72%) are in their twenties or thirties, and three are females. Thirty-six (or 84%) of those found to be HIV-positive live in Riga and its suburds.

Twelve (or 28%) of those found to be HIV-positive were revealed through their attendance for treatment of a STD (mainly syphilis). The suspected route of transmission of HIV is unsafe sex (56% homosexual/bisexual and 26% heterosexual). Transmission through sex workers and their clients, contaminated needles and from mother to child has not been confirmed.

The increase in the annual incidence has been evident since 1993, and it has accelerated this year to 18 HIV-positives within ten months. The cumulative incidence rate of 0.35 AIDS cases per 100,000 confirms the very low prevalence of HIV/AIDS in Latvia as yet. The broad spectrum of HIV transmission among newly recorded infected persons implies a wider prevalence of HIV transmission than the official figures may suggest.

Since 1989, surveillance data on venereal diseases such as syphilis, gonorrhoea and chlamydia, show strong upward trends. People infected with STDs are found among all strata of the population and the majority of them are 18 to 19 years old. It should also be noted that a high prevalence of hepatitis B and C has been recorded. The high prevalence of hepatitis might be an indication of widespread behaviour of intravenous drugs or nosocomial infection.

The HIV epidemic in Latvia is in its very early stages. In comparison with some other countries in Europe, the incidence is low. Latvia has, however, the potential for a more extensive spread of HIV infections among the population groups at higher risk. Behavioural patterns for sexual transmission (multiple partners and unprotected penetrative sex), as well as for transmission through blood (sharing of equipment among intravenous drug users), are present in different groups and this potential implies a threat to all segments of the population.

Indicators of the social stress of transition, e.g. alcoholism and drug abuse, are on the rise, and the growth in organized crime and prostitution has become very visible. Furthermore, the geographical location of Latvia, its transportation networks and open banking regulations make the country an increasingly attractive transit point for, among other things, narcotics and refugees.

Organization and structure of HIV/AIDS prevention work

National AIDS prevention was started on 14 August 1990, when an AIDS Centre was set up as a unit of the State Infectious Disease Hospital (now State Infectology Centre) and an order was passed on of HIV/AIDS epidemiological surveillance and care in the country.

The Ministry of Welfare is responsible for the implementation of the National AIDS Prevention Programme. The health sector of the Ministry of Welfare is divided into the Department of Environmental Health and the Department of Public Health. Following the RIGA Meeting in April 1993, the AIDS Centre was reorganized into two separate, but interrelated units: one for preventive activities (National AIDS Centre) located under the Department of Environmental Health, and one for HIV/AIDS diagnosis and care, attached to the State Infectology Centre and under the Department of Public Health.

In 1993 the National AIDS Centre developed a comprehensive Plan of Action for the period 1994 to 1996 which was approved by the Ministry of Welfare in March 1994. However, this plan has yet to be approved at government level.
Within the period from 1993 to 1995, the structure of the Centre was formed, staffed, and activities initiated in accordance with plans and allocated funding.

Funding, management and coordination

In 1992, the Cabinet of Ministers identified HIV/AIDS prevention as a health care priority, but has not provided targeted funding.
The Ministry of Welfare is responsible for the funding of national AIDS prevention through the state health budget. The National AIDS Centre has a clear mandate and programme of work, with well thought-out plans, but has had great difficulties in obtaining full funding for its activities due to the general shortage of funds for health projects. For example, in 1994 it was estimated that Ls 62 (US$ 122) per head are required to cover all the health needs of a person in Latvia; however, the overall financial situation could only allow Ls 41 (US$ 80) to be allocated per individual.

The AIDS funds from the state budget are divided into two parts – the funds allocated to the medical aspects, which provide treatment, care and support, including the reference laboratory, and are directed to the Senior Physicians of the State Infectology Centre, and

the funds allocated for the prevention aspects, which include funds for screening sera (except for blood collection services), epidemiological surveillance and for information, education and communication (IEC) programmes and are directed to the Director of the National AIDS Centre. In spite of a carefully laid programme of work which conservatively estimates the annual expenditure for prevention at Ls 153,800 (US$ 301,500), the 1995 budgetary allocation was only Ls 50,485 (US$ 99,000), which provides no room for preventive activities, such as IEC targeting various groups. However, the AIDS Centre is able to regularly implement educational activities, with some financial support from the Ministry of Education.

Additionally, training activities are integrated within other existing structures and funded through relevant government departments and institutions.
In terms of external donors, Latvia comes under the G-24 aid coordination mechanism, with the EU/PHARE Office serving as the local focal point. Within the United Nations, the UNDCP has established a regional office in Riga. The HIV/AIDS Prevention Programme has received external financial support (US$ 26,000) through the WHO Global Programme on AIDS – Sweden being a major donor.

Latvia regained its independence in May 1990, and this resulted in great changes in the health sector and society at large. The former, highly centralized state system of control and management in the health sector has for the most part gone, while district and local-level facilities are now managed locally. Municipal and private structures are involved in health care. The involvement of several NGOs representing vulnerable groups, such as HIV-positive groups and gay organizations, in STD/HIV prevention activities was an innovation. Comprehensive AIDS prevention requires the active and coordinated participation of different sectors and disciplines at the governmental and non-governmental level, including NGOs. Partnership with non-governmental organizations should ideally be focused on activities complementary to those of the government; however, a National AIDS Committee or other coordinating body which could facilitate the smooth coordination and evaluation of HIV/AIDS prevention activities did not exist until October 1995 when, by order of the Cabinet of Ministers, the National Coordination Committee on AIDS/STD Prevention was set up. Poor coordination of multisectoral involvement is a line of conflict which influences national AIDS prevention in Latvia.

The health care system is disease-oriented, and preventive and primary health care is not well developed in all sectors as yet. Inadequate attention to the primary prevention of HIV/AIDS and STDs is a major constraint.

The elements of national AIDS prevention

As mentioned above, risky behavioural patterns for sexual transmission, as well as for transmission through blood, are present in different population groups. However, not

everyone is at equal risk. In Latvia, the majority of those found to be HIV-positive are representatives of high-risk groups, e.g. those attending STD clinics. Other vulnerable groups include sex workers and their clients, homosexual men, intravenous drug users and their sex partners and potentially also young people, prisoners and refugees. There is a strong, documented correlation between HIV infection and the presence of other STDs in Latvia. Strategies and interventions aimed at preventing sexual transmission are the major goal of national AIDS prevention.

Epidemiological surveillance

The development of HIV/AIDS epidemiological surveillance in Latvia can be divided into three periods:

1) 1987–1993. Mandatory screening of large groups of the population – patients admitted for planned surgery, including abortions, patients admitted for drug problems, patients with clinical indications of HIV, STD clinic attendees, all medical workers, pregnant women, truck drivers, prisoners and sailors.
   This system completely disregards preventive work, as the HIV test itself cannot be considered a preventive measure without providing counselling.
   The National AIDS Centre has been very active in eliminating the old mandatory testing policies and in introducing the concepts of confidentiality, anonymity, voluntary testing and counselling.

2) 1994–1995. The screening policy is gradually changed to adhere more closely to the recommendations of the Global Programme on AIDS. There are several testing sites available and anonymous testing offered at most places. HIV tests are provided free of charge. Mandatory testing of certain population groups is still being implemented, e.g. HIV testing of blood donors, HIV testing of sailors is a prerequisite for employment.
   However, apart from the good work done by the staff at the specific anonymous counselling centres, very little real pre-test and post-test counselling took place.

3) 1996 – The system of epidemiological surveillance has been developed by means of state legislative acts, which are based on voluntary HIV testing with pre-test and post-test counselling, on strict observance of confidentiality (anonymity) and a maximum decrease of mandatory testing. Unlinked anonymous surveillance provides vital epidemiological information for targeting interventions and should be established to supplement voluntary testing.

Since 1993, Latvia has been participating in an external quality assessment system, directed by the Public Health Laboratories (UK).

Prevention of sexual transmission – Promotion of safer sexual behaviour

HIV/AIDS can be prevented if educational and other preventive measures are available and are understood and practiced by everyone.

General population

No study or survey has been undertaken to measure the level of knowledge about HIV/AIDS prevention in the population as such. However, STD data indicate that safer sex is not being practiced and interviews confirmed that the level of condom use is low. This is also the case among sub-groups, such as sex workers and their clients, homosexual men, and among intravenous drug users. The level of knowledge does, however, seem to be increasing among the general population.

A Unit for Education and Information was established as part of the National AIDS Centre. Within the field of prevention, high priority is given to IEC activities with an emphasis on educating young people. Information and education on HIV/STDs and on sexuality are in the process of being integrated into the general health education and promotion work taking place in society. Films have been translated into Latvian and video clips on HIV/AIDS prevention have been broadcast a few times on the state channel. Short video clips are also produced and shown on the private TV channels.

Relevant information is shared with the press on an on-going basis and the National AIDS Centre organizes press conferences twice a year, one before World AIDS Day to initiate this event. The press has regularly reported on this subject since 1990. The focus for this reporting has been factual information on HIV/AIDS, including recommended preventive measures and information about HIV testing facilities. "Sveiks un Vesels" (Safe and Sound) is a health promotion magazine with a monthly circulation of 20,000 copies in Latvian and regularly collaborates with the National AIDS Centre. The June 1995 issue will focus on HIV/AIDS.

A brochure on STDs was recently produced in the Latvian language for the first time. This brochure was a collaborative effort between the National AIDS Centre and the Family Planning Association. Furthermore, the National AIDS Centre has developed other brochures and booklets, e.g. on HIV testing, general knowledge "What is AIDS" and a booklet made in cooperation with the gay men's association (which has been finalized, but not yet printed due to lack of funds). It should be noted that the lack of funding has hampered – in different ways – the production of material. The STD brochure was pre-tested. A hotline aimed at the general population has been in operation since January 1994, and the staff received 1,700 calls during the first four months of 1995. The majority of callers were adult men, including homosexuals.

Physicians, nurses and teachers are in regular contact with the general population and represent potential "health promoters". Many physicians teach health promotion in schools. Teachers and nurses seem to be relatively well-informed about HIV/AIDS and seem able/willing to share their knowledge. However, the physicians are generally not very interested, and seem to underestimate the potential of an epidemic. STD doctors are, to a very high degree, only concerned with and occupied by the strictly biomedical aspects and are not involved in primary prevention of these diseases.

Future planning

a) A policy and strategic plan for the promotion of safer sex and condom use should be given priority.
b) The production and dissemination of material on HIV and other STDs should be increased. Messages for homosexuals and intravenous drug users should be integrated into the material developed for the general population.
c) Information, education and communication on STD/HIV/AIDS should be integrated into the daily work of health care staff and teachers.
d) Standard national guidelines on STD case management (current methodology of diagnosis, treatment, prevention, including counselling and condom promotion and partner notification) should be developed and made widely available.

Young people

HIV/STD prevention work among young people is mainly implemented in schools. Outside the school setting, little work is done on health-related issues targeted at this group. Some non-governmental youth centres exist, but no outreach or streetwork activities have been implemented.
Health education, including HIV-related issues, is integrated into the teachers' training curricula.

Today, health education may be integrated into existing relevant subjects or may be introduced as an optional subject. For the future, a decision has yet to be made on how health education will be formally organized in schools. STD/HIV/AIDS-related issues must form part of health education/health promotion in schools. This involves teaching about sexuality including homosexuality.
Since 1994, two-week training courses on health education for teachers and health staff have been conducted regularly by the AIDS Centre. The total number of staff trained is 244. Furthermore, an additional 189 school medical workers and teachers have been trained in two-day courses.
Teaching materials for the 9th grade and secondary schools have been produced. A Swedish brochure on STDs for students has been translated, pre-tested, adapted and produced in Latvian.

The National AIDS Centre provides material and condoms, when available, to a network of five youth centres.

Future planning
Organizations for youth, including youth centres, need to be more extensively involved and supported in promoting sexual health. Work on STD/HIV/AIDS prevention also needs to be integrated into health promotion activities carried out in the local communities. To reach out-of-school youth, efforts should be made to develop innovative methods.

Homosexuals

The gay men interviewed expressed the view that neither the use of condoms nor the practice of safer sex is the norm within the gay community. Furthermore, HIV is not talked about much.

The Latvian Association for Sexual Equality (LASV) was formed in 1990. Prevention of HIV is one of the organization's aims. LASV has received financial support from the European Union. The association has produced a pamphlet on safer sex. Additional information materials, including posters, are in the process of being produced. The National AIDS Centre has provided condoms. The organization is about to introduce safer sex shows in a club where gay men meet. However, no work is done in cruising areas or in the countryside. A gay and lesbian hotline will soon open and will operate twice weekly.

Although the relations with the National AIDS Centre are generally good, some problems exist. LASV and other similar organizations claim that the economic support they have received from the National AIDS Centre is insufficient. The organization would like to enhance cooperation with the National AIDS Centre but stressed that collaboration has to be on equal terms. LASV also expressed a wish to become involved in all activities concerning sexuality and HIV carried out by the National AIDS Centre.

Future planning

a) NGOs, including gay organizations and affected community groups, should be involved and supported in the planning and implementation of projects.
b) The National AIDS Centre should invite and encourage gay organizations to become involved in the STD/HIV prevention work carried out.
c) Information and educational materials on HIV/AIDS/STDs, addressing homo – and bisexual men and condoms and lubricants need to be made available in places where men meet.

Sex workers and their clients

Commercial sex or prostitution is recognized as a fast growing problem in Latvia. The number of women selling sex in Riga is estimated to be as high as 6,000, 1,000 of whom operate in the streets. The women in the streets are often from the rural areas or neighbouring countries and are also often young. Girls as young as 11 and 12 years old have been diagnosed with STDs.

Drug use is linked to prostitution to a growing extent. In some private settings, pimps provide women with ephedrine in order to make them more sexual. Both injection and oral use occurs. Among women selling sex in the street, opiates are most common.
Men buying sex rarely use condoms and their attitude towards condom use is negative. Among the prostitutes, no tradition of condom use exists nor does any moral pressure to use condoms.

Audio cassettes with preventive messages, produced by the National AIDS Centre, are being distributed among sex workers. However, no other targeted preventive work is being implemented.

Future planning

a) An outreach project involving prostitutes should be launched. Training in safer sex methods including the use of lubricants and the art of negotiating condom use should be part of the initiative.
b) Informational and educational material targeted at prostitutes and their clients should be developed and produced in both Latvian and Russian.

Injecting drug users and their sexual partners

The estimated number of drug users in Latvia is close to 10,000 of which 60 % have been estimated as injecting drug users. Drug addiction is moustly spread among urban population consisting presumably of non-Latvians, it is most popular among immigrants from Russia, Ukraine, Caucasus. This new situation raises in Latvia the danger of a rapid increase in hepatitis and HIV epidemics.

The drug scene is dominated by use of home-made heroin and by ephedrine. Needles and syringes are sold without restriction in pharmacies.

In the State Treatment Centre, 781 persons (among which there are 335 using heroin and 215 ephedrine) are registered as addicted drug users and an additional 300 is registered as non-addicted drug users. Although testing for HIV is not mandatory, new entries are routinely tested. No drug user has been found HIV positive.

Information on STD/HIV/AIDS has been shared with staff dealing with drug users. However, no extensive training aimed at behavioural changes among drug users has been conducted nor has training in crisis interventions been given. HIV prevention is not integrated into any kind of drug-related work as yet.

Future planning

A small outreach project focusing on health issues including STD/HIV should be designed and implemented in settings where drug users meet and mobilizing injecting drug users to do HIV preventive work among their peers. A strategy to prevent onset of injection among drug users who do not inject should also be developed.

Prisoners

Latvia has 15 prisons total and the prison population is about 12,000 of which 400 are women and 200 are under 18 years old. STD incidence among the inmates is very high. Prison authorities recognized that homosexuality is practised to some extent among the inmates and that drugs are used in the prisons.

All prisoners are mandatorily tested for STDs including HIV and two cases of HIV infection have been detected. In one case the infected person had been released and for the other case it was not clear what had happened.

Although information on HIV has been given to prison staff by National AIDS Centre, there is a need to develop more materials such as films, videos and posters.

Condoms should be available free of charge in prisons and disposable needles, and medical wards should be provided with syringes and gloves. Prisoners should be provided with informational and educational material – printed as well as audiovisual. Staff should be educated and trained in HIV-related subjects.

Monitoring, evaluation and quality assurance

The main monitoring tools for national AIDS prevention in Latvia are the prepared annual workplan and reports on relevant activities. Since 1994 the detailed work of the National AIDS Centre is planned annually and reflected in a plan which is regularly reviewed and revised, as needs arise through the year. Lack of coordinating/advisory bodies determines difficulties in getting a comprehensive picture of the full preventive work carried out.

Base line data, for the use of priority prevention indicators (PI) are scarce. Reliable information on knowledge, attitudes, believes and practices (KABP) in different population

groups, in relation to risk behaviours for acquiring HIV and STDs, is not available. Very little is known about the sexual behaviour and attitudes of vulnerable groups. No comprehensive qualitative studies have been carried out and most data available are derived from a few questionnaires and review surveys for school – based HIV/AIDS/STDs education.

This Country Paper is based on the first systematic assessment of the National AIDS Prevention (Programme) – External Programme Review (21–29 May, 1995) within the WHO's assistance to Latvias's National AIDS Programme. The review team consisted of eleven members five of which were externally recruited. The review process was strategically targeted to gain an understanding of key issues and concerns, identification of achievments and constraints while making recomendations for improvements. As an immediate feed-back was the development of the National Coordination Committee (NCC) on AIDS/STD prevention.

a) Evaluation shoud be built into project plans for the particular interventions and the programme as a whole, key indicators, PI including should be identified and an evaluation protocol designed.
b) KABP studies for monotoring of changes in behavioural patterns would be of much value for designing appropriate interventions.
c) Annual reviews of the programme should be conducted by the NCC.

3.6. AIDS Prevention in Lithuania

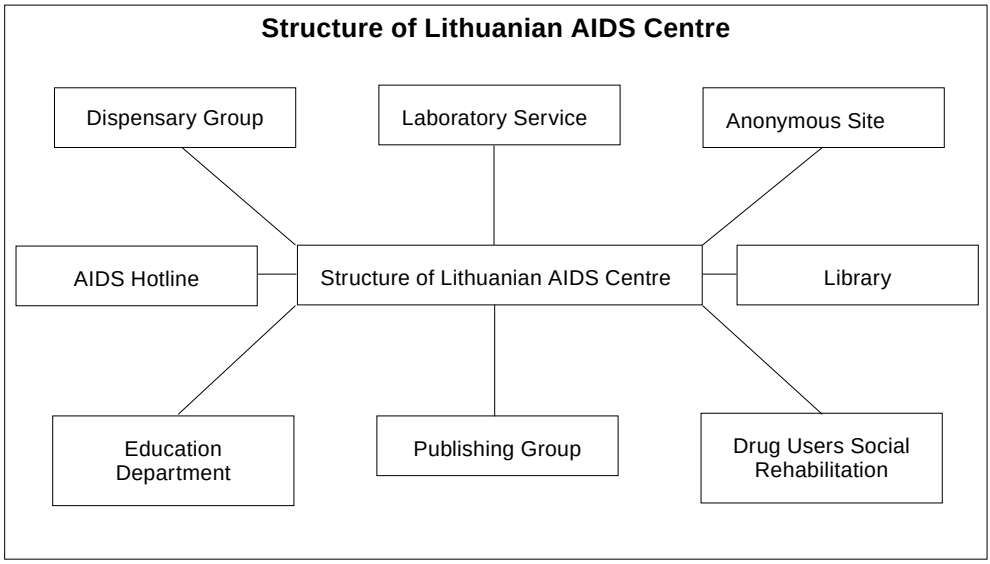
Saulius Chaplinskas, Lithuanian AIDS Centre, Vilnius

Background

Well-ordered and planned AIDS prevention work in Lithuania started on 1 June 1989, when the Lithuanian AIDS Centre was established. When signing the order on the establishment of the Centre, the Minister of Health at that time, Mr. A. Vinkus, wished us to take a line of decisive change, promised to provide every kind of assistance and give us a "free hand", which appeared to be especially important because the AIDS problem forced us to entirely rethink the former medical standards and those of social life. AIDS prevention came to Lithuania along with independence. Up to that time, we had followed all the directions and laws of the former Soviet Union, most of which were based on the compulsion principle and violated human rights. The prevailing conception was that the state had to care about the people's health.

Even now, it is not easy to gain approval for new ideas, because our activity is contradictory to prevailing moral attitudes and laws and legal directives.

The structure of the AIDS Centre (diagram) has developed gradually, taking into account the needs which appeared and the extent of work. Premises are located in four districts of Vilnius city (December 1994). It is a state institution, subordinated to the Ministry of Health.



AIDS prevention policy of the AIDS Centre has been dependent on the policy implemented by the Ministry of Health.

Changes in the mood of the Ministry of Health can be illustrated by the orders signed by constantly changing ministers:
In 1989, Minister A. Vinkus established Lithuanian AIDS Centre as an independent organization and allotted premises in the National Skin and Venereal Diseases Dispensary.
In 1990, Minister J. Iekas gave permission for the Lithuanian AIDS Centre to treat STDs, including syphilis and gonorrhoea, anonymously.
In 1993, Minister V. Kriauza signed an order to merge the Lithuanian AIDS Centre and the National Skin and Venereal Diseases Dispensary.
In 1993, Minister J. Bredikis revoked the merger of the Lithuanian AIDS Centre and the National Skin and Venereal Disease Dispensary and prohibited the anonymous treatment of STDs; treatment of syphilis and gonorrhoea was made the prerogative of dermatovenereologistes, and HIV-infected but healthy sailors were allowed to go to sea.
In 1994, Minister A. Vinkus set up a Commission at the Ministry of Health for coordination of medical workers' and society's attempts to prevent the spread of AIDS. The Director of this Commission was the director of the Kaunas Medical Academy, supernumerary head infectionist of Health Ministry A. Laiskonis. Members: G. Baleviciene (Dermatology Clinic of Vilnius University), V. Klimas (Family planing Centre director), Z. Javtokas (Republican Health Education Centre director), L. Valys (Head of Family Medical Clinic of Kaunas Medical Academy), G. Vitkus (Director of Kaunas Jesus College), E. Verbavicius (Vice-president of Lithuanian Stocks Innovation Bank), S. Caplinskas (Director of Lithuanian AIDS Centre).

Prevention of HIV infection in Lithuania

The purpose of HIV prevention in Lithuania was put into practice since 1989 with the new AIDS prevention programme for Lithuania in 1990–1994, Lithuanian AIDS Prevention Programme for 1992–1993 and AIDS Prevention Programme in Lithuania in 1994–1996. None of the mentioned programmes was confirmed by the Government, for none of them was financial budget allotted. All work was being done using mostly the means received from the Health Ministry. The World Health Organization has assigned a fund for educational purposes.
The activity of the Centre has consisted of the measures on republican level. The Lithuanian AIDS Prevention Programme for 1995–1997 is already developed and passed to Seym for consideration. Prevention measures on the local and regional level are foreseen there.

In 1992 the AIDS national coordinator post was set up in Lithuania. This person is responsible for development of the AIDS national policy, its integration into other medical and social spheres and its realization.

Public education

The main direction in the work of the Lithuanian AIDS Centre was and still is public education in general and that of certain groups. The aim of educational work is to achieve behavioral changes of the population, for every person would take care of himself and of the health of neighbouring people. All people have to perceive well what and how is to beware of. Therefore, the task of educational work is to provide with exhaustive and exact information on HIV/AIDS, the transmission modes and protection means. Only the well-informed person can decide how to act in any situation of life. The more people will know how to take care of their own health, how diseases could be avoided and behavior changed.

We can hope for successful AIDS prevention work only having the new public education system created and medicine and the society heaved up to the completely new level. Experiences of the Western world have proved that educational and promotional campaign should go on constantly because with the decrease of information flow the number fo HIV-infected people grows.

When organizing the educational work, we had the following tasks in mind:

- to provide the various groups of population with exhaustive information on HIV transmission modes and means of protection,
- to change the attitude towards people with HIV and AIDS, sexual minorities and drug users.

Among the population, young people, medical workers, people of other professions and certain target groups (drug users, homosexuals, prostitutes) have been provided with information on HIV infection modes, AIDS symptoms and protection measures since 1989. The workers of Lithuanian AIDS Centre base their educational work on the WHO principles i.e. do their best to provide people with the necessary information and try to modify their risky behaviour.
The first issue of the AIDS Chronicle newspaper was published in 1989. The main problems connected with AIDS were discussed: homosexuality, drug addiction, prostitution, sexually transmitted diseases. The 45th issue of the newspaper already appeared.
The main aim of AIDS Chronicle is to provide the society with understandable and acceptable information about the HIV protection. In 1994, the newspaper was reorganized into the journal Take Care of Your Health.

Since 1989, the issue For Practising Physicians has been published, the booklet for travellers, HIV-infected people and women edited, many leaflets published (issues For Practising Physicians appear by now), the book AIDS: Guidance for Counselling Support, MillerR., Bor R. was translated and published, the first newspaper Naglis for homosexuals appeared. A documentary on AIDS prevention has been shown in the cinemas of Lithua-

nia, created by the Lithuanian Movie Ccompany and the Lithuanian AIDS Centre, some videoclips were made and broadcasted on TV. Posters, stickers and samples of slides for medical workers were published. On 22 May 1994, the AIDS Victims Day was commemorated for the first time. The parliamentarian L. Alesionka, Deputy Minister of Health A. Vinkus, the reverent J. Vasiliauskas and others took place.

Public education on AIDS issues can be divided into the following stages:

1) Before the establishment of the AIDS Centre
2) From establishment of the Centre to the first Condom Festival
3) From the first Condom Festival to the 1st International Conference
4) Present stage

Only few articles were published in the national newspapers and journals, some information sheets appeared and lectures for various population groups were delivered in the first stage. With the establishment of the AIDS Centre, educational work became more active. More articles were published, targeted persons interviewed on TV, more broadcasts transmitted, certain public groups educated. Some contact with homosexuals was made and the targeted education of those and of drug users started. Various scientific articles from 60 countries, 44 States of America on AIDS themes have been collected. Since most printed materials were in English, we begann translation work. In 1992, we prepared the Public AIDS Education Programme and the AIDS Education Programme for Schools. Meetings with teachers were organized (5 of them took place), and also with physicians (gynaecologists, obstetricians, venereologists, infectionists, medical workers of detention facilities, students). 9 round tables with representatives of society were organized: Morals and AIDS, Drug Addiction and AIDS, etc.

The targeted education of risk groups has been put into practice. After the first Condom Festival, a more open discussion on safer sexual life and homosexuals' problems became common; HIV-infected persons from other countries spoke on TV. While the workers of AIDS Centre were going on with this work, physicians of some specialities (dermatovenereologists, health education and family planning experts) avoided any changes in educational activity and, seeking to be popular, backed up the opinion of our opponents in official publications. The aim of the first international conference Prevention of AIDS and STD in the Low HIV Prevalence Countries was to unify the people with a different way of thinking. Although certain resolutions were accepted when the conference was over, nothing special has changed. No common opinion exists on the matter of what public education directions are to be set; however, the journalists became more active in discussing some forgotten problems. Even more people (teachers, students, artists, scientists) wished to assist in public education on AIDS. Nevertheless, one trend became more obvious: the more actively the AIDS Centre worked, the more energetically its work was criticised, first of all by the colleagues who, by nature of their posts, should be interested in our activities being successful.

The Public Education and Information Department of the AIDS Centre (Director: R. Buceviciente, tel. 76 79 68) accumulates and computerises information on AIDS, STDs and other contagious diseases. Most of the printed materials are sent by the WHO, and also by other countries. Information sources consist of books, journals, booklets, copies of foreign scientific articles, posters, audio and video materials, newspapers. By 1 January 1995, there were 10,416 books, 10,040 articles, 304 video cassettes with consistent information material on HIV/AIDS, 45 audio cassettes, 1,000 information flyers and 452 posters available. More than 100 readers from various medical facilities are served. More than 20,000 printed units are at their disposal. Exhibitions on AIDS themes (printed matter, posters) are organized, and posters for medical workers and the population displayed during various conferences, workshops and other arrangements. Lists of new printed matters are prepared and disseminated every month. The bibliography list of material published in 1990–1992 was published in the bulletin of the AIDS Centre. The targeted information is provided for 62 subscribers, and separate requests of the readers are satisfied (approx. 200 a year). Approx. 22,000 information materials units are disseminated among the population every year: books, journals, newspapers, booklets, posters, stickers. We are not able to satisfy every demand because of the lack of financial resources. Every two weeks, the physicians of the AIDS Centre and other medical facilities are informed about new printed matters on AIDS and other themes. All foreign printed matters received are thoroughly revised; articles also published in our press and new films on AIDS subjects are shown. The aim of these regular reference arrangements is to provide all interested people with news on AIDS prevention, diagnostics and treatment as well as on STDs, drug addiction and prostitution.

Medical workers are not very interested in the materials collected by the AIDS Centre. They more often look for material in Lithuanian and not for special articles or publications in the original language.

Promotion in the mass media

From the very first functioning days of the AIDS Centre, special attention has been paid to cooperation with representatives of the mass media. Press conferences have been organized often involving not only the workers of the AIDS Centre, but also their guests. Journalists used to be informed about every new HIV infection case and other news. Since 1990, AIDS prevention has not been a frequent discussion subject on TV and radio; more and more broadcasts were transmitted on this subject later. Every week, the educational and informative TV spots Stop AIDS were broadcast on national TV (the AIDS Centre also took part in the preparation work). The subjects discussed were infection modes, prevention, use of condoms (the first time in the Republic). Infected persons and guests of the AIDS Centre participated in these transmissions, and videoclips and other educational material were used. 33 issues of Stop AIDS were transmitted on the first channel of TV, 23 on the second and 5 on East Lithuanian TV. The programme entitled 15 Minutes on AIDS

was transmitted by Kaunas TV. It was strange, but after the first transmissions of Health (popular broadcast) prepared by us, the interest in the AIDS problem diminished. Panorama and Night News always provide information about all new HIV infection cases and other topical questions on AIDS prevention. Five teleforums were organized on Lithuanian, Kaunas and Vilnius TV channels. The World AIDS Programme Coordinator for the European Region, S. E. Eckeid, and persons with AIDS from Denmark and Russia took part in these broadcasts. Studio A & A created 10 videoclips on AIDS prevention, most of which were shown by Lithuanian TV. In 1993, work started on the psychological documentary We Are Unique While We Are Alive (Director: R. Sipavichius), all parts of which were transmitted on various channels many times. The aim of this documentary was to draw public attention to newly arising AIDS problems and to encourage the society to solve them. Problems of infected persons and drug addiction were considered. Work on newparts is currently in progress. There are some commercial channels, except the state one in Lithuania at the time being, all of which are pleased to transmit all movies, videoclips and other matters on AIDS and understanding the importance of the subject free of charge. 10 new videoclips have been created, some of which have already been transmitted on all channels. The Tele 3, Baltijos and Kauno Plus channels provide the society with the most information on AIDS. The movies on AIDS are accessible in video centres and are shown on TV, e.g. Mama, Mama; Jungle Fever, Philadelphia; Rock Hudson; Moonlight, etc.

In 1994, broadcasts of five minutes duration were transmitted once a week (on Fridays) on Lithuanian radio, and weekly information on AIDS prevention for young people in the broadcast 38 Speed. Every day on 12.30 p.m. the audio clip How to Avoid AIDS was broadcasted. Since June 1994, the information on AIDS and STD was broadcasted by the state radio station twice a week. Discussions on AIDS were broadcasted on the second programme of Lithuanian radio. The radio station Znad Wilii talks about AIDS for the Polish speaking population for 4 minutes, and workers of Lithuanian AIDS Centre take part in this. In 1991 and 1992, regular short broadcasts were organized on the radio stations M1, Radiocentras, Vilniaus varpas (AIDS Lies In Ambush, etc.). Commercial radio stations, in contrary, demand payment for transmission.

From 1990, most articles in newspapers and journals used to be sensational, but journalists (with the assistance of the AIDS Centre, foreign guests, and subsequently on their own) later began to publish materials on AIDS prevention. At present all bigger dailies in Lithuania publish articles on AIDS. The independent creative movement Journalists Against AIDS was established in 1991. Its task is to warn Lithuanian people about the menacing epidemic, to bring them together for a fight against the plague of the 20th century. Attempts were made to draw in the reporters of regional issues, too. The club Journalists Against AIDS was established on 4 December 1994.

The WHO together with Lithuanian AIDS Centre, decided to induce journalists to write on HIV/AIDS and give them awards during the 1st international conference. This has turned into a tradition.

In October 1992, the American dance troupe Danceteller were on tour in Lithuania. They have showed a performance Before Forever. That was an exciting dance performance about people with AIDS, about the sensibility and rudeness of surrounding people, love and hatred; art and promotion were merged in it. The Duties of a Citizen of the Earth were obvious. The guests brought 20,000 condoms along and distributed them among the audience.

In 1994, Lithuania participated in the campaign against AIDS arranged by the European Community. Millions of Europeans on holiday were given a condom with a fancy passport. This campaign was prolonged by the Week of Safe Love, organized in September in Lithuania. We had the intention of giving journalists the opportunity of reminding people about AIDS, writing about it and encouraging everyone to think about themselves and their behaviour. The exhibition by the photographer S. Paukstis, Bodies, opened the campaign. Condoms were distributed to drivers by our workers, together with policemen; we tried to stress the relationship between safe traffic and love in this way. The culmination of the campaign was the distribution of condoms, together with instructions and the AIDS Chronicle newspaper to Parliamentarians; that was an initiative of the reporters of the Pirmadienis newspaper and the workers of the AIDS Centre; the motto of this campaign was Healthy Parliament – Healthy Nation. All these events were widely discussed on TV and in other mass media. This campaign and similar ones aim at providing the population with more information on STDs, including AIDS, transmission modes and protection means, and are to force them to think about their behaviour and the safety of people close to them.

In 1990–1994, 599 publications on AIDS were analysed which we republished in the Lithuanian dailies "Lietuvos rytas", "Mediku zinios", "Respublika", "Vakarines neujienos", "Tiesa"/"Diena", "Lietuvos aidas", "Gydytoju zinios".

One-third of all publications on AIDS appeared in the daily "Lietuvos rytas":
- Approx. 18 publications were published in 1990. 50% of them were messages.
- In 1994, approx. 75 publications appeared.
- Messages made up the biggest part of the publications (57.9%). The number of were translations increased especially. There were 71.4% translations published.
- In 1994, 4.9 times more messages were published, and the number of articles increased 2.6 times compared with 1990.
- In 1990–1994, approx. 167 publications were published. Character of these in percent:
- messages: 63.5%,
- articles: 18.5%,
- translations: 12.6%,
- interviews: 5.4% .

Messages were published most: 63.5%, interviews were published occasionally.

Sociological surveys

People always want to be well thought-of. Some of our authorities have a faible of thinking they always know what needs to be done and how, but the problem is that they base their actions not on the facts, but on their fancy. Being aware of this phenomen and not being able to ignore it, we decided to use sociological surveys. They make it possible to watch the possible changes of HIV and AIDS dynamics, to forecast the epidemiological situation in the future and to plan work effectively. Almost 10 large-scale sociological surveys have been carried out by the Lithuanian AIDS Centre. Some of them: Anonymus survey of students of secondary and professional schools; AIDS knowledge of students of technical schools by R. Kielius (900 students completed the questionnaire); Prospects of HIV infection spreading in Lithuania by G. Dzemyda; Attitude of medical facilities to the activities of the AIDS Centre by J. Rakickiene; Survey of 640 students at secondary schools by V. Ziediene. It should be mentioned that some mass media, e.g. the Kalba Vilnius newspaper, conducted their own surveys trying to learn the opinion of their readers on AIDS. A sociological survey is a complicated task. The basic preparation work has to be done, it needs time and financial means. That is why no sociological surveys of certain social groups (homosexuals, drug users, sex workers, patients of anonymous sites) have been conducted.

These are the main groups at risk. That is the reason why we plan to conduct some sociological surveys in 1995, which will certainly be complicated by the unwillingness of these groups to speak openly, even in the anonymous questionnaire. Besides, it is extremely difficult to get in contact with these groups, because they are afraid of discrimination and contempt and thus avoid communicating with medical workers and general public. The main group of the population at the greatest risk of becoming infected with HIV consists of young people. According to the results of the survey of pupils of Kaisiadorys secondary school, conducted by the Vilnius Pedagocical University, most pupils are aware of HIV transmission modes. However, only 54.3% of all respondents indicated the condom as the most reliable measure against HIV, although, they do not use a condom during sexual intercourse. More than 45.9% of the pupils would like to learn more about AIDS, so we should think about how to provide this group with understandable information of AIDS, because the common information obtained through TV, radio and the press is not enough. As our surveys revealed, most young people start their sex live early – at the age of 14-16 (44.6% boys and 30.6% girls had their first sexual intercourse at 16). More than 90.9% of the respondents stated that sex education in school is poor. In contrast to foreign students, Lithuanians are provided with poorer information on sexual issues during lectures. (As the survey by R. Karpaviciute revealed, only 1%; 47% of the information is obtained from foreign movies.)

In 1990, A. Rekuviene conducted a sociological survey, Attitude of Lithuanian Physicians To AIDS, which turned to be a good illustration of how little Lithuanian physicians even know about AIDS: 17.3% of respondents indicated that it is possible to get infected with

AIDS by a kiss, 10.7% that a vaccine against AIDS exists). 24.3% of pyhsicians expressed a wish to isolate HIV-infected persons, only 55.8% were ready to treat an infected person. S. Zimus, O. Pimpiene and T. Barkovska conducted a separate sociological survey, Knowledge of Medical Workers and Attitude To HIV Infection, which confirmed that most of medical workers are not ready to deal with AIDS. It is necessary to use the results of the sociological surveys by G. Dzemyda and others in order to forecast the trend of the spread of HIV infections in Lithuania. These results have shown that infection in Lithuania can be stabilized by working in two directions: preventive tests and education. Condoms are also to be promoted. It is apparent that the infection has no chance of spreading if 70% of all individuals use a condom during casual sexual intercourse. A new estimation will be possible after the surveys of drug users, homosexuals and sex workers, the main HIV risk groups, are conducted in 1995.

Education of young people

Young people are the part of the population most exposed to the danger of becoming infected with AIDS. Special attention should be paid to the moral habits of young people and to development of responsibility for the health of themselves and their peers. Students become part of most productive, active population; therefore, the spread of HIV infections among young people would cause immense damage to the country's economic structure, demographic situation and the stability of society. In spring of 1994, the psychologist of the AIDS Centre G. Aleksejunaite, and a student of Vilnius University, V. Goberys, have questioned 600 students from 10 Lithuanian universities. 72% of respondents confirmed that HIV/AIDS is a public problem.

Students' attitude to HIV/AIDS

The knowledge of the students as regards HIV transmission modes was sufficient. They indicated the following modes: 98% through blood, sex; 95% through contaminated medical instruments; 81% during a visit to the dentist. Many students also indicated other modes, that were infact safe (20% through an insect bite; 9% through sharing tableware; 8% by kissing; 6% by sharing a common toilet, 3% by shaking hands with an HIV-infected person). The attitude of students to sex education and information appeared to be conservative. Students usually discuss their sex life openly with: parents – 9%, relatives – 26%, physicians – 28%, friends – 54%, partners – 69%.

The most common information channel is TV, radio and press (96%).

Sources of HIV/AIDS information for students

Students do not avoid risks in their sex lives. 31% of respondents used to have more than one partner during the recent years, 79% used to have sex when drunk, 8% with prostitu-

tes, 27% with strangers, while 6% had sex with a partner of the same sex and 9% had sex with several partners at one time. Condoms are not popular among students. Only 26% always use them, never – 14%, sometimes – 60%. These data should be considered when developing prevention policy for students.

Homosexuality and AIDS in Lithuania

Homosexuals were the first persons infected with HIV in Lithuania. We have been looking for contacts with them from the very first issues of AIDS Chronicle. In 1992, an American boy, W. Longmire, started this kind of activity, and a little later it was continued by a Frenchman, G. Sanches. A gay support group was established at the AIDS Centre. Four issues of a newspaper for gay people Naglis (editor S. Dimbelis) were published with AIDS Centre support. In 1993, Article 122 of the Penal Code was abolished on the initiative of the AIDS Centre. The gay support group was registered as a public organization, the Lithuanian Movement for Sexual Equality (LJSL, chairman A. Zolotuchinas, tel. 76 79 68), and Naglis became the independent newspaper. Members of this group disseminate educational materials and means of protection. In 1994, LJSL and the gay club Amsterdam (tel. 76 65 83) together organized an annual ILGA (International Lesbian and Gay Association) for Eastern and South-Eastern Europe, which was financed by the WHO and supported by the AIDS Centre. That was the first public event for homosexuals in Lithuania, supported by a governmental organization. Wider activity is being disturbed by the disagreements among gay groups. It is to be hoped that the situation will improve in the future; the AIDS Centre has established an educational club for gays, where various meetings take place – movie nights, discos etc.

The Lithuanian Movement for Sexual Equality (E. Luksenaite and G. Plepyte) questioned 500 pupils of classes 11 and 12 (43% of them were male) in Vilnius secondary schools. Among the pupils questioned, 29% had already had sex: 36% boys and 24% girls. Among those who have had sex, 65% have had one sexpartner (63% boys and 98% girls), 22 % have had two partners (boys 34% and girls 21%), while 13% have had three and more partners (13% boys and 12% girls). 75% of pupils (boys 76% and girls 71%) approved sex before marriage. 75% of the pupils questioned used means of protection while having sex.

Drug addiction

In the soviet times, the problem of drug addiction was not considered seriously. Drug usage, homosexuality, prostitution and similar "plagues of capitalism" were taboo topics. Only the more recent years have been rich in discussions about the problem. The exact number of drug addicts is not clear. According to the official data of the Ministry of Health, there were 629 registered drug addicts on 1 January 1994, 69.3% male and 30.7% female. 7 drug addicts died of an overdose in 1993, and 4 of other reasons. According to

the data of sociological surveys conducted by the AIDS Centre, there are 5,000 regular drug addicts at present and approx. 10,000 occasional drug users. Their average age ist 20–40 years. 2–5% of drug addicts die per year: 63.6% of an overdose, 18.2% of other medical complications, 9.1% drug addicts commit suicide and 7% are killed in accidents not related to drug addiction. The total number of drug addicts dying per year is 130. 90% of them share their syringes and expose others to a danger of contracting various infections transmitted through blood, including HIV. The most popular drugs are: heroin (88.6%), prepared at home from poppies, and ephedrine (9%). Poppies grow all over Lithuania. Cannabis and amphetamines have become more and more popular, too; however, we do not have anymore exact data. Cocaine and crack are not popular at present.

Seeing that drug addicts are a very closed population group, which is afraid of penal consequences, it is extremely difficult to get in contacts with them and test these people for HIV and other diseases transmitted through blood. In the opinion of the experts of the AIDS Centre, there are many more drug addicts in the meantime, and a spread of HIV among them is to be expected at any moment. In 1994, 3,634 crimes connected with drugs were registered, i.e. 10.6% or 1.1 times more than in 1993. In comparison with 1992, 39% or 1.4 times more crimes were committed. These are mostly offences covered by Article 232 of the Penal Code, i.e. illegal production, purchasing, storing, transporting, dispatching or selling of drugs. In 1994, 233 persons were prosecuted under this article: 62 persons aged 18–24 years; 60 persons 25–29 years old, and 109 aged 30 or older; 49 of them were female. 82 persons committed a crime while high on drugs, that is 1.5 times more than in 1993.

Prostitution

Our knowledge of women prostitution is the most sufficient. Female prostitution is an often newspapers subject, and films on the topic are transmitted on TV, in recent years, many advertisements for this kind of service have been published in the press. We know far less about male prostitution, but it also exists.
The following groups of sex workers can be singled out:

1. Female alcoholics. Mostly they linger around the streets, squares, railway and bus stations. They often do not request any payment and have sex with drunk men. That happens at the same place, somewhere in the open or in flats of bad reputation.
2. 'Escorts' found through an advertisement. These firms mostly employ young girls coming from Belarus, Ukraine, Russia. Some girls from Lithuania go to Western Europe, Turkey, and other countries to earn money.
3. Constant visitors of restaurants, hotels and night clubs. They often act in close connection with the criminal world.
4. Girls who have left 'escorts' firms and have their own customers.
5. Workers of private firms, massage saloons.

In spite of governmental prohibition, the services provided by prostitutes are not decreasing at all, in fact they are becoming more stable. The services become more various according to the requirements of a client. The state has only a minimal influence. First contacts with firms providing prostitutes' services have been arranged. The collaboration started includes dissemination of educational materials and training on safer sexual behaviour. According to our own data, some prostitutes apply to the AIDS Centre anonymous site and undergo a treatment there. 55 women 'escorts' were tested here, only 10 of whom appeared to be healthy. Of the other 45 women, 3 have syphilis, 6 gonorrhoea and 2 candyloma. Audio clip on safer sex for prostitutes is being created. Lithuanian AIDS Centre is working on a special educational publication in the Russian language for prostitutes. WHO promise their support to publish it, some other international organizations also. We would like to distribute it in other countries with the help of organizations which try to educate Russian-speaking prostitutes.

Condoms

Condoms are being purchased not only in governmental institutions (drugstores, shops), but also in private shops and boothes. The number of condoms utilized is not clear and there are no official statistical data. The quality of the condoms sold is doubtful and they are mostly not certified. Therefore, on our initiative, checking of condoms was set up in 8 cities and 40 regions in 1994. Condoms beyond the expiry date were found on sale in 10 places, and in six places no expiry date was indicated at all. These condoms are mostly imported from Russia and Poland. The temperature regime was not kept on in four places. The present situation was evaluated and, on the basis of this evaluation, the decree of the Governmental Senior Physicians Hygienist No. 50, 1. 8. 1994, was passed, i.e. On a Matter of Condoms Control, which prohibits the sale of unchecked condoms; the condoms control system was foreseen. Thus, persons wishing to sell condoms must obtain a permit. Permits are granted by the National Hygiene Centre on the basis of a condom quality testing protocol provided by the Lithuanian AIDS Centre, responsible for the testing body. Various condoms are sold in Lithuania at present; prices vary between 0.26 and 5.00 Litas. A similar price for a condom is paid in the neighbouring Baltic countries. Lubricants are not so easy to find. Representatives of the Johnson & Johnson company sell lubricants, but they are expensive.

Activity of non-governmental organizations

Non-governmental organizations, so popular in the Western world, have no significant work experience, because all functions have always been realized by governmental organizations. A NGO is the constructive reaction of a group or single person to the need to solve a problem with participation of a governmental organization. NGO members are entirely different people, related by one problem and its solution. They are able to react

fast and act independently from the internal policy and ideology of a state. The structure of an NGO is not complicated. Groups of the population which establish a NGO trust their organization. A NGO is able, more quickly and without any immense expenses, to draw the interest of people who are willing and able to solve various problems. NGOs can assist governmental ones in inducing more people to AIDS prevention work, attracting non-governmental resources, including those from abroad (information, technology, finance, humanitarian aid), for the implementation of some concrete programmes, for the exchange of information on HIV/AIDS. NGOs need help from governmental organizations to deepen HIV/AIDS knowledge of employees and volunteers. Understanding all that, the AIDS Centre supports the NGOs. The AIDS Centre is not able to effectively solve all problems arising on its own and the success of preventive work depends on this. That is why, using the experience of the world, we are doing our best to assist the NGOs while establishing and starting their activity in the AIDS prevention field. On the initiative of the Lithuanian AIDS Centre, together with mothers of drug-users, the Fund for Drug user Support in Lithuania was established in 1992. This Fund has published a booklet for the community of drug users, Rehabilitation in the AIDS Centre, it supports drug users undergoing treatment and their families, and plans to publish an information book-poster in the future. In June 1993, the non-profit organization Lithuanian AIDS Fund was registered. The Fund published a book, Syphilis in Art, assisted in the organizational work of World AIDS Day, etc. After the penalty for homosexual intercourse was abolished, the possibility of officially registering the organization of homosexuals became real. In September 1993, the public organization Lithuanian Movement For Sexual Equality was registered. This organization was founded on the basis of the former Gay Support Group which used to be part of the AIDS Centre. In 1994, HIV-Positive Persons Support Group was established with its fund and regulations. At the moment, premises in a building of the AIDS Centre are being renovated for the purpose of educational events of NGOs.

In 1994, the non-profit organization AIDS Prevention was established, whose field of activity is women's health, sexual problems, sex education and public information on AIDS. The programme Sexual Problems of Women and AIDS Prevention for 1995–1996 was completed and confirmed by UNESCO. As mentioned above, two more organizations were established in 1994, the field activity of which is AIDS prevention. These are Journalists Against AIDS and Teachers Against AIDS. The public organization for lesbians already exists, and the organization Young People Against AIDS has been active since 1995. The Red Cross in America was one of the first organizations fighting persistently against AIDS by now. Inspired by this example, Red Cross of Russia organized an international Red Cross workshop, Society and AIDS, in Alma Ata on 16–21 September 1991. After this workshop, representatives of the Red Cross promised to consolidate the AIDS prevention work, although no more action has been taken yet.

AIDS hotline

The AIDS Hotline was opened on 15 March 1992. The need for counselling of this kind was proved by frequent calls to the AIDS Centre asking different questions. During the first year, the line programme was prepared, anonymous questionnaires for people calling were completed and counsellors trained. In 1993, the line was not widely advertised for the above-mentioned reasons and because of the lack of a separate room and phone line (the counsellors used to work in a general room and used a common department phone). In 1993, single rooms with single phones were arranged, but we were not able to spend more money on advertising, since the policy of the Ministry of Health towards the premises of the AIDS Centre was not clear. Thus, the prospects of the AIDS Hotline seem to be unclear, too.

Counselling support

Attempts are being made to put the counselling support into practice in Lithuania, i.e. to train physicians with the support of foreign experts (in 1992, 10 experts from England and Denmark) and middle medical staff of the Skin and Venereal Diseases Dispensary with the support of the workers of the AIDS Centre (in 1993). In 1992, the books Guidance of Counselling Support (Miller R., Bor R.) in Lithuanian and AIDS Background To Counselling Support (Trechiokas A.) were published. Recently, thanks to the enthusiasm of single persons, mostly physicians, pre-test counselling support has been implemented; however, in most of cases, the test for HIV has been carried out without counselling. It is mostly physicians and nurses who provide counselling support for HIV-infected persons and persons with AIDS.

Detention facilities

About 15,000 persons are in detention in Lithuania. According to the order of the Ministry for Internal Affairs, all prisoners in detention facilities are subject to obligatory testing for HIV and syphilis. One HIV-positive person has been found. He is free now. Cohesive homosexuality and drug addiction are common in prisons, and this means perfect conditions for the spread of HIV. Physicians of the AIDS Centre and medical staff working in detention facilities maintain close links. In 1991 and 1992, meetings on the subject of AIDS prevention took place in prisons. Lectures are being delivered, video films shown, printed matter distributed and attempts made to deliver condoms to prisons. According to the data of medical workers in detention facilities, the situation is improving gradually because the number of persons infected with hepatitis B is decreasing.

Education of the police and the armed forces

About 60,000 people serve in the Lithuanian armed forces and the police. They are mostly young, sexually active people. There is no special AIDS prevention programme. These people mainly obtain information from the mass media. Lectures at the Police Academy and the Military School have become traditional, the audience of that are being supplied with condoms and educational printed matter afterwards. Physician hygienist D. Voinovski educates soldiers, shows them films on HIV/AIDS, explains about transmission modes, homosexuality, distributes information materials and condoms.

The Medical Department of the Ministry for Internal Affairs organized the publication of a Reminder for Officials with a circulation of 10,000 copies at the end of 1994. This is an issue on prevention of AIDS and other STDs. Policemen working in custodies, sober sites, officials in detention facilities, servants of internal forces and students of police education facilities are provided with this publication.

Donorship

Lithuanian donors are usually people who give their blood for money. That are mostly alcoholics, jobless people and amoral persons. In 1993, 8 donors in Lithuania had hepatitis B and 3 hepatitis C. 18 with syphilis were tested in 1993, and as many as 43 in 1994. Donor's blood has been tested for HIV since 1987. In 7 years, more than 1 million samples of donor blood were tested and 2 HIV-infected donors found (in 1992 and 1994). Russian test kits only were used at first, the reliability of which was not sufficient (more than 61%). The situation has now improved. Since January 1993, donors' blood in Lithuania has been tested with the 'Abbott' test kit detecting IgG and IgM class antibodies. 4 blood centres and 46 blood transfusion departments prepare blood in the Republic. Donors make up 3.4% of the general population in the Republic (the maximal number of donors in European countries is up to 12–13%). On 28 April 1992, a regular donor of blood plasma with HIV was found (in Vilnius). Screening of donors proved that most donors are infected with the hepatitis C virus, as was that HIV-infected person. The hepatitis C virus spread among plasma donors in the National Blood Centre while carrying out plasmapheresis. More than 78% infected plasma donors were tested. Assessment of a contra-epidemic regime allows us to draw the conclusion that plasma and blood could be infected with hepatitis C virus during pumping of the plasma, through multiple bottles and blood transfusion systems or plasma pumping needles. AIDS can be transmitted this way, too.

Family planning

The Vilnius Family Planning Centre was established in 1991. The working directions of the Centre are as follows:

– *Organization of children, adolescents and young people sexual education and gynecological service.* In accordance with the data of 1993, more than one fourth of all marriages registered in Lithuania are early ones (average age up to 20 years), from 1,000 women in average age of 15–19 years 42 deliver a baby; 9% of all in 1993 infants born are illegitimate. That proves the necessity of adequate sexual education of young people. An anonymous telephone line has been established with an aim to consult and educate young people.

– *Pregnancy control*. More than 40 thousand abortions are made in Lithuania per year, for 100 deliveries – 80 abortions. More effective family planning methods are to be used. As to the data of WHO 75–95% undesirable pregnancies can be avoided with contraception. Modern contraception methods are to become legal which are so popular in industrial countries (surgery contraception, pregnancy interruption by antiprogesterone, prostaglandines usage, etc.). From the first functioning days the AIDS Centre has been keeping in touch with the Vilnius Family Planning Centre.

Relations with other countries

Workers of the Lithuanian AIDS Centre communicate with scientists of the Netherlands, Israel, England, Finland, Germany, Sweden, Russia, Canada, the USA and other countries giving us a hand to implement new sociological, economic and laboratory research, treatment methods which are necessary to plan, develop various programmes, fulfilling sociological surveys. These methods are of help to examine HIV infected persons, treat them, are applicable to other medical fields too, the Lithuanian AIDS Centre collaborates actively with the WHO Europe Region AIDS Programme Office, International AIDS Project, members of which are the USA, the Baltic States, Moscow and Sanct Petersburg. Lithuania was one of the main initiators to establish the AIDS Union of Baltic States what had been done on the 17th of December 1991 during a conference held in Helsinki. Its president became the Finnish Professor Pauli Leinikki. We stay in close relationship with the Russian Ostankino TV, Voice of America editor board and other organizations. In April 1992 the first issue of the newspaper SPID VESTI was published. This issue was a result of mutual work of the AIDS Chronicle published by Lithuanian AIDS Centre and Ural branch of the firm Anti VICH (HIV).

In 1990 Issue No 17 of Medicinskaja Gazeta was published developed by physicians and journalists of the Lithuanian AIDS Centre. The newspaper Tema published in St. Petersburg has published the whole issue of this edition with material prepared by our AIDS Centre. On the 1st December 1992 S. Chaplinskas participated in the popular Ostankino TV spot Tema assigned to the World AIDS Day. By the end of 1994 Ostankino TV spot Medicine For You has developed a cycle on AIDS discussing exhaustively AIDS Prevention work in Lithuania stressing Russia has chosen the wrong way and should take a lesson from Lithuanian experience.

Future prospects

The Lithuanian AIDS Centre has collaborated for several years with mathematicians in the field of AIDS spreading in Lithuania. All prognostic data gathered has been evaluated and a prognostic model for spreading of HIV infection developed. According to this model in 1990 could be not more than 155 HIV infected men and 39 women, and no less than 26 HIV-infected men and 1 woman in Lithuania in 1990. There were most probably 71 infected men and 8 women. Taking into account the present situation (public attitude to health, means of protection, prevention of STD), and supposing that infection would spread through sex only, the mathematicians think there could be about 680 HIV-positive persons in 1997. Investigation of the HIV infection transmission model has shown that the infection can be stabilized by acting into two main directions, i.e. preventive testing and education, condom promotion. Large resources are necessary for the development of the first direction. The infection should not spread, if all the necessary tests are made and approx. 70% of individuals use a condom during casual sexual intercourse.

HIV infection rate and condoms usage relation (1992)

Being aware of the fact that the HIV infection has spread among intravenous drug users, we can expect that the number of HIV-positive persons will increase several times. The model of infection spreading has been designed on the basis of the assumption that it will not spread among drug users. Taking into account the economic consequences of HIV infection, scientists noticed that, without wide public education (about 18–25% of AIDS programme resources are being allotted to this purpose and, in the opinion of WHO, more than 50% of all AIDS programme resources should be allotted to public AIDS education), 9.9 times more resources will be necessary in 1996 and more than 207 times more resources in 2001 with the increasing number of HIV-infected persons. One monetary unit allotted at present would spare 4 units in 1996 and 151 in 2001.

The paper AIDS Prognostics System and Its Implementation in Lithuania was read in Sydney in 1993, twice in Copenhagen, and at the Prague and Tokyo international conferences in 1994.

3.7. National AIDS Prevention in the Netherlands

Emma C. van Dongen, Stichting AIDS Fonds, Amsterdam

AIDS policy in the Netherlands

The Dutch government has been involved in formulating a policy on AIDS since the beginning of the epidemic. This policy is based on the following key goals; preventing the further spread of HIV; the development of a satisfactory structure for the care of people infected with HIV; preventing discrimination and stigmatisation of those infected with HIV and AIDS.

Epidemiology:
Almost 73% of AIDS cases are homosexual men and more then 10% are hard drugs users. Only 10% of all cases are heterosexuals, and 5% blood products, while only 10 children have developed AIDS as a result of an infection via the mother. HIV infection and AIDS is not widespread among prostitutes, although there are some new groups at risk, such as young Eastern European prostitutes. HIV infection and AIDS are so far limited mainly to the groups at risk: male homosexuals with variable contacts and intravenous drug users. If the constant upward trend in the incidence of AIDS continues, the cumulative total of AIDS cases will increase to 6,300 between 1991 and 2000.

The structure of AIDS policy

Dutch policy on the prevention and combating of AIDS is implemented at the national, regional and municipal level. The responsibility for the AIDS policy lies with the Minister of Health. Since January this year, the implementation of AIDS policy has undergone a major change. Since that time the AIDS Fund is the specific AIDS organization which plays a central role in the fight against AIDS. Some of the responsibilities of the National Committee on AIDS Control, the former advisory board on the Ministry of Health, were transferred to the AIDS Fund. A second advisory board, the Programme Committee for AIDS Research, has also been transferred to the AIDS Fund. Besides this, the Committee advises on the funding of research by Prevention Fund and the Ministry.

The Ministry came to an administrative agreement with the AIDS Fund in 1993. Since that time, the AIDS Fund has managed the disposable resources for projects in the field of information and prevention, care, legal and ethical issues an AIDS research.
Projects relating to AIDS and drugs do not come under the auspices of the AIDS Fund, they are financed by the national government.

Most important activities of the AIDS Fund

Fund-raising
Funds are received from donations (50%), campaigns, sponsoring (the AIDS Fund has three main sponsors; LRC, Wellcome, and Citroen Holland), legacies and collections. Besides these funds, the AIDS Fund manages the incentive funds of the Ministry of Health.

Fund alocation
The second important task of the AIDS Fund is fund allocation.
The AIDS Fund has a number of budgets at its disposal: a development budget, a research budget, the general AIDS Fund budget, and the regional budget.
These funds are allocated in concentrated annual subsidity procedures. The Ministry of Health establishes the AIDS Fund plan of operation. This plan of operation constitutes the framework which is used to obtain subsidy application. The Committee of AIDS Policy advises on subsidy-applications for projects. The Programme Coordination Committee advises on AIDS research.

The funds are allocated to projects in the following areas:
– individual assistance for people with AIDS,
– medical care and psychosocial care,
– information and prevention,
– scientific research,
– development cooperation.

Education and information
This is the third important task of the AIDS Fund, which has a performing character. Activities are:
– the National AIDS Hotline,
– the documentation centre,
– information campaigns,
– information materials.

In short, the objective of the AIDS Fund is to provide support and encouragement in the battle against AIDS

Some conflicts are:

– Cooperation between the AIDS Fund and other organizations on national and regional level. The AIDS Fund wants close cooperation with other organizations in implementing AIDS policy. However, there is a chance that the AIDS Fund is considered a bureaucratic organization which provides the conditions for organizations and projects on the subject of subsidy allocation;

– There is tension between the main tasks of the AIDS Fund, i.e. fund-raising and fund allocation. The sponsors of the AIDS Fund prefer sometimes to spend there money on specific projects, while the division fund allocation wants to prevent a preferential treatment due to policy reasons.
– Tension between general policy and specific AIDS policy.
The policy is to integrate AIDS-specific programmes in general health programmes. This can cause problems, because the general institutions, such as the regional and local health authorities, put insufficient priority to the AIDS problem.

World jamboree; to upgrade knowledge and awareness of youth leaders of HIV/AIDS in Dronten, the Netherlands, August 1995

– Tampep II project; transnational AIDS/STD prevention among migrant prostitutes in Europe project.
– AIDS & Mobility project; AIDS prevention for migrants, tourists, refugees and other target groups who cross international borders in Europe.
– European Information Centre AIDS and Youth; the aim of the project is to promote exchange and collaboration related to AIDS prevention among young people in and outside of school, with the aim of increasing the quality of AIDS prevention among young people in Europe.
– Electronic European HIV/AIDS information and documentation link by the HIV Foundation for people with HIV and AIDS.
– Translating the AIDS message across Europe. A project that aims to use the method of social action radio to raise awareness among migrant groups and to stimulate them to use the migrant helplines. Initiative from Great Britain, participating countries: The Netherlands, France and Italy.
– Healthy Cities Action Plan project Municipal Health Service Rotterdam.

The elements of national AIDS prevention

The Dutch national AIDS prevention policy is characterized by a twin-track approach: the provision of information to the general public, and a special approach for the different groups (target groups). These are the groups at increased risk, such as men with variable homosexual contacts, intravenous drug users, prostitutes and their customers, young people, and immigrants.
The main goals in AIDS prevention policy are:

– to prevent the further spread of HIV infections,
– to reduce the undesirable social and personal consequences of AIDS and HIV as far as possible.

The policy is based on the following ideas:

– each individual's sense of personal responsibility for himself and for others,
– respect for different values, norms and lifestyles,
– unambiguous, uniform advice on prevention,
– a broad concept of safer sex,
– the guarantee of an adequate level of provision.

During the initial phase of the information campaign, emphasis was put on informing as many people as possible, as quickly as possible, about HIV/AIDS and safe behaviour. Next, greater emphasis was placed on achieving changes in attitudes and behaviour.

Since 1987, there have been a variety of public information campaigns focused on the general public: General information – Concern for people with HIV and AIDS – AIDS and Work, AIDS and young people – Safe sex on holiday.

There have been various activities for the specific target groups:

– Organizations for homosexuals have developed various prevention activities and information materials in recent years. Studies have shown that a significant change has taken place in the behaviour of men with variable homosexual partners, manifesting in safer sexual practices. Despite this, the incidence of HIV among this group rose slightly due to an increase in unsafer sexual practices. Prevention activities aimed at men with homosexual contacts will remain a priority in the years ahead.
– The aim of prevention policy amongst drug users is based on a harm reduction model; the policy aims to reduce the risk of HIV infection caused by unsafer intravenous drug use and unsafer sex. Various campaigns have been run to advise drug users to use a new needle and syringe for every shot and to use a condom when they have sex. The so-called basic box which contains these attributes was a great success in the prevention activities. Studies have shown that 60–70% of hard drug users are being reached by the information and prevention campaigns. This is certainly owing to the methadone maintenance programmes, which reach large numbers of drug users. Recent studies have revealed a significant change in the behaviour of intravenous drug users. Fewer syringes are borrowed or lent, syringes are increasingly used once only. There are still groups of drug users who are hardly being reached or who are not being reached at all. Some may be reached through the prisons, as approximately 30% of the prison population of the Netherlands are drug addicts. A network of nurses has been established that is responsible for providing AIDS information in prisons. The Ministry of Justice has provided the funds for prevention and information activities in the prisons.
– In recent years, a number of information campaigns for prostitutes has been run, often in close cooperation with people from the target groups. The various national organizations involved are represented in the National Prostitution Forum. The coor-

dinating centre for prostitution is incorporated in the STD foundations. Evaluation research of projects on the main themes (boys, migrant women, addicted females) is established by the Programme Committee of AIDS Research.

- Special information activities have been developed for young people. The projects aim at the integration of AIDS information into general sex education. Extensive research has also been carried out on sexuality and safe behaviour among young people. Recent studies showed that the awareness among young people had increased but that the actual practice of condom use has remained similar. Older girls, in particular, have a tendency to practice unsafe behaviour with older young men.
- Since 1988, there has been an AIDS information project for immigrants. This project devotes extra attention to immigrants because of language and cultural differences. Studies have shown that certain sexually transmitted diseases are more prevalent among immigrant groups. Providing information on safe sexual behaviour is therefore a priority. The project is aimed at the four largest groups of immigrants in the Netherlands: Antilleans/Arubans, Moroccans, Turks and Surinamese. Moluccans and Cape Verdeans, Ghanians and other Africans, as well as asylum-seekers and refugees, are also important target groups for AIDS information.
- In 1988, the government conducted the AIDS and Work campaign. This campaign was extensively geared to people in professions with an increased risk of HIV infection. As a result of this, the new guidelines on the prevention of HIV infection for those working in hospital care were drawn up by the Working Party on Infection Prevention.
- Special attention is devoted to women and AIDS. This particular aspect of information is placed within the broader context of sexuality and sexual practice. Therefore the STD foundations and the project 'Women and AIDS' project, as a part of the Women's Health Centre Aletta, are working closely together.

Major changes

The policy on AIDS prevention has undergone some changes in the last decade. There are four important phases that can be distinguished:

- 1985–1988 was the phase of pioneering,
- 1988–1991 was the phase of growth,
- 1991–1994 was the phase of continuance,
- 1994 and further on is the phase of implementation.

As far as organization is concerned, the Netherlands can be described as having a network system. This means specific AIDS coordination both on a national level (the AIDS Fund) and on a local level (AIDS task forces within general organizations.) The phase of implementation is characterized by reorganization, decentralization, differentiation, and integration.

– *Reorganization:* Various reorganizations have taken place in the field of prevention on the national level. Organizations are working more closely together and are integrated in large institutions;
– *Decentralisation:* More emphasis has to be put on implementing the AIDS prevention policy on the local level. National organizations will play more of a supporting role. This is also stimulated by the Ministry of Health by the Law of Collective Prevention;
– *Differentiation:* There is a big difference between the possible approaches, effective media use and relevant target groups. Flexibility is needed in the different programmes on AIDS prevention;
– *Integration:* This means integration of the AIDS programmes in general organizations, not specific AIDS units. These can vary from health education and sex education to family planning, etc.

At the beginning of the epidemic, the central government was very closely involved in formulating the AIDS policy. For the last two years, the government has played a more distant role as a result of a more general policy that can be described as 'step back policy'. The AIDS Fund is now the central actor in coordinating the AIDS policy, although there is a close cooperation between the AIDS Fund and the Ministry of Health.

Since the new task of the AIDS Fund as a result of an agreement with the Ministry of Health, this organization is the main fund of AIDS programmes on the national, regional and local level.

Evaluation and quality assurance

Elements of national AIDS prevention that are empirically evaluated

A distinction can be made between:

a) monitoring on the (social) epidemiological level,
b) evaluation of the effectiveness of prevention methods,
c) evaluations of prevention policy.

Monitoring on the (social) epidemiological level
In 1994, HIV surveillance was established, based on a plan devised by the Programme Coordination Committee on AIDS in close cooperation with the Ministry of Health. The main goal of the HIV surveillance is to determine the rapidity of the HIV epidemic among the Dutch population. Surveillance is performed by the system of sentinel groups and based on informed consent. Surveillance takes place at the STD clinics in Amsterdam and Rotterdam, among pregnant women and visitors of an abortion clinic in Amsterdam, and among drug users in six different places in the Netherlands. HIV surveillance fills the gap

between the high-risk groups followed by the Amsterdam cohort studies, and the low-risk group of blood donors followed by the central laboratory of blood transfusions.

Evaluation of the effectiveness of prevention methods
To be able to reconsider our AIDS prevention objectives, we make use of studies that go into the subjects of awareness, attitude, and behaviour. The so-called MDI measures gauge the impact of mass-media campaigns, to get an impression of the knowledge, attitudes, behaviour and practices, as regards HIV prevention, among the Dutch population. Furthermore, a scientific approach is adopted by a 4-year study on knowledge, attitude and behaviour at the Kurt Lewin Institute. Evaluation of the effectiveness of prevention methods is based on research, such as self-evaluation, process evaluation and social science studies. There has only been a small amount of research and evaluation of effect measurement and method development.
It is also important to strenghten the link between the prevention practice and social science studies. These have been two different worlds until now. The AIDS Fund is preparing the function of research agent to connect these two fields.

Evaluation of prevention policy
Evaluation of prevention policy is needed to measure the effectiveness of the prevention policy goals by the results of concrete projects. Up until now, the emphasis in all activities has been set too much on a fast transfer of information. Since we are now in the new phase of the implementation of AIDS prevention policy, more emphasis is needed on process evaluation and research. The AIDS Fund is preparing a project on monitoring the results and effects of the various AIDS projects and campaigns.

Main experiences derived from (scientific) evaluation

General public
- Evaluation of the national campaign (1990–1995)
- Evaluation of policy measures (1989–1990)
- Evaluation of patient-GP interaction in decision-making on early intervention (1993–1995)

Young people
- Evaluation of the school education package (1990–1993)
- Evaluation of convenience advertising meeting-places youth (1994)
- Evaluation of the outreach of drop-out youth (1993)
- Follow-up evaluation youth and sex (after 5 years)

Homosexual men
- Evaluation in a cohort study homosexual men (since 1984, extended to include young homosexual men since 1995)

– Evaluation of safer sex video show
– Evaluation of preventive messages to homosexual men (1990–1992)
– Evaluation of prevention policy and the meaning of anal intercourse for homosexual men (1993–1995)
– Evaluation of 4 preventive interventions in young homosexual men (1995–)

Drug users
– Evaluation of diverse preventive activities in a cohort of drug users (1985–)
– Evaluation of support systems for drug users (1989–1991)

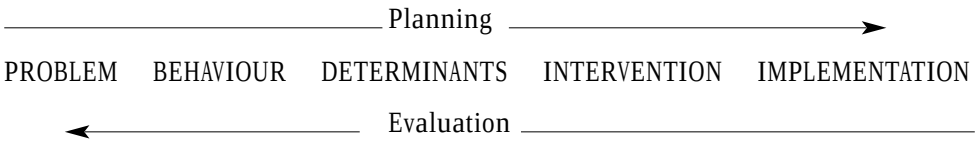
Prostitution
– Evaluation of consulting-hour for female window prostitutes in Alkmaar (1992)
– Evaluation of transnational prevention in female migrant prostitutes (1993–1995)
– Evaluation of prevention in young male prostitutes (1995–1996)

Migrants
– Migrants and prostitution (see above)
– Evaluation of prevention campaign in four major migrant groups (in preparation, planned for 1996–1997).

Further quality assurance considerations

Cooperation with other countries
The European seminar Indicators and Methods for Monitoring AIDS Prevention Brussels, 27–29 October 1994: In principle, this seminar formulated a series of more general resolutions, such as that it is essential to set up a regular monitoring system for AIDS prevention on the national and European level, and there is an urgent need to work on methodological problems.

Feedback of external advisors
In the Netherlands, we make use of the model of Professor Kok from the University of Maastricht. This model gives a framework for the evaluation of the AIDS problem situation as follows:



Planning is related to both prevention activities and research projects.
Evaluation is also related to both fields, but research is only related to scientific evaluation.

Problem is related to data collection on the prevalence of HIV/AIDS, incidence, risk behaviours and other relevant aspects via epidemiological research.
Behaviour is very closely related to the AIDS problem, data are collected via epidemiological research and social studies.
Determinants are related to the (social) factors related to behaviour, such as the role of the social environment in risk behaviour. With the help of scientific research on these determinants we can collect information what the influence is of these determinants on behavioural change.
Intervention is related to concrete prevention activities which are set up to realize behavioural change.
Implementation is related to the evaluation of the effectiveness of interventions.

The emphasis of AIDS evaluation was put on the first four phases of the model of Kok. For the near future it is urgent to put emphasis on the phase of implementation. This is a very important priority of the AIDS Fund.

Talks with representatives of the target groups
Most evaluation projects are set up to the accompaniment with members of the target groups and other experts.

Future and prospective planning

Goals and quality requirements which are essential

Important quality criteria for intervention-projects are based on the policy-programme of the AIDS Fund, organizations and projects are invited to pay special attention (with financial support from the AIDS Fund) to the following priorities:

Table of contents:

- To guarantee optimum information-campaigns for the general public and specific target groups, not only through written materials but also by specific local and regional methods;
- To continue mass medial campaigns on HIV/STD especially for specific target groups like migrants, young people, and women;
- To integrate HIV-prevention in STD-prevention, sexual health-education and emancipation, specific attention to consolidate determinants of behaviour;
- Special attention to the group of homosexual men, especially to the role of the social surroundings in continuous safer sex behaviour;
- Within the target group of drug users special attention is needed for women and migrants, besides the message of safe use more emphasis is needed on the safer sex message;

– Within the target groups of migrants, women, and young people, attention is needed for specific (sub)target groups;
– Evaluation research of prevention interventions directed at consolidation of safe behaviour, the influence of the social surroundings, and the evaluation of determinants of behaviour especially when new target groups are concerned.

Quality-criteria of judgement are:

– The quality of the project; a coherent design giving attention to concrete goals, specific target groups, innovative methods and the application for funds in the future;
– A good balance between costs and benefits;
– Relevance for the fight against AIDS; the table of contents is the guideline in this context;
– Supplemental character of the AIDS Fund; a contribution of other funds is a condition for an AIDS Fund subsidy.

Relevant strategies

The most important strategy to safeguard the quality of intervention projects is the application of the policy cycle:

– Policy analysis; analysis of the developments and trends in the implementation of HIV policy;
– Call attention to new developments based on the analysis in coordination with the performing organizations, followed by the policy programme. This programme must be approved by the Policy Committee and Programme Committee on AIDS Research, by the AIDS Fund and the Ministry of Health;
– Based on the policy programme, organizations and projects can make a request for financial support by the AIDS Fund;
– Monitoring and evaluation; in this phase, the effects of AIDS policy are measured, the results providing the basis for policy analysis.

3.8. The National AIDS Campaign in Switzerland

François Wasserfallen, Federal Office of Public Health, Berne

Current epidemiological situation

A total of 4,756 cases of AIDS had been reported in Switzerland by 31 August 1995, of whom 3,504 (73.7%) had died. The following modes of transmission were reported for all the cases of AIDS recorded in Switzerland: 40% were men infected by homosexual or bisexual contacts, 38.7% were intravenous drug users infected through the use of contaminated syringes, 16% were the result of heterosexual contacts, and 1.9% were infected via blood transfusions or blood products. Children with AIDS who were infected with HIV by the mother during pregnancy and birth accounted for 1.6% of reported cases. The remaining 1.8% comprised cases with unknown mode of infection.
The following pattern emerges for the 716 cases reported exclusively during 1994: 35.6% homosexual or bisexual men, 40.1% intravenous drug users, 19% heterosexually infected, 1.8% recipients of blood transfusions or blood products, 0.8% children, and 2.7% with unknown sources of infection.

HIV-positive test results have been recorded anonymously since 1985, and the figures are based on laboratory reports (a total of 21,010 reports by 31. 8. 1995) and complementary reports submitted by doctors. Although double reporting for identified individuals can be ruled out, a considerable number of reports, particularly from the laboratories, probably relates to unidentified individuals undergoing two or more tests. Six anonymous HIV testing centres regularly forward their test figures.
The following pattern emerges for the 6,786 complementary reports of positive test results by doctors as of 31. 12. 94: 33% homosexual or bisexual men, 20.3% intravenous drug users and 41.1% heterosexually infected.

The Federal Office of Public Health (FOPH) estimates the number of people with HIV in Switzerland at 12,000 – 18,000, corresponding to an incidence of 0.4 – 0.8% of the overall population. This estimate has to take into account both multiple reporting and the possibility of a high number of undisclosed cases.

Structural framework for the AIDS prevention programme

Political structure

Under the Constitution of Switzerland, public health is a general responsibility of the cantons, while health insurance is a federal responsibility. However the two are closely

linked. The Constitution states that the cantons are sovereign whenever this is not limited by the Constitution; the Confederation is responsible for health insurance, as well as for fighting communicable diseases (such as AIDS), administering medical licensing examinations, and ensuring public safety against radiation and toxic substances. The cantons are re-sponsible for health services, preventive care, and public health regulations. Each canton therefore has his own health legislation. Municipalities are primarily responsible for services to the elderly, social assistance, and home care. Thus, the health care system is divided into different levels arranged vertically and linked to one another. It therefore makes it sometimes difficult to clearly define the responsibilities between the cantonal health administrations and the Federal Office of Public Health (FOPH).

Federal measures and responsibilities in the fight against the AIDS epidemic (executive body: FOPH) focus on five aspects:

1) Monitoring of the epidemic,
2) Information and prevention,
3) Training of staff (for optimizing counselling and care of people living with HIV/AIDS),
4) Coordination of research,
5) Coordination of evaluation.

The responsibilities are executed by several units within the FOPH.

Responsible institutions and organizations
Cantons, NGOs (Swiss AIDS Federation, AIDS Info Doc Switzerland, PWA Switzerland; Swiss AIDS Federation and PWA have a network of local agencies, working independently on a local level, in cooperation with the cantons).

Main conflict sources

- Federal structure: although a lot of prevention programmes have been launched on a national basis, differences between cantons remain for local interventions. These differences are mainly in controversal subjects, such as AIDS prevention for IVDUs (syringe exchange programme; low-threshold programmes: yes or no); AIDS prevention for homosexuals (outreach work); AIDS prevention in prisons (only two prisons in Switzerland distribute clean syringes for IVDU prisoners).
- On the national level, the main aims of the AIDS programme are well accepted. However, funding of the programme is still a critical issue in a period of economic recession.
- Some fundamentalist groups (mainly fundamentalist Christians) make loud criticism of the programme. They are not representative of the majority of the population, but very active.
- The federal drugs prevention measures raise more controversies than the AIDS prevention: roughly, we can say that rural cantons have a more conservative approach

than urban areas. Some orientation differences also exist between French and German-speaking parts of the country. These controversies have an influence on the AIDS discussion, as far as the discussion focuses on programmes for IVDUs.

International cooperation
In the field of mass media campaign, cooperation exist with the Netherlands, and with the "Europe against AIDS" project launched by Belgium. Furthermore, some programmes have been launched with swiss support in Eastern European countries. Scientific exchanges with European researchers, public health experts and epidemiologists are common.

Elements of the national AIDS prevention programme

The Swiss AIDS prevention programme: Three Main Goals

Goal I: Prevention of new infections
As there is still is no vaccine and only a few improvements in causal therapy, prevention by modification of behaviour is currently the only means of preventing further AIDS cases. Only through the repeated explanation of the modes of transmission and protective measures, a sufficient understanding of risk situations, and the motivation of every individual to show a sense of responsibility by practising protective behaviour the desired goal can be achieved.

Goal II: Reduction of negative effects of the epidemic
This demands:
- responsible behaviour by all individuals,
- reduction of morbidity and mortality,
- adequate care of infected persons with no symptoms,
- optimum medical care and nursing of the sick,
- psychosocial support and promotion of quality of life and
- reduction of socio-economic consequences.

Goal III: Promotion of solidarity
Solidarity assumes an understanding and respect for different standards and values. It contributes significantly to the promotion of confidence, reciprocal responsibility, and the quality of life of the sick person. Every individual, including the person concerned, must be appealed to with respect to his/her sense of responsibility towards others. Solidarity implies a mutual sense of responsibility and concern, and not merely the material care and integration of those who are already sick. The national authorities bear particular responsi-bility for a policy of integration and solidarity, especially for the creation of the necessary structural conditions (e.g. social security, labour law) for the promotion of solidarity.

Levels of intervention

The FOPH, together with the cantons, adopted a strategy to counter the spread of HIV infection, focusing on education and counselling. As a consequence, interventions are implemented at three levels:

- Level 1: general population
- Level 2: target groups
- Level 3: individuals

This three-level intervention model is designed to ensure that the risk awareness and the relevant modification of behaviour of every individual is promoted. Various interventions must be combined and introduced on all three levels to attain the primary target of HIV prevention in the long term.

Target Groups

Interventions aimed at motivating and modifying behaviour are based on widespread education through the media. All efforts are characterised by their adaptation to the particular features of the group in question. A target group is not defined by a specific risk, but by the need to use specific intervention means. The following target groups can be identified, although a certain amount of overlapping is possible within them:

Target groups defined by a higher probability of HIV infection
At the outset of the epidemic, attention was primarily devoted to the groups with high HIV prevalence. In Switzerland, this still includes homosexual men and intravenous drug users.

Target groups defined by ethnic or cultural characteristics
The justification for specific prevention programmes for groups of foreign nationals is not due to their particularly high-risk behaviour, but because of the need to pay special attention to their cultural, ethnic and linguistic differences. Specific prevention messages must be adopted for these groups. This helps to ensure that the messages are accepted and understood.

Persons in risk situations
Other groups have been identified, based on the following observation: depending on the social context, situations exist where the risk of HIV infection is underestimated, repressed or neglected. This observation applies, for example, to sexual behaviour when travelling and it concerns a large proportion of the population. The risk situation is also an important feature of work in connection with sex workers and intravenous drug users. One essential prerequisite for prevention is that risk situations are recognized as such.

The prevention messages are therefore set in contexts as close to the risk situation as possible, so that target groups can readily identify the situation.

Institutions with mediator functions for target groups
Training concepts for institutions and persons with mediator and multiplier functions can be included in target group prevention. The work environment, educational institutions or the military represent spheres which, by their institutionalized character, provide access to large segments of the population. Establishing the AIDS prevention programme within the frameworks of such institutions will ensure that the current issue is not seen as a permanent "special case", but as a more comprehensive, innovative concept of health education in the long term.

Changes in the national prevention strategy

No major changes have occurred since a first national concept for the control of AIDS was formulated and institutionalized in Switzerland in 1987. An updated version was published in 1993 (manual entitled HIV Prevention in Switzerland; Targets, strategies, interventions). The objective of this manual is to provide guidelines on the strategies, interventions and methods to be used to ensure that the AIDS prevention targets are achieved in the most effective manner possible. The AIDS prevention activities are continuously evaluated to ensure that the national concept takes newly gained experience into account. The concept will be evaluated and adapted as needed to meet new developments in the future.

Evaluation and Quality Assurance

Targets for Evaluation

The evaluation of the measures focuses on the following targets:

- To investigate patterns/processes relevant to implementation of the prevention strategy (process evaluation),
- To evaluate strategy development and make recommendations for possible adjustments (process evaluation),
- To measure the results of the prevention efforts, so as to be able to identify trends (effect evaluation),
- To examine organizational and management structures (structural evaluation). While close cooperation with those responsible for the prevention strategy is important, it is essential that the independence of the evaluation team be guaranteed and maintained.

Evaluation programme: The organization of the evaluation programme, coordination of the studies and summarizing of results have been undertaken by the Institute for Social and Preventive Medicine of the University of Lausanne since 1986. Lausanne delegates sub-projects to other institutes or independent researchers. The evaluation programme is based on an analysis model according to which the adoption and maintenance of protective behavioural practices depend on the following factors:

– learning processes generated by prevention measures,
– change in knowledge and attitudes,
– influence of the social environment.

The main aspects of the prevention processes and the results are examined by a series of complementary qualitative or quantitative studies. These are pieced together like a jigsaw puzzle then, and the resulting synthesis permits an overall evaluation of the strategy pursued. Summary reports are, according to the evaluation mandate, prepared at intervals of 12 to 24 months.

Results

(The following chapter consists of citations from Evaluation of the AIDS prevention strategy in Switzerland, see bibliography)

The main results revealed by the evaluation programme are as follow:

– Knowledge about protective measures against HIV transmission in the general population aged between 17 and 45: using condoms has been spontaneously mentioned by almost 90% of people since 1988; being faithful is spontaneously mentioned (1992) by 27% of people aged between 17–30 and 38% of people aged 30–45; at the same time, spontaneous mentions of forms of protection which show that the respondent's knowledge of AIDS is inaccurate (such as taking the HIV antibody test) are very low (1992: 2 to 3%).
– Use of condoms for protection against AIDS: while the indicator of potential exposure to a risk (the proportion of people with casual sexual partners during the preceding six months) has remained stable since 1987, systematic use of a condom for protection against the potential risk of infection with HIV in these situations has increased enormously: in the 17–30 age group, use has increased from 8% in 1987 to 61% in 1992; in the 31–45 age group the corresponding figures are 22% in 1989 and 52% in 1992. Between 1987 and 1992, there was an increase in the use of condoms with a new steady partner in both age groups. The 1992 figure is 66% in the 17–30 group and 68% in the 31–45 group, i. e. around the same level as with casual partners.
– Sexual behaviour: evaluation studies have shown that explicit prevention messages for the general population, encouraging condom use and sexual education in the schools have no unwanted side-effects, such as a greater sexual promiscuity; on the contrary, the trends in young people tend towards longer and faithful relationships.

– Prevalence of HIV tests: the 1992 survey (general population aged between 17–45; n=2,800) showed that the prevalence of the HIV antibody test is very high in Switzerland: 47% of the respondents have already had at least one test (test during blood donation: 24%; voluntary test: 17%; during blood donation and voluntary test: 6%).
– Behavioural change in homosexuals: a survey among homosexuals showed that AIDS had lead to dramatic changes in sexual behaviour: in 1992, 82% of the respondents (n=934) reported no unprotected anal sex with a partner whose HIV status was unknown. An HIV antibody test was reported by 72% of the sample.
– Drug users: several studies have shown that there has been a considerable decrease in syringe sharing in Switzerland. This is a general trend, though sharing is currently more common in the French-speaking area than in the German-speaking area. This could be because injection material is more difficult to obtain there, and because services supplying syringes were only introduced more recently. It would appear that sharing is more common among beginners or those who use drugs only occasionally (in less close contact with centers offering sterile equipment). Although there is evidence of progress in the use of condoms in this population group, preventing the sexual transmission of HIV remains a major problem among drug users, many of whom have relations with non-injecting partners. Changes in behaviour to date are insufficient, given the prevalence of HIV within this group. Sexual relations could therefore become the predominant mode of transmission among drug users, and the infection could be spread from them to other groups by the same means.
– Regular evaluation surveys also provide more information about the opinion of the Swiss population on certain controversial subjects, such as distribution of syringes for HIV prevention purposes. The survey carried out in 1989 found that the large majority (86%, n=703) is in favour of easy access to clean syringes for i.v. drug users.

WHO Evaluation

In 1992, a team from the World Health Organization, Regional Office for Europe, conducted an independent assessment of the management and impact of the ongoing programme on AIDS prevention. The report revealed the strategic qualities of the Swiss programme, and also pointed out the weaknesses. Furthermore, the evaluation report formulated some recommendations, which have been of great use for the further management of the programme.

Future

Measures

Having simultaneous interventions on three levels (information for the general population, target group programmes and counselling offers for individuals) has proven to be a successful strategy. Therefore, this model will continue to be followed in the coming

years. Thus, the balance between the three levels can be adapted to the current epidemiological situation.

The general population campaign makes it possible to raise awareness about the AIDS epidemic, and is the best instrument for promoting mutual solidarity between people with HIV/AIDS and the population. The campaign must go on, even in a somehow reduced form.

Target group prevention must be developed and, in order to be more successful, should also take into account the fundamental needs of the target groups, such as non-discrimination and social support.

The quality of the personal counselling must improve, not only in specific HIV counselling centres, but also by GPs and family planning centres.

Ensuring quality
The manual HIV Prevention in Switzerland; Targets, Strategies, Interventions; published in 1993, introduced management of AIDS prevention by quantitative and qualitative objectives. Experience showed that this sort of management, governed by precise and detailed objectives, is an essential instrument for permanently readjusting the programme, for motivating partners to take initiatives, and that it helps to assess the results. This instrument will be updated in 1998.

Strategies
The implemented strategy should go on and be improved, where and when necessary. Solidarity at different levels (between social groups and between people with HIV/AIDS) and the determined fight against HIV/AIDS-related discrimination will be a key to success for HIV prevention. On the management side, systematic evaluation of all measures taken should allow quality control and measurement of success.

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Appendix I

4.1. Scope and Purpose of the Expert Conference

Within the framework of the cooperation between the Federal Republic of Germany and the Regional Office for Europe of the World Health Organization (WHO/EURO), the Federal Centre for Health Education (FCHE), Cologne, a WHO Cooperation Centre for Health Education and Health Promotion, is holding an expert conference on the subject of "Quality Assurance in AIDS Prevention" from 13 to 15 November 1995 in Cologne.

Problem statement

Since the mid-1980s, most European countries have developed national programmes for AIDS prevention. The pressure of the alarming epidemiological prognoses necessitated fast, determined action.
Strategy differences became evident as a result of the evaluation of AIDS prevention in several countries, and within the frameworks of review studies (Brungs and Bengel, Choi and Coates, Moekerk, Wellings, among others). The success of AIDS prevention was equally revealed in this context.

Regardless of this, we must keep one thing in mind: new infections exist and a renewed increase in new infections is even being reported in some groups of people. The sustained establishment of national AIDS prevention thus becomes a primary challenge. At the same time, the economic climate in Europe often leads to an increasingly critical assessment of what is necessary in national programmes, and this also includes AIDS prevention.

Goals

The goal of the expert discussion is an exchange on
- the essential experiences gained in a decade of AIDS prevention,
- quality assurance concepts and activities of national AIDS prevention programmes,
- interventions, which can ensure the sustained effectiveness of AIDS prevention in future,
- taking into account cost-effectiveness considerations.

Structure and working method of the conference

Comparative country presentations on national AIDS prevention, their essential developmental steps and experiences make up the first part of the conference.

In the second part, the focal criteria of quality assurance and strategies of AIDS prevention programmes are to be reflected on and elaborated through the creative development of scenarios.

We will certainly not be able to find an optimum strategy for everyone, due to the different framework conditions and historical development of AIDS prevention in the participating countries. However, international meetings held in the past have given an impressive demonstration of how inspiring and supportive the exchange can be. This effect is to be intensified through the relatively small number of participants of this meeting and through the approach based on jointly developed scenarios.

4.2. Topics for the Country Papers

Essential framework conditions for AIDS prevention

a) What structural characteristics of the health system in your country have an important impact on AIDS prevention?
b) Who are the most important sponsors of AIDS prevention?
c) Are there any major lines of conflict which influence AIDS prevention?
d) Are there any joint projects with other countries?

The elements of national AIDS prevention

a) How would you describe national AIDS prevention in your country?
   - Goals
   - Target groups
   - Messages
   - Communication strategies (mass communication approaches, community-oriented approaches, counselling, exhibitions, etc.)

b) Have there been any major historical changes and, if so, for what reasons? (political priorities, financial support, evaluation results, external events, etc.)

Evaluation and quality assurance

a) What elements of national AIDS prevention are evaluated empirically and since when?
b) What are the main experiences derived from evaluation?
c) What further quality assurance considerations and activities have been standard practice to date, based on national AIDS prevention in your country? (cooperation with other countries, feedback from external experts, coordination talks with representatives of the target groups, etc.)

Future and prospective planning

a) Which concrete interventions or combinations of interventions do you feel are indispensable in future and in the long term?
b) What goals and quality requirements do you feel are essential in this context, and
c) What strategies should safeguard this?

4.3. Matrix: Extract from the Country Papers – introduction to discussion

	B (VL)	CH	D	EE	F	LT	LV	NL
Organization/ Coordination								
Centralisation increasing?	+	constant	constant	+	+	+		
Decentralisation increasing?		constant	constant	?+		+	+	
Integration of NGOs?		+	+	+	?+	+	+	+
Development of finances								
Governmental financing decreasing?	?	?	+	–	?–	?	+	?
Sponsoring?	?	?	–	+	?	?	+	+
Aims								
Prevention of infection	+	+	+	+	+	+	+	+
Solidarity with the affected?	+	+	+	?	?	+	?	+
Care?	+	+	?	?	+	?	?	+
Strategies								
Promotion of individual protective behaviour by motivation to condom use as a main strategy	?+	+	?+	+	+	?	+	+
AIDS integrated in sex education								+
AIDS integrated in STD education								+
Solidarity as infection prevention	?+	?+						?+

+ yes – no ? point to be discussed

	B (VL)	CH	D	EE	F	LT	LV	NL
Safer use promotion	+	+	+	?	+	?	?	+
Quality control of condoms?						+		
Quality control of blood conserves ?						+		
Evaluation of programmes								
Effect of single media/activities	+	+	+	?	+	?	?	+
Overall effects		+	+		+	+		+
Feedback on strategy development?								
Feedback on programme development?								
Means and methods been preferred in future								
1. General population								
a) New special target groups								
b) New strategies								
2. Target groups								
a) New special target groups								
b) New strategies								
3. Multipliers								
a) New special target groups								
b) New strategies								

+ yes – no ? point to be discussed

4.4. Programme of the Conference

"Quality Assurance in AIDS Prevention"

Date:	13 to 15 November 1995
Location:	Hotel Mondial, Cologne
Start:	Monday, 13 November 1995, 12.30 p.m.
End:	Wednesday, 15 November 1995, approx. 12.00 noon
Facilitator:	Hans Saan, Netherlands Institute for Health Promotion and Disease Prevention

MONDAY, 13. 11. 1995

Morning	Participants arrive/check in
12.30 p.m.	**Lunch**
2.00 p.m.	Plenary session: **Welcoming of the participants** **Opening address** Dr. Elisabeth Pott, FCHE Director **Welcome address of the Federal Ministry of Health** Dorle Miesala-Edel **Welcome address of the WHO/Regional Office for Europe** Dr. Johannes Hallauer **Information on the programme** Hans Saan
2.45 p.m.	**Country papers on national AIDS prevention strategies**
2.45 – 3.00 p.m.	Plenary session: **Explanation of the procedure** Hans Saan
3.00 – 4.00 p.m.	**Country presentations and interviews in the first group of countries**
4.00 – 4.30 p.m.	**Break**
4.30 – 5.30 p.m.	**Country presentations and interviews in the second group of countries**
5.30 – 6.00 p.m.	**Break**
6.00 – 7.00 p.m.	**Country presentations and interviews in the third group of countries**
7.00 p.m.	**Buffet**

TUESDAY, 14. 11. 1995

9.30 a.m.	Plenary session: **Visual summary of the most important results of the country papers** Dr. Dr. Wolfgang Müller, Jürgen Töppich, FCHE
10.00 – 10.15 a.m.	**Explanation of the goals of the target group-specific working groups** Hans Saan
10.15 – 12.30 p.m.	Working groups: **Listing of existing strategies for the respective target groups**
12.30 – 3.00 p.m.	**Lunch** and **opportunity to visit Cologne Cathedral**
3.00 – 4.00 p.m.	Working groups: **Assessment of the strategies according to aspects of quality**
4.00 – 4.30 p.m.	**Coffee break**
4.30 – 5.30 p.m.	Working groups: **Reasons for quality assessment**
5.30 – 6.00 p.m.	**Coffee break**
6.00 – 7.00 p.m.	Working groups: **Summary of the working group results**
7.00 p.m.	**Dinner**

WEDNESDAY, 15. 11. 1995

9.30 – 10.00 a.m.	Plenary session: **Working group reports**
10.00 – 10.30 a.m.	**Coffee break**
10.30 – 11.45 a.m.	Plenary assembley: **Ways of implementing the work results**
11.45 – 12.00 noon	**Closing address** Dr. Elisabeth Pott
12.00 noon	**Lunch** **Conclusion of conference**

4.5. Participants

Presentations

BELGIUM
Anne-Lies Vanmechelen
Flemish AIDS Coordination Centre
Marnixplaats 16/17
B – 2000 Antwerpen Fax: +32 3/2 48 42 90
Belgium Tel.: +32 3/2 38 68 68

ESTONIA
Dr. Ludmilla Priimägi
Institute of Preventive Medicine
Paldiski nmt 52 / 6 A Fax: +372 2/4 93-1 85
EE – 0006 Tallinn Tel.: +372 2/4 94-4 76
Republic of Estonia +372 2/4 92-2 45

FRANCE
Dr. Pierre-Christian Soccoja
Ministère de la Santé Publique
de l'Assurance Maladie
Division SIDA
1, Place Fontenoy Fax: +33 1/46 62 43 14
F – 75007 Paris Tel.: +33 1/46 62 44 21
France

GERMANY
Dr. Elisabeth Pott
Bundeszentrale für
gesundheitliche Aufklärung
Ostmerheimer Str. 220
D-51109 Köln Fax: +49 (0)2 21/89 92-300
Germany Tel.: +49 (0)2 21/89 92-0

LATVIA
Dr. Andris Ferdats
National AIDS Centre
7, Klijanu street
LV – 1012 Riga Fax: +371/7 33 90 06
Republic of Latvia Tel.: +371/2 37 82 78

LITHUANIA
Dr. Saulius Chaplinskas
AIDS Centre of Lithuania
Kairiukscio 2 Fax: +370 2/72 02 25
LT – 2021 Vilnius Tel.: +370 2/72 04 65
Republic of Lithuania +370 2/76 32 38

NETHERLANDS
Emma C. van Dongen
Stichting AIDS Fonds
Keizersgracht 390 – 392
NL – 1016 GB Amsterdam Fax: +31 20/6 27 52 21
The Netherlands Tel.: +31 20/6 26 26 69

SWITZERLAND
Dr. François Wasserfallen
Bundesamt für Gesundheitswesen
Sektion AIDS
Hess-Straße 27 e
CH – 3097 Bern-Liebefeld Fax: +41 31/3 23 87 89
Switzerland Tel.: +41 31/3 23 87 29

Experts/Observers

Dr. Claire Baron
European Public Health
Foundation
20, Queen Anne's Gate Fax: +44 1386 701 098
GB – London SW1H 9AA Tel.: +44 1386 700 225
United Kingdom +44 171 222 0905

Dr. Johannes Hallauer
Weltgesundheitsorganisation/
Regionalbüro für Europa
8, Scherfigsvej
DK – 2100 Copenhagen Fax: +45/39 17 18 75
Denmark Tel.: +45/39 17 12 73

Dr. Wolfgang Kröhn
Ministerium für Arbeit,
Soziales, Jugend und Gesundheit
des Landes Schleswig-Holstein
Adolf-Westphal-Straße 4
D – 24143 Kiel Fax: +49 (0)431/9 88-54 16
Germany Tel.: +49 (0)431/9 88-54 83

Dorle Miesala-Edel
Bundesministerium für Gesundheit
Postfach 17 02 08
D – 53108 Bonn Fax: +49 (0)228/9 41-49 32
Germany Tel.: +49 (0)228/9 41-32 10

Sigrid Reichert
Bundesministerium für Gesundheit
Postfach 17 02 08
D – 53108 Bonn Fax: +49 (0)228/9 41-49 32
Germany Tel.: +49 (0)228/9 41-0

Hans Saan
NIGZ Netherlands Institute
for Health Promotion and
Desease Prevention
P.O. Box 500
NL – 3440 AM Woerden Fax: +31 348/43 76 00
The Netherlands Tel.: +31 348/43 76 66

Dr. Elfriede Steffan
Sozialpädagogisches Institut (SPI)
– Forschung –
Stresemannstr. 30
D – 10963 Berlin Fax: +49 30/2 51 60 94
Germany Tel.: +49 30/25 38 93 11

Anne W. Bunde-Birouste
Union International de
Promotion de la Santé et
éducation pour la Santé
2, rue Auguste Comte
F – 92140 Vanves Fax: +33 1/46 45 00 45
France Tel.: +33 1/46 45 00 59

BZgA/FCHE

Gerhard Christiansen
Anne Hoffmann
Dr. Dr. Wolfgang Müller
Thomas Porschen
Helene Reemann
Jürgen Töppich
Günther Welsch

Fax: +49 (0)221/89 92-3 00
Tel.: +49 (0)221/89 92-0

Rapporteur

Thomas Hafer
Mauritiuswall 33
D – 50676 Köln
Germany

Tel.: +49 221 2402908

Interpreters

Jennifer Neuhann
Am Kreuz 17
D – 40489 Düsseldorf
Germany

Christa Gzil
Brausewindhang 78 B
D – 45359 Essen
Germany

5

Appendix II (German Version)

5.1. Einleitung

10 Jahre Aids-Prävention

Zehn Jahre Aids-Prävention in der Bundesrepublik Deutschland und in anderen europäischen Ländern haben gezeigt, daß eine breitangelegte Aufklärung mit massenmedialen, zielgruppenspezifischen und persönlichen Angeboten erfolgreich ist. Aids-Prävention – auch als internationale Gemeinschaftsaufgabe – hat dazu beigetragen, daß die HIV-Epidemie in Europa sehr weitgehend begrenzt werden konnte.

Wie die nationalen Koordinatoren der Aids-Präventionsprogramme aus Belgien, Estland, Frankreich, Lettland, Litauen, den Niederlanden und der Schweiz berichten, haben, beginnend etwa Mitte der 80er Jahre, nach und nach viele europäische Länder übergreifende nationale Programme entwickelt. Unter dem Druck alarmierender Voraussagen über die Weiterverbreitung der Krankheit wurde in der Regel rasch und entschlossen gehandelt.

Alle vertretenen Länder verfolgen mit sehr unterschiedlichem Kampagnenhintergrund bislang im wesentlichen die gleichen Ziele:

- Prävention von Neuinfektionen,
- Verhinderung der Diskriminierung Betroffener,
- Aufbau einer optimalen medizinischen und psychosozialen Beratung und Betreuung für infizierte und erkrankte Menschen.

Wirkungen der Aids-Prävention

Veränderungen des Schutzverhaltens, hoher Informationsstand der Allgemeinbevölkerung und ein vergleichsweise niedriger Stand der weiteren HIV-Ausbreitung sind Zeichen für den Erfolg dieser Bemühungen. Hier wurde in einem europäischen Vergleich deutlich, daß nur ein komplexes System intensiver Aufklärungsbemühungen, das sich an die Bevölkerung insgesamt und unterschiedliche Zielgruppen mit einer Vielfalt von Medien und Maßnahmen richtet, zu den genannten Erfolgen führt.

In Deutschland werden von der Bundeszentrale für gesundheitliche Aufklärung seit 1987 jährliche Repräsentativbefragungen in der Bevölkerung zu Wissen, Einstellungen und Verhalten zu Aids durchgeführt. Die aktuellen Ergebnisse dieser Untersuchung aus dem Jahre 1994 zeigen jedoch – vor dem Hintergrund geringer gewordener finanzieller Mittel – erstmals auch Anzeichen für rückläufige Tendenzen in der Reichweite präventiver Maßnahmen und im Schutzverhalten.

Sicherstellung wirkungsvoller Präventionsarbeit

Angesichts dieser Situation stellt sich die Frage: Wie können die Erfolge der Aids-Prävention auch in Zukunft gesichert bzw. weiter ausgebaut werden?

Der internationale Erfahrungsaustausch zeigte, daß trotz der für jedes Land spezifischen Rahmenbedingungen in allen Ländern folgende Elemente unverrückbare Bestandteile einer wirkungsvollen Präventionsarbeit sein müssen:

- Ein breites Angebot von Aufklärungsmaßnahmen für die gesamte Bevölkerung muß die Grundlage für zielgruppenbezogene Medien und Beratungsangebote bilden.
- Die Entwicklung von Präventionsstrategien sollte in Zukunft noch stärker als bisher auf wissenschaftlicher Grundlage erfolgen, weniger auf der Basis von Meinungen und eingefahrenen Denkgewohnheiten.
- Die Arbeit muß kontinuierlich fortgesetzt werden, da es sich um langfristige soziale Lernprozesse in sehr intimen, komplex interagierenden Persönlichkeitsbereichen handelt.
- Ständige wissenschaftliche Überprüfung der Präventionskampagne eines Landes und Berücksichtigung der Ergebnisse bei der Weiterentwicklung der Arbeit.
- Enge Zusammenarbeit von staatlichen und nichtstaatlichen Stellen und Konsens aller wichtigen gesellschaftlichen Gruppen über die Inhalte und Ziele der Prävention sind erforderlich.

5.2. Ziele und Ergebnisse der Expertentagung

Die Bundeszentrale für gesundheitliche Aufklärung (BZgA), Köln, veranstaltete vom 13. bis 15. November 1995 zusammen mit der Weltgesundheitsorganisation, Regionalbüro für Europa (WHO/EURO), Kopenhagen, eine internationale Expertentagung zum Thema „Qualitätssicherung in der Aids-Prävention".

5.2.1. Hintergrund und Ziele der Veranstaltung

Zehn Jahre Aids-Prävention und aktuelle epidemiologische Situation

Seit Mitte der 80er Jahre entwickelten die meisten europäischen Länder Programme der Aids-Prävention. Durch unterschiedliche Rahmenbedingungen bildeten sich z.T. Unterschiede in der Struktur und Strategie der einzelnen nationalen Programme heraus. Gleichwohl hat die Aids-Prävention in allen Ländern Europas im wesentlichen die gleichen Ziele:

- Verhinderung von Neuinfektionen,
- Verhinderung von Diskriminierung der Kranken und Infizierten,
- Aufbau von Systemen der psychosozialen wie medizinischen Versorgung Betroffener.

Als Ergebnis dieser Präventionsprogramme sind heute eindeutige Erfolge festzustellen. Ein hoher Informationsstand in der Allgemeinbevölkerung und in den Hauptbetroffenengruppen sowie Veränderungen im Schutzverhalten trugen zu einem im Vergleich zu anderen Kontinenten relativ niedrigen Stand der Ausbreitung von HIV und Aids bei.

Allerdings macht die epidemiologische Situation von HIV in Europa deutlich, daß Aids trotz eindeutiger Erfolge der bestehenden Präventionsprogramme weiterhin eines der dringendsten Probleme der Gesundheitspolitik bleibt. Nach Informationen der WHO werden täglich in Europa 2.000 HIV-Infektionen und 70 Aids-Erkrankungen neu diagnostiziert (Dr. J. Hallauer, WHO/EURO 1995). Allgemein ist eine Zunahme der Fälle durch heterosexuelle Übertragung zu beobachten. Auffallend ist der Anstieg der Neuinfektionen durch Gebrauch intravenöser (i.v.) Drogen z.B. in südwestlichen Regionen wie Spanien, Frankreich und Italien sowie ein rasanter Anstieg des i.v. Drogengebrauchs in Osteuropa. Auf ein großes und wachsendes Potential zukünftiger Infektionen verweist ein ebenfalls deutlicher Anstieg der Fallzahlen sexuell übertragbarer Krankheiten in Osteuropa, die

seit 1988 etwa das Zehnfache des davor Üblichen erreichen. Durch die gewachsene Mobilität innerhalb Europas entstehen weitere Infektionsgefahren, was die Notwendigkeit weiterer Prävention unterstreicht.
Die dauerhafte Implementation nationaler und internationaler Aids-Prävention wird zu einer zentralen Herausforderung, um neben menschlichem Leid zunehmende finanzielle Belastungen zu verhindern.

Knapper werdende Ressourcen

Angesichts der wirtschaftlichen und finanziellen Situation in Europa stehen die Leistungen von Gesundheitsförderungs-Programmen insgesamt auf dem Prüfstand, und damit auch die Aids-Prävention.
Fragen nach der Effektivität, Effizienz und Qualitätssicherung treten in den Mittelpunkt der Betrachtung und Bewertung. Eine kritische Diskussion der Erfahrungen aus einer Dekade Aids-Prävention ist für die Bewertung und Planung zukünftiger Programme eine entscheidende Basis.

Trotz der z.T. unterschiedlichen Rahmenbedingungen, Entwicklungen und Erfahrungen ist es wichtig, diese Reflexion auch auf internationaler Ebene zu führen, um die vielfältigen Erfahrungen zu nutzen und zu prüfen, welche Präventionsstrategien sich bewährt haben und auch zukünftig tragfähig sein können.

Ziele der Veranstaltung

Ziel der Tagung war eine Bestandsaufnahme europäischer Aids-Prävention. Sie orientierte sich an den Leitfragen:

- Was wurde vor welchem nationalen Hintergrund gemacht?
- Was wurde wie evaluiert?
- Was hat sich in den unterschiedlichen nationalen Programmen bewährt?
- Was hat sich als veränderungsbedürftig erwiesen?

Darauf aufbauend sollten allgemeine Empfehlungen zu wesentlichen Bestandteilen und Aspekten des Qualitätsmanagements zukünftiger Aids-Prävention erarbeitet werden.

Die Teilnehmer

Entsprechend der Zielsetzung setzte sich der Teilnehmerkreis aus 26 Personen zusammen, die in der nationalen Aids-Prävention des jeweiligen Landes an der Konzipierung, Steuerung und Weiterentwicklung der Aids-Präventionsprogramme entscheidend betei-

ligt sind und autorisiert waren, das nationale Programm zur Aids-Prävention offiziell zu vertreten. Die begrenzte Teilnehmerzahl sollte ein besonders intensives und ergebnisorientiertes Arbeiten ermöglichen.
Es nahmen Experten aus europäischen Ländern mit vergleichbarer epidemiologischer Situation und ähnlicher Geschichte der Aids-Prävention teil: Belgien, Frankreich, Deutschland, Niederlande, Schweiz. Darüber hinaus waren Teilnehmer aus Estland, Lettland und Litauen vertreten, deren Präventionsprogramme sich im Aufbau befinden.

5.2.2. Konzept und Verlauf der Veranstaltung

Die Tagung begann mit Grußworten der Bundeszentrale für gesundheitliche Aufklärung (Dr. Elisabeth Pott), des Bundesministeriums für Gesundheit (Dorle Miesala-Edel) und der Weltgesundheitsorganisation/Regionalbüro für Europa (Dr. Johannes Hallauer) sowie einer inhaltlichen Einführung durch den Moderator (Hans Saan, NIGZ), der Konzept und Struktur der Tagung vorstellte.
Um jedem Teilnehmer die Möglichkeit zu geben, die Aids-Prävention seines Landes ausführlich vorzustellen und gleichzeitig genügend Zeit für gemeinsame Analyse und Diskussion bereitzustellen, war folgendes Vorgehen gewählt worden:

- Im Vorfeld der Tagung wurden die Teilnehmer gebeten, ihr nationales Aids-Präventionsprogramm entlang einheitlicher Fragestellungen (s. Kap. 5.5.) zu beschreiben.
- Eine Arbeitsgruppe der Bundeszentrale wertete die eingereichten Länderberichte aus und faßte die Ergebnisse in einer Matrix zusammen (s. Kap. 4.3.). Ziel der Auswertung war es, einen ersten Überblick über Gemeinsamkeiten und Unterschiede nationaler Aids-Präventionsstrategien zu gewinnen und offene Fragen zu identifizieren. Diese Auswertung stand den Teilnehmern zur Verfügung und konnte im Verlauf der Tagung ergänzt bzw. modifiziert werden.
  Die durch diese Auswertung sichtbar gewordenen offenen Fragen und erkennbaren Schwerpunkte bildeten die Grundlage für eine Befragung der Experten durch den Moderator, die am Anfang der Tagung stand und – in Kombination mit Kurzvorträgen – den fachlichen Input lieferte.
- Auf dieser Basis wurden am folgenden Tag in zwei Arbeitsgruppen Qualitätsanforderungen an ein „optimales“ Präventionsprogramm zusammengetragen. Ziel war es, diejenigen Elemente zu benennen, die sich im Rahmen nationaler Programme bewährt haben und deshalb Bestandteil zukünftiger Prävention sein sollten.

  Dabei wurden in jeweils einer Arbeitsgruppe
  - Präventionsangebote für Jugendliche, die Allgemeinbevölkerung und
  - Präventionsangebote für Hauptbetroffenengruppen in den Mittelpunkt gestellt.

– Der dritte Tag diente der Vorstellung und Diskussion der Arbeitsgruppenergebnisse im Plenum.
  Eine kleine Ausstellung von Konzepten und Medien aus den verschiedenen Aids-Präventionsprogrammen bot Gelegenheit, Eindrücke aus den beteiligten Ländern zu vertiefen.

Im folgenden sind die gemeinsam erarbeiteten Schlußfolgerungen der Tagung thematisch gegliedert zusammengefaßt.
Wichtig ist zu betonen, daß diese Empfehlungen und die damit – implizit oder explizit – formulierten Qualitätsmerkmale der Aids-Prävention durch jahrelange Erfahrungen der an nationaler Stelle Verantwortung tragenden Experten und/oder durch Forschungsdaten gestützt sind und damit als valide Basis zukünftiger Programme dienen können.

5.2.3. Aspekte der Qualitätssicherung – Ergebnisse und Schlussfolgerungen

Grundelemente der Aids-Prävention

Folgende Grundelemente werden übereinstimmend als notwendig für eine wirksame, rational begründbare Aids-Prävention identifiziert:

Lebensweisenakzeptanz und Eigenverantwortlichkeit als Prinzipien
Als Prinzip für wirksame Aids-Prävention wurde auf der Tagung übereinstimmend die Akzeptanz von Lebensweisen formuliert, oder wie es eine Teilnehmerin beschrieb: „Stelle sicher, daß du Menschen am Leben erhältst, so wie sie selber es wollen, und nicht, daß sie so leben, wie du es willst." Analog zum Lebensweisenkonzept der WHO ist zu empfehlen, spezifische und akzeptierende Angebote für unterschiedliche Zielgruppen wie Homosexuelle, Konsumenten intravenöser Drogen, Prostituierte usw. zu machen.

Dieses – wie auch das Prinzip der Eigenverantwortlichkeit – ist zentrale Voraussetzung für eine effektive Aids-Prävention.

Gesellschaftlicher Konsens zu Zielen und Botschaften
Von besonderer Wichtigkeit für die langfristige Wirkung und Effizienz der Präventionsarbeit in einem Lande ist das Erreichen eines gesellschaftlichen Konsenses über Prinzipien und die daraus folgenden grundsätzlichen Ziele und Botschaften der Prävention. Es sollte z.B. versucht werden, gesellschaftliche Einigkeit darüber herzustellen, daß die Forderung nach staatlichen Zwangsmaßnahmen (im Vergleich zu einer Strategie der Eigenverantwortlichkeit) ineffektiv ist. Es ist wichtig, insbesondere in der Anfangsphase auszuhan-

deln, wie das präventionsnotwendige Thema „Kondome“ angesprochen werden kann, und es ist darauf zu achten, daß die aktuelle Gesetzgebung mit der lebensstilakzeptierenden und auf Eigenverantwortlichkeit setzenden Präventionsarbeit soweit wie möglich kompatibel ist.

Vermeidung von Ängstigungs-Strategien
Aids-Aufklärungsstrategien, die mit den Mitteln der Angsterzeugung (Furchtappellen und Schock) arbeiten, wirkt nicht in der gewünschten präventiven Weise. Effektiver sind sachliche Informationen zu den Gefahren bei gleichzeitigem Aufzeigen von Schutzmöglichkeiten.

HIV-Test ist kein Präventions-Instrument
Der HIV-Antikörper-Test an sich ist kein Instrument der Prävention. Den Test ohne Einverständnis der zu testenden Personen und ohne Beratungsangebot durchzuführen ist als Kunstfehler der Prävention zu werten.

Berücksichtigung anderer sexuell übertragbarer Krankheiten sowie mit HIV-Infektionen zusammenhängender Gesundheitsrisiken und Krankheiten
An den sexuellen Übertragungsweg bei Konsumenten intravenöser Drogen sollte ebenso gedacht werden wie an die Gefahr der Übertragung anderer STDs sowie an mögliche Mischungen verschiedener Risiken (wie ungeschützter Sex, Alkohol und andere Rauschdrogen).

Breite Anlage und Kohärenz

Kohärenz der Ziele und Botschaften
Ein nationales Programm der Aids-Prävention sollte zugleich umfassend und differenziert angelegt sein. Unverzichtbar sind präventive Maßnahmen und Angebote

- für die Allgemeinbevölkerung,
- für die Zielgruppen und
- zur individuellen Beratung und Kommunikation.

Angebote für die Allgemeinbevölkerung können TV-Spots, Broschüren, Plakate, Anzeigenschaltungen etc. umfassen. Zentrale Telefonberatungen (Hotlines) sowie lokale Beratungsangebote existieren in vielen europäischen Ländern.

Die verschiedenen Angebote sollten jedoch ein zusammenhängendes Ganzes bilden und untereinander erkennbar und nachprüfbar dieselbe Philosophie und dieselben Botschaften vertreten.
Massenmediale Kampagnen müssen dabei auf dem Konsens zwischen den Hauptakteuren einer Gesellschaft aufbauen (z.B. Politik, Wissenschaft, Kirche, Selbsthilfe), in massen-

mediale Maßnahmen sollten alle Zielgruppen (implizit oder explizit) einbezogen werden (Inklusionsstrategie).

Spezielle Zielgruppenansprache
Zielgruppen lassen sich über Risiken und/oder über die Erreichbarkeit durch spezielle Kommunikationswege definieren. So steht die Aids-Prävention ständig vor der Notwendigkeit, adäquate Zugänge zu den Zielgruppen zu finden. Z.B. reagieren jüngere und ältere Jugendliche unterschiedlich auf Interventionen und müssen daher mit unterschiedlichen Interventionen erreicht werden. Ein weiteres Beispiel sind die verschiedenen und sich schnell verändernden Jugendszenen wie Techno, Punk, Scater usw. Aufgrund der steigenden Neuinfektionsraten müssen im Rahmen der Präventionsprogramme Frauen gezielt und verstärkt angesprochen werden.

Über Zielgruppenbefragungen hinaus ist es empfehlenswert, bei der Konzeption von Angeboten Zielgruppenmitglieder von Anfang an zu beteiligen. So können spezielle interne Kenntnisse bzgl. der Sprache, des Bedarfs oder besonderer Empfindlichkeiten genutzt und die Akzeptanz der Angebote erheblich gesteigert werden.

Über spezielle Risiken definierte Zielgruppen der Aids-Prävention sind vor allem die sogenannten Hauptbetroffenengruppen:

Hauptbetroffenengruppen von HIV
- Männer, die mit Männern Sex haben: Homosexuelle, Bisexuelle, männliche Prostituierte sowie Männer, die sich als Heterosexuelle begreifen, aber gelegentlich Sex mit Männern haben.
- Konsumenten von intravenösen Drogen, darunter Männer und Frauen, Homo-, Bi- und Heterosexuelle.
- Menschen aus Regionen mit hoher HIV-Verbreitung (z.B. Zentralafrika), darunter alle sexuellen Gruppen, überwiegend jedoch Heterosexuelle. In manchen Ländern werden auch andere Gruppen speziell berücksichtigt. In Litauen z.B. sind das Seeleute und Menschen mit anderen sexuell übertragbaren Krankheiten.

Kommunikative Erreichbarkeit von Männern mit gleichgeschlechtlichen Aktivitäten ohne homosexuelle Identität
Gerade die kommunikative Erreichbarkeit von Männern mit gleichgeschlechtlichen Aktivitäten ohne homosexuelle Identität gilt als eine der wesentlichen Lernerfahrungen aus den vergangenen Jahren. Es wird empfohlen, sie über massenmediale Kampagnen zu erreichen, da diese Männer nur von allgemeinen Medien für ein männliches Publikum erreicht werden. Eine Zielgruppenstrategie, die sich ausschließlich auf diese Gruppe bezieht, scheitert an der Identifizierbarkeit der Zielpersonen. Erfolgreiche Beispiele von Plakaten, deren visuelle Aussage Sex von Männern sowohl mit Frauen als auch mit Männern einschließt, wurden diskutiert. Vortests von Plakaten oder Anzeigen in diesem Bereich sind sinnvoll.

Kontinuität und Konzentration

Kontinuierliche Information

Für den Ausbau und die Aufrechterhaltung von Präventionswirkungen bedarf es der Kontinuität von spezifischen Informations- und Präventionsangeboten und der Präsenz des Themas Aids in den allgemeinen Massenmedien. Ein kontinuierliches „Hintergrundrauschen" von einfachen und grundlegenden Informationen zu Aids verhindert Vergessenseffekte. Erfahrungen und Evaluationsergebnisse zeigen, daß ein Rückgang dieses „Grundrauschens" unmittelbar zu einem Rückgang der allgemeinen gesellschaftlichen Aufmerksamkeit und mittelbar des Schutzverhaltens führen kann.

Kontinuierliche Strukturen

Die gleiche Forderung nach Kontinuität ist an die Strukturen der Aids-Arbeit zu richten. Hier ist an Institutionen der Beratung, der Testdurchführung, der psychosozialen, pflegerischen und medizinischen Betreuung sowie selbstverständlich an die verschiedenen Elemente von Präventionsarbeit zu denken. Einmal aufgebaute und von den Menschen angenommene Einrichtungen dürfen in Zeiten zurückgehender Ressourcen nicht leichtfertig aufgelöst werden.

Dies ist beim Aufbau von Strukturen von vornherein zu beachten. Die kontinuierliche Erhaltung solcher Strukturen ist in jedem Fall kostengünstiger als ggf. ein notwendiger Wiederaufbau. Zur Strukturqualität gehört auch die Qualifikation der Präventionskräfte.

Konzentration auf wesentliche Inhalte und Botschaften

Für den größtmöglichen Erfolg der Präventionsarbeit ist eine Konzentration auf zentrale Aspekte notwendig. Sowohl in Print- und AV-Medien als auch in Veranstaltungen und persönlichen Gesprächen ist eine pointierte Hervorhebung des wirklich für den persönlichen Schutz Wichtigen und Relevanten besser als eine umfassende Thematisierung einer Vielzahl von z.T. randständigen Aspekten des Themas. Texte, die allein vom ersten äußeren Eindruck her zu lang und ausführlich wirken, werden erfahrungsgemäß kaum gelesen. 100%ige Vollständigkeit kann nicht nur nicht gelingen, sie würde auch die real möglichen Effekte von Prävention stören.

Koordination

Systematische Koordination als Fundament des gesamten nationalen Programms

Die Koordination der verschiedenen Elemente eines nationalen Aids-Präventionsprogramms ist einer der wichtigsten Aspekte überhaupt. Die Klarheit der Strukturen, der Steuerungs- und Kommunikationsmechanismen ist das eigentliche Fundament, auf dem das Gebäude einer differenzierten Kampagne aufgebaut werden kann. Ohne ein solches Fundament ist ein effektives, in sich zusammenhängendes und in seinen Botschaften und seiner Philosophie kohärentes System von Präventionsangeboten nicht zu realisie-

ren. Und schließlich kann eine Kampagne Stabilität, Kontinuität und damit Wirksamkeit auch bei veränderten Bedingungen und bei Rückgang der finanziellen Mittel auf einer solchen Grundlage am besten bewahren.

Unterschiedliche Lösungen in verschiedenen europäischen Ländern
Die auf der Tagung vertretenen Länder haben z.T. recht unterschiedliche Lösungen für dieses Problem gefunden, die in ihren Vor- und Nachteilen diskutiert wurden.
Während in der Schweiz und in Deutschland eine langfristig eher konstante Konstruktion zu beobachten ist, finden in anderen Ländern Veränderungsprozesse statt. In Frankreich, das lange Zeit durch einen deutlichen Zentralismus gekennzeichnet war, hat das Prinzip der Dezentralisierung derzeit allgemein in der Politik einen hohen Stellenwert. In der Aids-Politik heißt das, daß künftig von seiten des Gesundheitsministeriums an die Departement-Regierungen jährliche Budgets gezahlt werden sollen, die diese selbständig in eigenen Aktivitäten und durch Vergabe an freie Träger verwenden. Aufgabe des Ministeriums bleibt damit die Steuerung der übergeordneten Gesamtstrategie und der Forschung.

Eine ähnlich gerichtete Politik zeigt sich in den Niederlanden. Auch hier ist man bemüht, die lokale Ebene im Bereich der präventiven Praxis und damit der Mittelverwendung mit eigenständigen Kompetenzen auszustatten und der nationalen Ebene eher eine ergänzende und unterstützende Rolle zu geben. Andererseits zeigt sich gerade in den Niederlanden gleichzeitig eine Tendenz der Zentralisation auf nationaler Ebene im Bereich der Strategienentwicklung und Evaluation.
Dem liegt die Einsicht zugrunde, daß sogenannte „Umbrella-Organisationen“ von großer Bedeutung für dezentral und zielgruppenbezogen arbeitende Organisationen sind. Sie bieten letzteren wissenschaftliche Kenntnisse und insbesondere Anleitungen und Hilfestellungen für die Praxis an (z.B. Fortbildung).

Die niederländische Gesundheitsministerin hat die zentrale steuernde Verantwortung auf den AIDS-Fund als nichtstaatliche Organisation übertragen. Hier sind unter einem Dach Strategie, Mittelakquisition (auch Fundraising s.u.), Mittelverteilung und Forschung vereint. Die Ministerin bleibt letztlich allerdings trotzdem in der Verantwortung für die nationale AIDS-Prävention, indem sie das Programm des AIDS-Fund jährlich prüft.

In Belgien besteht in gewisser Weise eine entgegengesetzte Situation wie in Frankreich. Hier sind die Kompetenzen in der Politik und gerade auch in der Gesundheitspolitik uneinheitlich und dezentral weitgehend eigenständig verteilt. Während Fragen der medizinischen Versorgung Kranker in staatliche Zuständigkeit fallen, liegen die Aktivitäten der Prävention in regionaler Kompetenz. Aus Gründen der Effektivität ist man hier in besonderer Weise bemüht, im Bereich der Strategie eine gemeinsame Linie zu erreichen. In Flandern beispielsweise ist das zentrale koordinierende Instrument ein regelmäßiger Projektbericht. Jede Institution, die öffentliche Mittel erhält, muß alle sechs Monate einen ausführlichen Bericht vorlegen, in dem die Aktivitäten, Strategien und Methoden, die feststellbaren Ergebnisse, Kontakte mit kooperierenden Institutionen und mit den Ziel-

gruppen, vor allem aber auftretende Probleme und Lösungsmöglichkeiten dargestellt werden. Erst die Vorlage und Akzeptanz dieses Berichtes ermöglicht die Vergabe weiterer Mittel. Andere spezielle Wege sind den Länderberichten (Country Papers) in diesem Band zu entnehmen.

Allgemein gilt die Erkenntnis, daß
- man die Aufgaben der nationalen, regionalen und lokalen Ebene in ihrer Unterschiedlichkeit sehen und kooperativ (aber eindeutig!) klären sollte, statt Kompetenzen gegeneinander auszuspielen,
- Netzwerke kooperierender Institutionen und Personen von großer Bedeutung sind, und
- Strukturen, die nicht schnell verändert werden können, akzeptiert werden sollten, um das Beste aus ihnen zu machen.

Zentrale koordinierende Institution
Die Aufgabe einer zentralen Präventions-Institution muß vor allem die Koordinierung der im engeren Sinne an einer Kampagne Beteiligten und der Kampagnen-Maßnahmen sein. Sie lädt z.B. zu Arbeitskreisen und gegenseitigen Konsultationen ein. Sie stimuliert, unterstützt und kontrolliert aber auch. Sie ist verantwortlich für die kohärente, wissenschaftlich begründete und stetig überprüfte und optimierte Gesamtstrategie und Konzeption der Kampagne. Ihre Aufgabe ist zudem, die über die Zuteilung der öffentlichen Mittel entscheidenden Politiker optimal zu informieren und präventionspolitische Entscheidungen vorzubereiten. Um ihrer Aufgabe gerecht zu werden, benötigt sie die Akzeptanz der Beteiligten, die sie sich durch fachliche Kompetenz zu erwerben hat.

Einbindung anderer präventiv tätiger Institutionen und Personen
Kooperationspartner zu gewinnen und sie in einen Gesamt-Koordinierungsprozeß einzubeziehen, ist eine weitere wichtige Aufgabe.
Mögliche Kooperationspartner (Individuen und Organisationen), die als Mediatoren/Multiplikatoren und Verbündete agieren könnten, sollen adäquat ausgewählt und in angemessener Weise eingebunden werden. Ihre Handlungsmöglichkeiten sowie ihre Bedürfnisse und Erwartungen müssen fair und offen abgeklärt werden. Die gegenseitige Zufriedenheit in der Zusammenarbeit ist wesentlich.

Eine Beispielliste möglicher Kooperationspartner ist von einer der Arbeitsgruppen erstellt worden: Journalisten, Künstler, Elternverbände, Sexualberatungsstellen, Jugendgruppen, Sportorganisationen, Verbände der Zielgruppen, Jugendarbeiter, Hotels, Restaurants, Clubs, Bars, Cafés, Apotheken, Flughäfen, Bahnhöfe, U-Bahn-Stationen, Tankstellen, kirchliche Gruppen usw.

Training
Die professionellen Kooperationspartner müssen auf ihre Rolle und für ihre Aufgabe im Kampf gegen Aids gut vorbereitet sein. Dazu bedarf es u.a. auch entsprechender Trainings- bzw. Ausbildungsinhalte für Studierende der betreffenden Berufsgruppen wie Psy-

chologen, Pädagogen, Sozialarbeiter usw. sowie ständiger Fortbildung der bereits professionell in der Prävention Tätigen.

Kooperation mit Journalisten
Einen auf der Tagung diskutierten Sonderfall stellt die Kooperation mit Journalisten dar. Falsche Informationen, Skandalisierung wie Bagatellisierung gehören zu den schlechten Erfahrungen, die aus vielen Ländern zu berichten sind. Auf der anderen Seite haben Präventions-Institutionen fast aller Länder auch sehr gute Erfahrungen gemacht. Estland beispielsweise konnte von der kostenlosen Veröffentlichung von mehr als 4.000 informativen Zeitungsartikeln zum Thema Aids in den vergangenen Jahren berichten. Voraussetzungen für eine gute Zusammenarbeit sind Fairneß und ein klares Aushandeln der gegenseitigen Interessen. Die beteiligten Präventions-Institutionen sollten dabei bedenken, daß es nicht die Aufgabe und das primäre Interesse von Journalisten ist, Aids-Prävention zu betreiben. Journalistenseminare zur ausführlichen Information über korrekte Inhalte und Strategien der Aids-Aufklärung können die Kooperation fördern.

Grenzüberschreitende Kooperation
Im Bereich der Präventionsangebote für Migranten ist internationale Kooperation notwendig. Arbeitstreffen zum Austausch von Erfahrungen, Strategien und Problemen wie auch zur Entwicklung gemeinsamer und grenzüberschreitender Projekte sind wichtig. Beispiele sind Präventionsprojekte in grenznahen Regionen wie z.B. an der deutsch-tschechischen und der deutsch-polnischen Grenze.

Koordinierung von staatlichen und nichtstaatlichen Organisationen: „Integrierte Separation“
Ausführlich ist auf der Tagung die Koordinierung von staatlichen (Governmental Organisations, GO) und nichtstaatlichen Organisationen (Non-Governmental Organisations, NGO) diskutiert worden. Am Beispiel der unterschiedlichen Konstruktionen in Deutschland und Frankreich wurden mögliche Wege deutlich.

In Deutschland besteht seit Mitte der achtziger Jahre eine offizielle Vereinbarung zwischen der Bundeszentrale für gesundheitliche Aufklärung (BZgA) als GO und der Deutschen Aids-Hilfe (DAH) als NGO bezüglich der Aufgabenteilung und Mittelvergabe. Die BZgA führt Aids-Prävention für die Allgemeinbevölkerung durch, während sie die Präventionsarbeit für die Hauptbetroffenengruppen, also vor allem Homosexuelle und Fixer, an die DAH delegiert und diese dafür mit den nötigen Mitteln unterstützt. 90 % ihrer Mittel erhält die DAH-Bundesgeschäftsstelle auf diese Weise über die BZgA aus Regierungsmitteln. Es ist allerdings zu berücksichtigen, daß auch in Deutschland private Spenden und Sponsoring im Bereich der beiden Aids-Stiftungen bundesweit und im Bereich der lokalen Aids-Hilfe-Organisationen eine erhebliche Rolle spielen.

Über die Zuteilung der Mittel hat die BZgA auf der einen Seite Einfluß auf die Arbeit der DAH. Auf der anderen Seite wird der DAH grundsätzlich konzeptionelle, präventionsstra-

tegische Eigenständigkeit zugestanden. Diese ist schließlich die Grundlage für ihre Akzeptanz bei den Zielgruppen. Schwule und Fixer können die DAH als eine ihre Interessen vertretende Institution erleben, die selbsthilfeorientiert und solidarisch mit ihnen arbeitet. Ein wesentlicher Effekt dieser geregelten Kooperation ist ein im allgemeinen kooperatives und akzeptierendes Auftreten der beiden Organisationen in der öffentlichen Diskussion.

In Frankreich existiert auf nationaler Ebene zwischen der Division Sida, Direction Générale de la Santé als GO und Aides als NGO kein solcher offizieller Kontrakt. Das Ministerium konsultiert jedoch freiwillig Mitarbeiter von Aides z.B. bei der Entwicklung von Materialien für Schwule. An einigen Stellen kommt es zu heftiger öffentlicher Kritik von Aides an der Aids-Arbeit des Ministeriums. Allerdings ist zu berücksichtigen, daß die Integration von GO und NGO auf der Ebene der Departements recht gut gelingt. Auch die Mittelvergabe ist anders geregelt. Höchstens 49 % seiner Gesamtmittel darf Aides aus öffentlichen Mitteln erhalten. Das macht es notwendig, in erheblichem Umfang Spendemittel zu akquirieren. Die Fundraising-Aktivitäten von Aides verdeutlichen und fördern auf der einen Seite die Verantwortung von Gesellschaft und Wirtschaft für die sozialen Folgen von Aids. Andererseits erschwert das System natürlich die Möglichkeiten regelmäßiger Arbeit.

Mit dem solche sehr unterschiedlichen Prozesse beschreibenden Kernbegriff „Integrierte Separation“ wurde eine übergreifende Formulierung des Ziels der GO-/NGO-Koordinierung gefunden. Diese ist sicher nur im jeweiligen landesspezifischen Stil möglich.

Wissenschaftliche Begleitung als Element einer Qualitätssicherung

Maßnahmen des Qualitätsmanagements sollten von Anfang an integraler Bestandteil der Strategie sein. Dabei kommt wissenschaftlichen Untersuchungen eine wichtige Rolle zu. Die folgenden Anforderungen an ein System der wissenschaftlichen Qualitätssicherung in der Aids-Prävention wurden in einer Arbeitsgruppe zusammengetragen:

Epidemiologische Überblicksstudien als Ausgangspunkt und Steuerungshilfe

Eine wichtige Grundlage von Konzeptionen sollten epidemiologische Überblicksstudien bzgl. HIV und Geschlechtskrankheiten des betreffenden Landes sein. Sehr wichtig ist zudem, bereits im Vorfeld tatsächlich sichtbar werdender Infektionsfälle potentiell riskante Verhaltensweisen zu beobachten (z.B. KAB-Surveys), um rechtzeitig präventiv tätig werden zu können.

Evaluationen als Steuerungshilfe

Grundsätzlich sollten alle präventionsstrategischen Empfehlungen auf der Grundlage empirischer Daten erfolgen.

Während in den frühen Phasen der HIV-Prävention weltweit Intuition und normative Setzungen eine größere Rolle spielten, können heute empirische Evaluationsergebnisse und die systematisierte Erfahrung verläßlich praxisleitend sein.

Ein weiterer schon in der Konzeptionsphase von Maßnahmen wichtiger Schritt der Qualitätssicherung ist es, grundsätzlich evaluierbare Ziele zu setzen.

Praxis-Dokumentation
Im Rahmen der Durchführung von Präventionsmaßnahmen lassen sich auch ohne Beauftragung externer wissenschaftlicher Institutionen vielfältige systematische Ergebniskontrollen durch die Praktiker selber durchführen. So können z.B. allein durch die Zählung der erreichten Personen, die Nennung der besprochenen Themen und der häufig gestellten Fragen etc. wichtige Hinweise für die Steuerung und Bewertung einer Maßnahme gewonnen werden.

Bedeutung von Evaluation für politisch sensible Projekte
Ergebnisse von Evaluationen sind in politisch brisanten und sensiblen Bereichen besonders wichtig. Ein Beispiel hierfür ist die modellhafte und eigens zu Zwecken der Ergebniserforschung durchgeführte Abgabe von Einmal-Spritzbestecken an Gefängnisinsassen, von der aus der Schweiz berichtet wurde. Hier hat die Evaluation die Funktion der empirischen Bewertung eines politisch strittigen Themas.

Evaluation als Erfolgskontrolle
Die idealtypische Evaluation des Erfolgs eines nationalen Aids-Präventionsprogramms umfaßt die Untersuchung
- der Wirkung einzelner Medien und Maßnahmen,
- der aktuellen Ausprägung und Entwicklung von Wissen, Einstellungen und Verhalten,
- der Entwicklung der Infektionszahlen (HIV und STD),
- der Relation von Kampagnenaktivitäten und Effekten.

Vortests von massenmedialen Angeboten
Aus der Schweiz wurden Warnungen vor einer Überbewertung von Massenmedien-Vortests formuliert. Die Eindrücke, die z.B. ein Plakat im bewußt und konzentriert hinschauenden Vortest hervorruft, unterscheiden sich oft sehr vom Eindruck im flüchtigen Vorbeigehen. Andererseits können gerade solche Vortests von Bedeutung sein, wenn Inhalte und Formen der Aufklärung auf der Entscheidungsebene strittig sind. Notwendig ist immer eine klare Zielformulierung und die Auswahl einer angemessenen Methode.

Pilotprojekte
Neben einer kontinuierlichen Begleitforschung (Monitoring, Medienevaluationen etc.) können Pilotprojekte sinnvoll und effektiv sein, wenn spezielle Aktionen gefordert sind, Kenntnislücken geschlossen und/oder Erfahrungen in einem neuen Präventionsfeld gesammelt werden sollen.

Sinnvoll ist dann – wie bei Evaluationen generell – das folgende Vorgehen:
– Maßnahmenplanung anhand der vorhandenen wissenschaftlichen Erkenntnisse,
– Sammlung praktischer Erfahrungen mit den Präventionsmaßnahmen,
– Wissenschaftliche Evaluation durch Prozeßevaluation,
– Modifizierung der Maßnahme,
– Evaluation der Effekte der Maßnahme.

Kommunikation und Rückkopplung
Wirksam für die Optimierung der Programme können wissenschaftliche Ergebnisse von Begleituntersuchungen wie auch Grundlagenforschung im Bereich von Psychologie, Soziologie, Pädagogik usw. nur werden, wenn es einen geregelten Prozeß der Kommunikation und Rückkopplung mit der Praxis gibt. Wesentlich ist der Austausch zwischen
– Forschungsprojekten untereinander,
– Forschern und Programmentwicklern,
– denjenigen, die Evaluationsprogramme implementieren.
Auch eine direkte Rückkopplung mit den Endadressaten kann sinnvoll sein.

Beispiele für Rückkopplungsmechanismen in den europäischen Ländern
Eine Reihe von Beispielen für diesen Rückkopplungsprozeß ist auf der Tagung vorgestellt und diskutiert worden. In Deutschland ist die ständige Begleitforschung nicht nur Grundlage der weiteren Planung der bundesweiten Aufklärungsmaßnahmen durch die BZgA, es tagt zudem eine regelmäßige Bund-Länder-Kommission, in der die verschiedenen Evaluationsergebnisse der nationalen Aids-Prävention vorgestellt und in ihrer Bedeutung auch für die Aids-Präventionsaktivitäten der föderalen Ebene diskutiert werden. In Belgien hat diese Funktion der bereits beschriebene regelmäßige Projektbericht der Projektverantwortlichen und die Prüfung nach einem klaren Katalog von Qualitätskriterien für Projektanträge.

Die Schweiz erstellt alle zwei Jahre einen Synthesebericht über Programm und Resultate der nationalen Aids-Prävention durch die mit der Evaluation beauftragte Universität Lausanne. In der Zwischenzeit sorgt die ständige Anwesenheit von Mitgliedern des Evaluationsteams bei Schritten der Programmkonzeption für die Berücksichtigung der Forschungsergebnisse in der Fortentwicklung des Programms und der Medien und Maßnahmen. Als Beispiel für die Kommunikation von Präventionsergebnissen an die Endadressaten ist ein Plakat über den Anstieg der Kondomnutzung von 1986 bis 1994 in der Schweiz vorgestellt worden.

In den Niederlanden hat der sogenannte Aids-Fonds als übergeordnete Institution die Aufgabe, den Kommunikationsprozeß zwischen unterschiedlichen Organisationen besonders eng zu gestalten: Zusammenfassung von Programmstrategie, Mittelakquisition, Mittelvergabe an dritte und Planung und Implementation der Forschung sowie die Integration der Aids-Arbeit in allgemeinere Zusammenhänge wie Sexualpädagogik, Familienplanung etc. sind hier unter einem Dach.

Ein Beispiel für den Umgang mit Kritik aus der Bevölkerung wurde aus den Niederlanden berichtet. Ein Elternverband hatte das Fehlen der Option Treue als Schutzmöglichkeit in neu entwickelten Jugendmaterialien kritisiert. Dieser Elternverband wurde daraufhin gebeten, selber eine Seite zu diesem Thema zu entwerfen, die in die Materialien aufgenommen wurde. Das führte zu einer hohen Akzeptanz, der Verband war anschließend aktiv an der Verteilung des Materials beteiligt.

5.3. Aids-Prävention und Qualitätssicherung in Deutschland

Wolfgang Müller, Jürgen Töppich,
Bundeszentrale für gesundheitliche Aufklärung, Köln

Rahmenbedingungen der Aids-Prävention

Strukturelle Besonderheiten des Gesundheitssystems in Deutschland, die wichtige Auswirkungen auf die Aids-Prävention haben

– *Öffentlicher Gesundheitsdienst:* Das flächendeckende Netz des öffentlichen Gesundheitsdienstes, insbesondere der in den Kommunen lokal arbeitenden Gesundheitsämter, wurde von Beginn an als Träger von Beratung und aufsuchender Präventionsarbeit in die Aids-Bekämpfung einbezogen. Mit dem „Großmodell Gesundheitsämter" wurde an allen damals 309 Gesundheitsämtern der alten Bundesländer ab 1988 je eine „Aids-Fachkraft" eingestellt, um HIV-Testberatungen, schulischeund außerschulische Präventionsarbeit und andere Aufgaben in diesem Zusammenhang zu übernehmen. Auch Streetworker wurden teilweise in die Arbeit der Gesundheitsämter integriert.

– *Föderale Struktur:* Für die Gesundheitsvor- und -fürsorge sind in Deutschland grundsätzlich die Bundesländer zuständig. Primäre Aids-Prävention sowie Sekundär/ Tertiärpräventions-Aktivitäten wurden in praktisch allen Bundesländern ab 1987 begonnen; teilweise mit der Unterstützung des Bundes durch eine Vielzahl von Modellprogrammen zur psychosozialen Betreuung, für Sozialstationen, für Frauen, Kinder und Drogenabhängige usw.
Seit 1985 führt im Auftrag der Bundesregierung die Bundeszentrale für gesundheitliche Aufklärung (BZgA) die bundesweite, an die Allgemeinbevölkerung gerichtete Aids-Primärpräventionskampagne in enger Abstimmung mit den Bundesländern durch.

– *Aids-Hilfe-Netz:* Die aus der Selbsthilfebewegung entstandenen Aids-Hilfe-Gruppen sind seit 1983/84 in nunmehr 130 Städten (alte und neue Bundesländer) aktiv in der Prävention, Betroffenen-Selbsthilfe und Betreuung infizierter und erkrankter Menschen. Der Dachverband (Deutsche Aids-Hilfe, DAH) ist in Arbeitsteilung mit der BZgA als NGO mit der Prävention in den Hauptbetroffenen- und Hauptgefährdetengruppen beauftragt (seit 1986). Die lokalen Aids-Hilfen kooperieren in der Regel eng mit den Gesundheitsämtern vor Ort, dem Drogenhilfesystem und den niedergelassenen Ärzten sowie Pflegediensten.

Wesentliche Träger der Aids-Prävention und ihr Aufgabengebiet in diesem Zusammenhang

– *Bundesministerium für Gesundheit:* Fachaufsicht für die BZgA und das Aids-Zentrum im Robert-Koch-Institut; Aids-Politik; Gesetze; Mittelvergabe für die Prävention.

– *Bundeszentrale für gesundheitliche Aufklärung (BZgA), Köln:* Aids-Prävention für die Allgemeinbevölkerung incl. spezieller Zielgruppen, Bund-Länder-Koordination und -Kooperation, WHO-Kooperations-Zentrum, EU-Projektträger, Förderung der Deutschen Aids-Hilfe.

– *Bundesländer:* Öffentlicher Gesundheitsdienst, regionale Präventionskampagnen, Förderung regionaler/lokaler Institutionen; Bund-Länder-Kooperation.

– *Deutsche Aids-Hilfe (DAH):* Primär-/Sekundär-/Tertiärprävention für Hauptbetroffenen-/Hauptgefährdetengruppen in enger Kooperation mit regionalen/lokalen Aids-Hilfen als deren Dachverband (NGO).

– *Kommunale Gesundheitsämter:* HIV-Test-Beratung; STD-Beratung und -Kontrolle; aufsuchende Präventionsarbeit zum Thema Aids; Gesundheitsförderung und Vernetzung.

Wesentliche finanzielle und personelle Ressourcen der nationalen Aids-Prävention

Benennbar sind hier die für Primärprävention im nationalen Bereich zur Verfügung gestellten finanziellen und personellen Ressourcen, die für BMG, BZgA und DAH zusammengefaßt werden:

1985	ca. 5	Mio. DM	(2,5 Mio. ECU)
1986	ca. 2	Mio. DM	(1 Mio. ECU)
1987	ca. 48	Mio. DM	(24 Mio. ECU)
1988	ca. 41	Mio. DM	(20,5 Mio. ECU)
1989	ca. 42	Mio. DM	(21 Mio. ECU)
1990	ca. 32	Mio. DM	(16 Mio. ECU)
1991	ca. 28	Mio. DM	(14 Mio. ECU)
1992	ca. 27	Mio. DM	(13,5 Mio. ECU)
1993	ca. 25	Mio. DM	(12,5 Mio. ECU)
1994	ca. 20	Mio. DM	(10 Mio. ECU)
1995	ca. 20	Mio. DM	(10 Mio. ECU)

Nicht erfaßt sind hierbei Kosten für die nationale Telefonberatung (Hotline) der Bundeszentrale für gesundheitliche Aufklärung.

Der Anteil der DAH als NGO an diesen Mitteln hat sich seit 1987 kontinuierlich auf inzwischen 37,5 % der Gesamtsumme erhöht.

Die personellen Ressourcen sind mit Bezug auf die nachfolgenden Institutionen:
BZgA: seit 1986 von 0 auf (heute) ca. 8–9 Stellen angewachsen,
DAH: seit 1987 auf 34,5 vom Bund geförderte Stellen gewachsen.

DAH und BZgA agieren in *Arbeitsteilung* und enger inhaltlicher Abstimmung der Maßnahmen.

Wichtige Konfliktlinien, die die Aids-Prävention beeinflusst haben oder beeinflussen

– In den ersten Jahren starker, inzwischen weitgehend im Konsens entschiedener Konflikt über die Grundkonzepte von Aids-Prävention: die „Such- und Containment-Strategie" versus der „Gesellschaftlichen Lernstrategie" mit dem Prinzip der Freiwilligkeit und Anonymität. Durch die Installation von parteiübergreifenden parlamentarischen (Enquetekommission des Deutschen Bundestages) und außerparlamentarischen (Nationaler Aids-Beirat) Expertengremien wurde der Entschluß zugunsten der langfristig angelegten gesellschaftlichen Lernstrategie als effektiver Aids-Prävention abgesichert.

– Die explizite Kondompropagierung führte vor allem in den ersten Jahren zu Widerständen bei Personen und Institutionen, die sich dadurch in einen Konflikt mit ihren moralischen Grundüberzeugungen versetzt sahen. Die Tatsache, daß der Hauptübertragungsweg der ungeschützte Sexualverkehr bei nicht monogam lebenden Bevölkerungsgruppen ist, führte dazu, daß sich eine weitgehende Toleranz gegenüber der Kondompropagierung herausbildete.

– Eine anfangs deutliche Distanz von NGO und staatlichen Trägern der Aids-Prävention, die Kooperationen und Synergieeffekte erschwerte, hat sich im Laufe der 90er Jahre zu einer deutlich pragmatischeren gegenseitigen Anerkennung hin entwickelt. Es bleiben zum Teil Dissense im Bereich von drogenpolitischen Konzepten, Umfang der staatlichen Förderung sowie des Grades der staatlichen Einflußnahme auf die Medien und Maßnahmen der NGOs über die finanzielle Förderung. Insgesamt kann jedoch von einer arbeitsteiligen-kooperativen Haltung und Aktion der staatlichen und nichtstaatlichen Partner in der Aids-Prävention gesprochen werden.

– Der Rückgang der Ressourcen (personell wie finanziell) für Aids-Prävention in fast allen Regionen Deutschlands und auf allen Ebenen (lokal, regional, national sowie im GO/NGO-Bereich) zusammen mit der wachsenden Zahl zu betreuender Menschen mit HIV und Aids führt zunehmend zu „Verteilungskämpfen" um die knappen Mittel

und zur stärkeren Belastung der hauptamtlich Beschäftigten. Im Bereich der NGOs verliert die Primärprävention in diesem Zusammenhang teilweise ihre Priorität gegenüber Betreuung und Versorgungsmaßnahmen.

Gemeinsame Projekte mit anderen Ländern

- Sowohl BZgA und BMG als auch die DAH arbeiten in einem internationalen Netzwerk von Informationen und gemeinsamer Konzeptbildung (über WHO, EU, durch Kongresse, Expertentreffen und institutionellen Fachaustausch etc.).
- Daneben existieren (in Einzelfällen) binationale Projekte der BZgA, insbesondere mit dem deutschsprachigen Ausland (z.B. mit der Schweiz). Hier handelt es sich vor allem um die Übernahme von Broschüren oder AV-Medien.
- Das seit 1994 europaweit agierende „Europe against Aids"-Programm hat ein Projekt für reisende Jugendliche („Flying Condom-Project") realisiert, das seit 1995 auch von der BZgA zusammen mit national agierenden Jugendorganisationen (Deutsches Jugendherbergswerk, Deutsches Jugendrotkreuz, Jugendreisebüros) übernommen wurde und mit national modifizierten Medien propagiert wurde.
- Die BZgA veranstaltet seit 1988 im Rahmen der WHO-Kooperation europäische Aids-Konsultationen und Experentreffen zu zentralen Aspekten der Aids-Problematik.

Die Elemente der nationalen Aids-Prävention

Ziele

Die Aids-Aufklärungskampagne will einen hohen Informationsstand der Bevölkerung über Infektionsrisiken, Nichtrisiken und Schutzmöglichkeiten erreichen und stabilisieren, Schutzmotivation und Schutzverhalten in Risikosituationen fördern und ein soziales Klima schaffen, das gegen Stigmatisierung und Ausgrenzung Infizierter und Aids-Kranker gerichtet ist.

Durch nachhaltige Veränderungen dieser Variablen soll die weitere Übertragung des HI-Virus (d.h. Neuinfektionen) verhindert und die Integration Betroffener gefördert werden.

Zielgruppen

Mit Bezug auf die Ziele gibt es unterschiedliche Zielgruppenschwerpunkte:

- Hoher Informationsstand (Basiswissen über Aids)
  – Allgemeinbevölkerung
- Schutzmotivation/Schutzverhalten

  – Jugendliche und nicht monogam lebende Bevölkerungsgruppen
– Integration Betroffener
  – Allgemeinbevölkerung

Gruppen mit höheren Infektionsrisiken, zu denen staatliche Institutionen nur einen begrenzten Zugang besitzen (z.B. homosexuelle Männer, i.v.-Drogenabhängige), werden über die DAH angesprochen (Arbeitsteilung).

Botschaften

Das Hauptmotto (Logo) der Kampagne heißt „Gib Aids keine Chance". Es integriert die folgenden Botschaften: „Aids ist keine medizinisch beherrschbare Krankheit. Ob eine HIV-Infektion stattfindet, kannst du weitgehend selbst beeinflussen, da der Hauptübertragungsweg der ungeschützte Sexualverkehr und intravenöser Drogengebrauch ist, deshalb
– informiere dich,
– schütze dich (in sexuellen Risikosituationen durch Kondomnutzung!),
– grenze Betroffene nicht aus, sondern das Virus."

Kommunikationsstrategie

Um langfristig stabile Präventionseffekte zu erzielen, muß es Aufklärungskampagnen gelingen, einen auf Dauer gestellten Kommunikationsprozeß aufzubauen und aufrechtzuerhalten.
Die in einer Kampagne eingesetzten Medien und Maßnahmen haben damit nicht nur die Aufgabe, Botschaften und Informationen zu verbreiten, sondern sie müssen auch die Möglichkeit schaffen, Wissen rekapitulieren, korrigieren oder vertiefen zu können. Und es muß erreicht werden, daß interpersonale Kommunikationsprozesse zum Thema der Kampagne in Gang gesetzt oder aufrechterhalten werden, so daß in Gesprächen mit Vertrauenspersonen, Meinungsführern, Partnern, Freunden oder professionellen Beratern Verhaltensorientierungen entstehen und Verhaltensweisen verändert oder gefestigt werden können (Two-step-flow of communication).

Um derartige gesellschaftliche Lernprozesse zu initiieren und in Gang zu halten, hat die Bundeszentrale für gesundheitliche Aufklärung (BZgA) eine Kampagne entwickelt, die sich aus drei aufeinander bezogenen Maßnahmenblöcken – massenmediale Angebote, Telefonberatung und personalkommunikative Aktivitäten – zusammensetzt (siehe Schaubild 1).

Der massenmediale Teil der Kampagne hat die folgenden Aufgaben: Über unterschiedliche, aufeinander abgestimmte, reichweitenstarke Medien werden die wesentlichen Bot-

schaften und Basisinformationen zu Infektionsrisiken und Schutzmöglichkeiten verbreitet, aber auch Kenntnisse über Situationen ohne Risiken, die vor allem für das Zusammenleben mit HIV-Infizierten und Aids-Kranken notwendig sind.

Aufbau der Aids-Aufklärungskampagne

Teilkampagne	Kommunikationsziel	Medien/Maßnahmen
Massenmediale Kampagne	Verbreitung von Grundbotschaften und Informationen durch reichweitenstarke Massenmedien	TV-Spots Kinospots Anzeigen Plakate
Telefonberatung	Beantwortung aktueller Fragen zur Information und Angstreduktion/Stützung von Verhaltenssicherheit	Bekanntmachung durch Massenmedien Beratung zu allen Aids-bezogenen Themen
Personalkommunikative Kampagne	Schaffung von Angeboten mit interpersonaler (zweiseitiger) Kommunikation zur Verhaltensmotivation und -änderung	Veranstaltungen Gesprächskreise Beratungen Schulungen Workshops
▼ Lernprozeß durch Nutzung mehrerer unterschiedlicher Medien		▼ Lernprozeß durch Schaffung und Anregung interpersonaler Kommunikation
	▼ **Ziele** Information über Aids Schutzmotivation und Schutzverhalten Integration Betroffener	

Schaubild 1

Hinzu kommen Medien, die vertiefende Informationen anbieten und zielgruppenbezogen die zentralen Botschaften aufbereiten und umsetzen, um Wissen, Motivation, Einstellungen und die Bereitschaft zur interpersonalen Kommunikation zu unterstützen und zu verstetigen.

Die Tatsache, daß dem einzelnen mehrere unterschiedliche Medien zur Verfügung gestellt werden, bildet die Voraussetzung für Lernprozesse, in denen Informationen miteinander verglichen werden können und das eigene Wissen korrigiert, wiederholt, ausgeweitet und gefestigt werden kann.

Da mediale Aktivitäten nicht alle Fragen beantworten können und deshalb in der Regel Nachfragen auslösen, werden ergänzende personalkommunikative Informations- und

Diskussionsmöglichkeiten geschaffen und angeboten. Damit sollen neben einer parallel zur Medienkommunikation stattfindenden alltäglichen interpersonalen Kommunikation auch gezielte personalkommunikative Rückkopplungsmöglichkeiten zur Kampagne gewährleistet werden. Auf diese Weise wird also ein weiterer Lernprozeß initiiert mit dem Ziel, Einstellungs- und Verhaltensänderungen in Richtung auf die o.g. Kampagnenziele zu unterstützen.

Gibt es wesentliche historische Veränderungen?

Die anfangs aufgestellten Prognosen über den explosionsartigen Verlauf der HIV-Infektion bewahrheiteten sich nicht – wie wir glauben, aufgrund einer gesamtgesellschaftlichen präventiven Anstrengung, die im Vergleich zu früheren Maßnahmen als einmalig anzusehen ist.
Seitdem deutlich wurde, daß Aids aktuell als eingegrenzt zu beurteilen ist, sind die Gesamtmittel für die Prävention kontinuierlich rückläufig.
Wir befürchten, daß die kurzfristig erreichten Effekte/Erfolge der Prävention ihre eigene finanzielle Grundlage – als Voraussetzung dauerhafter Lernprozesse – entziehen können (Präventionsfalle).
Erste Anzeichen rückläufiger Wirksamkeit sind feststellbar.

Evaluation und Qualitätssicherung

Evaluationsansatz

Die Bundeszentrale für gesundheitliche Aufklärung begleitet die Aids-Aufklärungskampagne seit 1987 mit verschiedenen Evaluationsstudien.
Zum einen werden einzelne Bestandteile der Kampagne daraufhin überprüft, inwieweit sie jeweils spezifische (Teil-)Ziele erreichen.
Evaluationsstudien dieser Art liegen vor für
(1) einzelne Medien,
(2) für die Telefonberatung und
(3) für die personalkommunikative Kampagne.
Eine Zusammenstellung aller bisher durchgeführten Studien enthält die jährlich aktualisierte „Dokumentation abgeschlossener Studien der BZgA".

Wie sich die Gesamtheit der Kampagnenaktivitäten im Hinblick auf die Ziele der Prävention von HIV und Aids auswirkt, wird mit Hilfe einer kampagnenbegleitenden Monitoring-Studie bei der Allgemeinbevölkerung und bei präventionsrelevanten Teilgruppen untersucht.
In jährlich wiederholten Repräsentativbefragungen werden Veränderungen in Wissen, Einstellungen und Verhalten registriert und in einem ebenfalls jährlichen Erschei-

nungsturnus unter dem Titel „Aids im öffentlichen Bewußtsein der Bundesrepublik“ von der Bundeszentrale für gesundheitliche Aufklärung (BZgA) publiziert.
Darüber hinaus werden im Auftrag der BZgA spezifische, auf die speziellen Lebenssituationen von homosexuellen Männern abgestellte Wiederholungsbefragungen durchgeführt, die regelmäßig von der Deutschen Aids-Hilfe veröffentlicht werden (zuletzt Michael Bochow „Schwuler Sex und die Bedrohung durch Aids – Reaktionen homosexueller Männer in Ost- und Westdeutschland“, Aids-Forum DAH, Band XVI, Berlin 1994).

Die inhaltlichen Fragestellungen der Studie „Aids im öffentlichen Bewußtsein“ sind aus den Hauptzielen der Kampagne abgeleitet. Im einzelnen wird untersucht:

- Inwieweit werden die verschiedenen Medien der Aids-Aufklärungskampagne genutzt, wie groß ist die Reichweite der Kampagne insgesamt, entstehen die intendierten interpersonalen Kommunikationsprozesse, werden weitere Kommunikationsmöglichkeiten in Anspruch genommen?
- Inwieweit wird in der Bevölkerung ein hoher Informationsstand über Aids hergestellt und aufrechterhalten?
- Inwieweit wird selbstbestimmtes und verantwortungsbewußtes Verhalten zum Schutz vor Aids gefördert?
- Inwieweit wird ein gegen die Ausgrenzung von HIV-Positiven und Aids-Kranken gerichtetes Klima aufgebaut?

Hauptlernerfahrungen aus der Evaluation in bezug auf die Gesamtkampagne

Durch die kommunikationsstrategische Anlage der Kampagne konnte nahezu die gesamte Bevölkerung mit Angeboten (Medien/Maßnahmen) erreicht werden – Bildungsdifferenzen lassen sich nicht erkennen.

- Es konnte sehr schnell ein hoher Basis-Informationsstand erreicht und aufrechterhalten werden – und zwar in allen Bildungsschichten.
- Das soziale Klima gegenüber HIV-Infizierten und Aids-Kranken wurde verbessert.
- Schutzmotivation und Schutzverhalten (Kondomnutzung) sind kontinuierlich angestiegen und steigen in den Bevölkerungsgruppen mit potentiell höheren Infektionsrisiken weiter an – ebenfalls bildungsunabhängig.
- Die im Rahmen der Studie mehrfach durchgeführten Analysen zum Zusammenhang zwischen der Nutzung von Kommunikationsangeboten und der Ausprägung der Zielvariablen lassen erkennen, daß Effekte auf die Aufklärungsaktivitäten zurückführbar sind. Dies gilt für Informiertheit, Einstellungen gegenüber HIV-Positiven und Aids-Kranken sowie für das Schutzverhalten bei neuen Sexualkontakten.
- 1994 wird deutlich erkennbar, daß immer weniger Menschen mit den einzelnen Medien und Maßnahmen in Kontakt kommen.

Diese rückläufige Dichte von Informationsmöglichkeiten hat, zusammen mit dem deutlichen Rückgang an interpersonaler Kommunikation, weitreichende Konsequenzen für die Kommunikationsprozesse der Aids-Aufklärungskampagne: Soziale Lernprozesse werden unwahrscheinlicher.

– In jüngeren Altersgruppen wird eine rückläufige Entwicklung des Schutzverhaltens sichtbar.
  Bei den 16- bis 45jährigen Alleinlebenden ist sowohl der Anteil derjenigen zurückgegangen, die in der letzten Zeit überhaupt Kondome verwendeten, als auch die Häufigkeit ihrer Nutzung.
  Noch auffälliger ist der Rückgang in der regelmäßigen Nutzung von Kondomen bei der nachwachsenden Generation der 16- bis 20jährigen.

Da gezeigt werden konnte, daß das Schutzverhalten bei neuen Sexualbeziehungen von der Intensität der Nutzung von Informations- und Kommunikationsangeboten abhängt, bedeutet dies auch, daß die beiden rückläufigen Tendenzen – Rückgang der Kommunikationsdichte und Rückgang der Kondomnutzung bei den nachwachsenden Altersgruppen – nicht unabhängig voneinander verlaufen. Eine weitere Verringerung von Informations- und Kommunikationsmöglichkeiten erhöht damit die Wahrscheinlichkeit eines langfristigen Rückgangs des präventiven Verhaltens insgesamt.

Hauptlernerfahrungen in bezug auf einzelne Medien/Massnahmen

– Formen der Ansprache von Zielgruppen bei „tabuisierten" Themen (Sexualität) konnten im Rahmen von Evaluationen geprüft werden. Daraus ließen sich inhaltlich Gestaltungsempfehlungen für Medien und Maßnahmen ableiten (Planungskriterien).

Weitere Aktivitäten der Qualitätssicherung

Kooperation mit anderen Ländern:

– in bezug auf Kampagne insgesamt: siehe Ziele dieser Veranstaltung,
– Evaluation: Vereinheitlichung von Indikatoren zur Messung von Effekten (EU-Aktivitäten).

Feedback durch andere Experten

– Diskussion von Maßnahmen mit Experten/Evaluateuren (Beratung, schriftliche Expertisen).

Zielgruppen

– Einbezug von Zielgruppenvertretern in die Erarbeitung von Medien/Materialien,
– zielgruppenbezogene Testung von Medien (z.B. von audiovisuellen Medien, Broschüren).

Zukunft und perspektivische Planung

Welche konkreten Massnahmen oder Kombinationen von Massnahmen werden in Zukunft und auf Dauer für unverzichtbar gehalten?

1) Zur Sicherstellung des hohen Basis-Kenntnisstandes über HIV und Aids in der Bevölkerung insgesamt und in den nachwachsenden Generationen sind reichweitenstarke massenmediale Maßnahmen weiterhin unabdingbar. Damit läßt sich auch ein kontinuierliches „Hintergrundrauschen" erzielen, das im Sinne von „Erinnerungsimpulsen" deutlich macht, daß Aids weiterhin als Risiko existiert.
   Kampagnenmedien, die sich zur Erreichung dieser Effekte eignen, sind insbesondere Fernsehspots, Kinospots, Anzeigen und Plakataktionen.

2) Zielgruppenspezifisch ausgerichtete Broschürenangebote, die Möglichkeiten zu einer intensiveren Auseinandersetzung mit dem Thema Aids bieten, sind ebenfalls weiterhin als zentraler Bestandteil des Kommunikationskonzeptes anzusehen.

3) Neben den massenmedialen Aktivitäten sind personalkommunikative Maßnahmen wichtig, um Lernprozesse aufzubauen, in Gang zu halten und zu verfestigen.
   Vor allem sind Multiplikatoren anzusprechen, um die Aids-Prävention in einzelnen Orten, Regionen oder Institutionen zu fördern (Fortbildung/Training).

4) Kooperation mit anderen Institutionen und Personen zur Verstetigung der Präventionsarbeit und zur Erhöhung der öffentlichen Aufmerksamkeit für die Thematik „Aids" ist erforderlich (u.a. Schaffung von Medienereignissen, Ankopplung an und Mitgestaltung von öffentlichkeitswirksamen Ereignissen, „Sponsoring").

Welche Ziele und Qualitätsanforderungen sind dabei wesentlich?

Ziele

Die Hauptzielsetzungen bleiben weiterhin
– die Verhinderung von Neuinfektionen und
– die Integration von HIV-Positiven und Aids-Kranken.

Die Sicherstellung eines hohen Informationsniveaus (u.a. auch bei den nachwachsenden Generationen), die Förderung der Kondomnutzung in Situationen mit einem möglichen Infektionsrisiko (Zielgruppe: Jugendliche und nicht monogam lebende Bevölkerungsgruppen) und Maßnahmen zur Schaffung eines sozialen Einstellungsklimas, das gegen die Ausgrenzung Betroffener gerichtet ist (Zielgruppe: Allgemeinbevölkerung), sind damit auch zukünftig die wichtigsten Aufgaben der Aids-Aufklärungskampagne.

Qualitätsanforderungen

- Sicherstellung von bewährten Elementen (Begründung u.a. durch Evaluationsresultate),
- Planung und Begründung weiterer Maßnahmen mit Bezug auf das kommunikationsstrategische Konzept (keine isolierten Extramaßnahmen),
- Beachtung der empirisch ermittelten Gestaltungskriterien bei der Entwicklung von Medien/Maßnahmen,
- Kooperation/Arbeitsteilung mit Partnern auf der Grundlage gemeinsamer Konzepte (u.a. Sponsoring),
- Förderung und Evaluation innovativer Präventionsansätze (z.B. Integration des Themas in Soap-operas, peer-education etc.),
- begleitende Evaluation der Kampagne und einzelner Aktivitäten,
- Erfahrungsaustausch mit nationalen und internationalen Kooperationspartnern/Experten.

Welche Strategien der Zielerreichung und Qualitätssicherung sollten das absichern?

Im folgenden Strukturmodell einer Qualitätssicherung wären die vorab vorgeschlagenen Aktivitäten einzubetten (siehe Schaubild auf Seite 61).
Es handelt sich dabei um ein Diskursmodell, in das Vertreter aus Wissenschaft, Präventionsinstitutionen, Politik und Kooperationsinstitutionen/-organisationen einbezogen sind.
Diese Diskursteilnehmer sollten ihre Vorstellungen über die Ziele, Inhalte, Methoden und Ergebniserwartungen vortragen und inhaltlich begründen, um so zu gemeinsam getragenen Konzepten und Programmen zu gelangen.
Die Präventionsinstitutionen wären dann für die konkrete Ausgestaltung von Programmen verantwortlich.
In der Phase der Implementation und Wirksamkeitskontrolle spielt die Wissenschaft eine entscheidende Rolle, die mit den Stichworten Qualitätssicherung und Wirksamkeitskontrolle zu kennzeichnen ist.
Deren Ergebnisse bilden die Grundlage für Bewertungen im Rahmen eines erneuten Diskussionsprozesses aller Diskursbeteiligten.
Aus den Resultaten dieses Bewertungsprozesses wären nun Konsequenzen für die weitere Planung und Umsetzung der Prävention, aber auch für die weitere Forschung zu ziehen.

Das heißt, der Prozeß beginnt von neuem.
Perspektivisch halten wir die stärkere Institutionalisierung eines solchen „Qualitätssicherungssystems“ für zentral, um die Aids-Prävention aus ihrer finanziellen, inhaltlichen und politischen Konjunkturzyklik zu befreien und anhand fachlicher Standards weiterzuentwickeln.

Epidemiologische Situation in der Bundesrepublik Deutschland zum 31.12.1994

HIV-Infektionen

Gesamtzahl (geschätzt) der seit Beginn der Epidemie Infizierten:	50.000 – 60.000
Verteilung nach *Geschlecht:*	
Männer:	80% – 85%
Frauen:	15% – 20%
Kinder unter 13 Jahren:	etwa 500 (1 %)
Zahl der *Neuinfektionen* pro Jahr:	2.000 – 3.000

Heute wichtige *Infektionswege:*	
Homosexuelle Kontakte bei Männern:	65%
I.v.-Drogenmißbrauch:	15%
Heterosexuelle Kontakte:	10%
Personen aus Pattern-II-Ländern:	10%
Vertikale Transmission (Mutter–Kind):	< 1%
Bluttransfusionen und -produkte:	< 1%
Hämophile:	0%

Regionale Verteilung:
55% aller HIV-Infizierten leben in den Großstädten Frankfurt a.M., München, Berlin (West), Düsseldorf, Köln und Hamburg. 44% aller HIV-Infizierten leben außerhalb der oben genannten Großstädte in den alten Bundesländern. In den neuen Bundesländern wurden bisher einige hundert (1%) HIV-Infektionen diagnostiziert.

Trends:
Nach wie vor erfolgt die überwiegende Zahl der Neuinfektionen über homosexuelle Kontakte bei Männern. Die Rate von Neuinfektionen bei i. v.-Drogenabhängigen scheint eher abzunehmen. Die Zahl der durch heterosexuelle Kontakte übertragenen Infektionen wird dagegen zunehmen. Die wichtigsten Infektionsquellen sind Kontakte mit Angehörigen der primären Risikogruppen. Eigenständige Infektketten unter Heterosexuellen wurden bisher nur selten berichtet.

In den neuen Bundesländern nimmt die Zahl der HIV-Infektionen – auf niedrigem Niveau – zu. In den alten Bundesländern wird sich die bisher beobachtete regionale Verteilung – entsprechend der regionalen Verteilung der Gruppen mit Risikoverhalten – nicht grundsätzlich ändern.

Aids-Fälle

Vollständigkeit der Erfassung:	> 85%
Gesamtzahl der Meldungen seit 1982:	12.379
Davon als *verstorben* gemeldet:	7.522
Verteilung nach *Geschlecht:*	
Männer:	90%
Frauen:	10%
Kinder unter 13 Jahren:	98 (0,8%)
Neuerkrankungen pro Jahr:	um 2.000
Infektionswege (1994 diagnostizierte Fälle):	
Homosexuelle Kontakte bei Männern:	65%
I.v.-Drogengebrauch:	14%
Heterosexuelle Kontakte:	8%
Patienten aus Endemiegebieten (Pattern-II):	3%
Hämophile:	2%
Bluttransfusionen und -produkte:	2%
Vertikale Transmission (Mutter–Kind):	< 1%
ohne Angabe:	6%

Regionale Verteilung:
57% aller Erkrankten leben in den Großstädten Frankfurt a.M., München, Berlin (West), Köln, Düsseldorf und Hamburg. 42% aller Erkrankten leben außerhalb der oben genannten Großstädte in den alten Bundesländern. Aus den neuen Bundesländern stammen bisher 126 (1,0%) der diagnostizierten Aids-Fälle.

Trends:
Die Zahl der jährlich neu diagnostizierten Aids-Fälle wird sich in den nächsten Jahren nicht wesentlich verändern. In der Verteilung der Fälle nach dem Infektionsrisiko ist kurzfristig nicht mit größeren Änderungen zu rechnen. Verschiebungen im Spektrum der Erstmanifestationen der Immunschwäche und zunehmende Überlebenszeiten sind durch verbesserte therapeutische Möglichkeiten zu erwarten.

Quelle:
Robert-Koch-Institut, Bundesinstitut für Infektionskrankheiten und nicht übertragbare Krankheiten, RKI-Hefte 6/1995

5.4. Gegenstand und Zielsetzung der Expertentagung

Die Bundeszentrale für gesundheitliche Aufklärung (BZgA), Köln, WHO-Kooperationszentrum für Gesundheitserziehung und Gesundheitsförderung, veranstaltet im Rahmen der Zusammenarbeit der Bundesrepublik Deutschland mit dem Regionalbüro für Europa der Weltgesundheitsorganisation (WHO/EURO) vom 13. bis 15. November 1995 in Köln eine Expertentagung zum Thema „Qualitätssicherung in der Aids-Prävention".

Problemstellung

Seit Mitte der 80er Jahre haben die meisten europäischen Länder nationale Programme der Aids-Prävention entwickelt. Unter dem Druck alarmierender epidemiologischer Prognosen war rasches und entschlossenes Handeln geboten.

Als Ergebnis von Evaluationen der Aids-Prävention und ihrer Elemente, wie sie einzelne Länder unternahmen, sowie im Rahmen von Überblicksstudien (Brungs und Bengel, Choi und Coates, Moekerk, Wellings u.a.) wurden Strategie-Unterschiede deutlich. Es zeigten sich hierbei auch die Erfolge der Aids-Prävention.
Gleichwohl bleibt festzustellen: Es gibt Neuinfektionen, für manche Personengruppen wird sogar wieder von einem Anstieg der Neuinfektionen berichtet.
Die dauerhafte Implementation der nationalen Aids-Prävention wird dadurch zu einer zentralen Herausforderung.

Gleichzeitig bewirkt das wirtschaftliche Klima in Europa vielfach eine kritischer werdende Prüfung hinsichtlich dessen, was innerhalb der nationalen Programme notwendig ist. Dies betrifft auch die Aids-Prävention.

Zielsetzung

Ziel des Fachgesprächs ist ein Austausch über

- die wesentlichen Lernerfahrungen aus einer Dekade Aids-Prävention,
- Konzepte und Aktivitäten der Qualitätssicherung/-optimierung der nationalen Aids-Prävention,
- Maßnahmen (bzw. Maßnahmenkombinationen), die zukünftig eine nachhaltige Wirksamkeit der Aids-Prävention sicherstellen können – unter Berücksichtigung von Kosten-/Effektivitätsüberlegungen.

Struktur und Arbeitsweise der Tagung

Vergleichende Länderbetrachtungen der nationalen Aids-Prävention, ihrer wesentlichen Entwicklungsschritte und Lernerfahrungen bilden den ersten Teil der Tagung.

Im zweiten Teil sollen durch die kreative Entwicklung von Szenarien zentrale Kriterien und Strategien der Qualitätssicherung von Programmen der Aids-Prävention reflektiert und erarbeitet werden.

Sicherlich wird wegen der unterschiedlichen Rahmenbedingungen und historischen Entwicklung der Aids-Prävention in den beteiligten Ländern nicht unbedingt eine für alle optimale Strategie gefunden werden können. Die internationalen Treffen der Vergangenheit haben aber immer wieder eindrucksvoll gezeigt, wie inspirierend und weiterführend der Austausch sein kann. Durch den relativ eng gefaßten Rahmen dieser Veranstaltung sowie durch den Ansatz gemeinsam entwickelter Szenarien soll dieser Effekt intensiviert werden.

5.5. Fragestellungen

Wesentliche Rahmenbedingungen der Aids-Prävention

a) Welche strukturellen Ausprägungen des Gesundheitssystems Ihres Landes haben wichtige Auswirkungen auf die Aids-Prävention?
b) Wer sind die wesentlichen Träger der Aids-Prävention?
c) Gibt es wichtige Konfliktlinien, die die Aids-Prävention beeinflussen?
d) Gibt es gemeinsame Projekte mit anderen Ländern?

Die Elemente der nationalen Aids-Prävention

a) Wie ist die nationale Aids-Prävention zu beschreiben?
   - Ziele
   - Zielgruppen
   - Botschaften
   - Kommunikationsstrategien (massenkommunikative Ansätze, gemeindeorientierte Ansätze, Beratung, Ausstellungen usw.)

b) Gibt es wesentliche historische Veränderungen und wenn ja, aus welchen Gründen? (politische Prioritäten, finanzielle Ausstattung, Evaluationsergebnisse, äußere Ereignisse usw.)

Evaluation und Qualitätssicherung

a) Welche Elemente der nationalen Aids-Prävention werden wie seit wann empirisch evaluiert?
b) Was sind die Hauptlernerfahrungen aus der Evaluation?
c) Welche weiteren Überlegungen und Aktivitäten der Qualitätssicherung, bezogen auf die nationale Aids-Prävention Ihres Landes, sind bisher üblich?
   (Kooperation mit anderen Ländern, Feedback durch externe Experten, Abstimmungsgespräche mit Vertretern der Zielgruppen usw.)

Zukunft und perspektivische Planung

a) Welche konkreten Maßnahmen oder Kombinationen von Maßnahmen halten Sie in ukunft und auf Dauer für unverzichtbar?
b) Welche Ziele und Qualitätsanforderungen halten Sie dabei für wesentlich und
c) welche Strategien sollen das absichern?

5.6. Programm der Expertentagung

„Qualitätssicherung in der Aids-Prävention“

Termin:	13.–15. November 1995
Ort:	Hotel Mondial, Köln
Beginn:	Montag, 13. November 1995, 12.30 Uhr
Ende:	Mittwoch, 15. November 1995, ca. 12.00 Uhr
Moderation:	Hans Saan, Dutch Centre for Health Promotion and Health Education

MONTAG, 13. 11. 1995

vormittags	Ankunft der Teilnehmerinnen und Teilnehmer/Check in
12.30 Uhr	**Mittagessen**
14.00 Uhr	**Begrüßung der Teilnehmerinnen und Teilnehmer**
	Eröffnung Dr. Elisabeth Pott, Direktorin der BZgA **Grußwort des Bundesministeriums für Gesundheit** Dorle Miesala-Edel **Grußwort der Weltgesundheitsorganisation/Regionalbüro für Europa** Dr. Johannes Hallauer **Erläuterung des Programms** Hans Saan
14.45 Uhr	**Länderbetrachtung der nationalen Strategien der Aids-Prävention**
14.45 – 15.00 Uhr	**Vorstellung des Verfahrens** Hans Saan
15.00 – 16.00 Uhr	**Befragung und Vortrag der ersten Ländergruppe**
16.00 – 16.30 Uhr	**Pause**
16.30 – 17.30 Uhr	**Befragung und Vortrag der zweiten Ländergruppe**
17.30 – 18.00 Uhr	**Pause**
18.00 – 19.00 Uhr	**Befragung und Vortrag der dritten Ländergruppe**
19.00 Uhr	**Abendessen**

DIENSTAG, 14. 11. 1995

09.30 Uhr	**Visualisierte Zusammenfassung der wesentlichen Ergebnisse der Länderbetrachtungen** Dr. Dr. Wolfgang Müller, Jürgen Töppich, BZgA
10.00 – 10.15 Uhr	**Erläuterung der Arbeitsaufträge für die zielgruppenspezifischen Arbeitsgruppen** Hans Saan
10.15 – 12.30 Uhr	Arbeit der Arbeitsgruppen: **Auflistung der bestehenden Strategien für die betreffende Zielgruppe** Hans Saan
12.30 – 15.00 Uhr	**Mittagessen** und **Gelegenheit zum Besuch des Kölner Doms**
15.00 – 16.00 Uhr	Arbeit der Arbeitsgruppen: **Beurteilung der Strategien nach Qualitätsgesichtspunkten**
16.00 – 16.30 Uhr	**Kaffeepause**
16.30 – 17.30 Uhr	Arbeit der Arbeitsgruppen: **Begründung der Qualitätsbeurteilungen**
17.30 – 18.00 Uhr	**Kaffeepause**
18.00 – 19.00 Uhr	Arbeit der Arbeitsgruppen: **Zusammenfassung der Arbeitsgruppenergebnisse**
19.00 Uhr	**Abendessen**

MITTWOCH, 15. 11. 1995

09.30 – 10.00 Uhr	**Berichte der Arbeitsgruppen**
10.00 – 10.30 Uhr	**Kaffeepause**
10.30 – 11.45 Uhr	Plenum: **Möglichkeiten der Umsetzung von Arbeitsergebnissen**
11.45 – 12.00 Uhr	**Schlußwort** Dr. Elisabeth Pott
12.00 Uhr	**Mittagessen** **Ende der Veranstaltung**

In the specialist booklet series "Research and Practice of Health Promotion" has been published previously:

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