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CONTINUUM *Complete*

International

ENCYCLOPEDIA OF SEXUALITY

Updated, with More Countries

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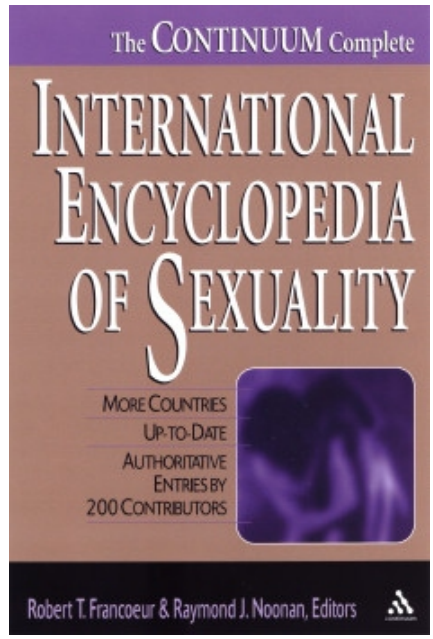

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CU59

(CIA 2002)

Switzerland

(The Swiss Confederation)

Prof. Johannes Bitzer, M.D., Ph.D.,* Judith Adler, Ph.D., Prof. Dr. Udo Rauschfleisch Ph.D., Sibil Tschudin, M.D., Elizabeth Zemp, M.D., and Ulrike Kosta

Contents

Demographics and a Brief Historical Perspective

SIBIL TSCHUDIN

A. Demographics

Switzerland is located in central Europe and spreads over an area of 15,942 square miles (41,290 km^2), about twice the size of the state of New Jersey in the U.S. Most of the country is composed of a mountainous plateau bordered by the great bulk of the Alps in the south and by the Jura Mountains in the northwest. This long, relatively narrow plateau is crossed by the Aare River and contains the lakes of Neuchâtel and Zürich. The country's largest lakes—Geneva, Constance (Bodensee), and Maggiore—straddle the French, German-Austrian, and Italian borders, respectively. The Rhine, navigable from Basel to the North Sea, is the principal inland waterway. The strategically important alpine north-south communications are assured by numerous passes and by railroad tunnels, notably the Lötschberg, St. Gotthard, and Simplon. Switzerland consists of 26 federated states, of which 20 are called cantons and 6 are called half cantons. The cantons are Zürich, Bern, Lucerne, Uri, Schwyz, Glarus, Zug, Fribourg, Solothurn, Schaffhausen, Saint Gall, the Grisons (Graubünden), Aargau, Thurgau, Ticino, Vaud, Valais, Neuchâtel, Geneva, and Jura. Of the half cantons, Obwalden and Nidwalden together form Unterwalden, Basel-Land and Basel-Stadt form Basel, and Ausser-Rhoden and Inner-Rhoden form Appenzell. The capital of Switzerland is Berne.

German, French, and Italian are Switzerland's major and official languages; Romansh (a Rhaeto-Roman dialect spoken in parts of the Grisons) was designated a "semi-official" language in 1996, and entitled to federal funds to help promote its continued use. German dialects (Schwyzerdütsch) are spoken by about 65% of the inhabitants. French, spoken by about 20% of the population, predominates in the southwest; Italian, spoken by about 8%, is the language of Ticino, in the south. The few Romansh-speakers are in the southeast.

In December 2001, Switzerland had an estimated population of 7.3 million. The largest cities by population are Zürich (about 340,000), Basel (180,000), Geneva (170,000), Berne (130,000), and Lausanne (120,000). (All data are from the latest Swiss Census unless otherwise noted; data designated (*WFB*) are from *The World Factbook 2002*, CIA.)

Age Distribution and Sex Ratios (*WFB*): *0-14 years*: 16.8% with 1.05 male(s) per female (sex ratio); *15-64 years*: 67.7% with 1.03 male(s) per female; *65 years and over*: 15.5% with 0.69 male(s) per female; *Total population sex ratio*: 0.97 male(s) to 1 female

Life Expectancy at Birth (in 2000): *male*: 76.9 years; *female*: 82.6 years; (*WFB Total Population*: 79.86 years)

Urban/Rural Distribution: 85% to 15% (*WFB*)

Ethnic Distribution: German: 65%; French: 18%; Italian: 10%; Romansch: 1%; other: 6% (*WFB*)

Religious Distribution: Roman Catholic: 42%; Protestant: 35%; other Christian communities: 2%; Jewish: 0.2%; Islam: 4%; others: 1%; no religion: 11%

Communications: Prof. Johannes Bitzer, M.D., Ph.D. Leiter Gyn. Sozialmedizin und Psychosomatik Universitäts-Frauenklinik, Spitalstrasse 21, CH-4031 Basel, Switzerland; jbitzer@uhbs.ch.

Birth Rate: 10.1 births per 1,000 population; (*WFB* 9.84)

Death Rate: 8.4 per 1,000 population

Infant Mortality Rate: 3.2 deaths per 1,000 live births

Net Migration Rate: 2.01 migrant(s) per 1,000 population; (*WFB* 5.54)

Total Fertility Rate: 1.41 children born per woman; (*WFB* 1.73)

Population Growth Rate: 0.8%; (*WFB* 0.24%)

HIV/AIDS: *Total positive HIV tests (1985-2000)*: 25,007; *Persons with AIDS (1983-2000)*: 7,036; *Deaths*: 5,009. (*WFB* 1999 estimates: *Adult prevalence*: 0.46%; *Persons living with HIV/AIDS*: 17,000; *Deaths*: 150.) (For additional details from www.UNAIDS.org, see end of Section 10B.)

Literacy Rate (*defined as those age 15 and over who can read and write*): 99%; education is free and school attendance compulsory during 9 years, from age 7 to 16

Per Capita Gross Domestic Product (*purchasing power parity*): $28,600; *Inflation*: 1.5%; (*WFB* 2.4%); *Unemployment*: 3.8%; (*WFB* 5.3%); *Living below the poverty line*: NA

B. A Brief Historical Perspective

In 58 B.C.E., the Helvetii who inhabited the area of Switzerland (called Helvetia in those times) were conquered by the Romans. In 1033, the territory was incorporated into the Holy Roman Empire. In the 1200s, Habsburg encroachments on the privileges of the three mountainous localities of Uri, Schwyz, and Unterwalden resulted in the conclusion of a defensive league among them in 1291. In the following centuries, the Swiss Confederation slowly added new cantons. In 1648, the Treaty of Westphalia gave Switzerland its independence from the Holy Roman Empire. French revolutionary troops occupied the country in 1798 and named it the Helvetic Republic, but Napoleon in 1803 restored its federal government. By 1815, the French- and Italian-speaking peoples of Switzerland had been granted political equality. In 1815, the Congress of Vienna guaranteed the neutrality and recognized the independence of Switzerland. In the revolutionary era of 1847, the Catholic cantons seceded and organized a separate union called the Sonderbund, but they were defeated and rejoined the federation. The victorious Radicals transformed the confederation into one federal state under a new constitution adopted in 1848 and recast in 1874, establishing a strong central government while giving significant control to each canton. National unity grew as the country prospered from its neutrality. Strict neutrality was its policy in both World Wars I and II. Geneva became the seat of the League of Nations (later the European headquarters of the United Nations) and of a number of international organizations. In September 2002, Switzerland became the 190th member of the UN.

Politically, Switzerland is a direct democracy. The referendum, as well as popular initiatives, are frequently employed to achieve political change. A council of states (two members from each canton, and one from each half canton) and a 200-member national council (whose members are directly elected every four years) together form the federal assembly. The chief executive, or federal council, is composed of seven members (elected for four years by the federal assembly) and includes the president of the confederation (elected by the federal assembly annually).

1. Basic Sexological Premises

ELIZABETH ZEMP and JOHANNES BITZER

A. Character of Gender Roles

The people of Switzerland have had a longstanding history in which there was a strong traditional model, with men being economically responsible, involved in paid work and in public issues, and women being responsible for the family and education and limited to the private sector. This system was maintained by legislation and a social security system, both of which have economic qualities. From the 1960s and 1970s on, important changes have occurred, which modified and diminished the gender-role separation. Women were given the right to vote and to be elected to Parliament in 1971. This was decided in a plebiscite by the male population. Changes in gender roles have developed heterogeneously, with traditional family concepts prevailing more in rural areas, while in urban areas, the changing roles of women became more visible and equality between men and women was achieved.

While an increasing percentage of women have entered the workforce, the childcare situation still reflects traditional family role patterns. Daycare options for children, child-nurseries, and maternity and day schools, exist for only a small percentage of children under 14 years of age. There are regional differences with regard to this situation, with childcare options for only 2% of the children in the German-speaking part, 7% of the children in the French-speaking part, and 34% of the children in the Italian-speaking area of Switzerland. The Swiss school system has not yet adapted to the needs of employed women, with schedules changing from day to day and children expected to eat their lunches at home. Persisting traditional gender roles are still reflected in inequalities with regard to education, income, and participation in political boards. It is also reflected in the higher percentage of women with part-time employment. While the percentage of women in the workforce has consistently increased in the last four decades, only 53% of working women, and around 25% of women with children under age 15, work full-time.

B. Sociolegal Status of Males and Females

Equal rights for women and men became part of the Swiss Constitution only in 1981. While some gender-specific differences persist in the law, such as those related to maternity and to military conscription (mandatory only for men), all others have been changed in the last decades. With regard to maternity and childcare, a 1945 plebiscite approved social security for maternity although the corresponding law was never enacted. Three related plebiscites were rejected in 1984, 1987, and 2001. Consequently, Switzerland still lacks a federal law concerning maternity policy. Since 1989, women may not be dismissed during pregnancy or the first 16 weeks after giving birth. Some cantonal laws regulate the duration and funding of maternity leaves, producing a wide range of practices among the administrative authorities. The Swiss social security system for the elderly is based on three pillars: a basic pension insurance, an occupational benefit plan, and private savings. Basic insurance was started in 1948, and is based on paid employment. Until 1997, women retired at age 62 and men at age 65. Thereafter, the age of retirement for women has risen to 64 years. As part of the ongoing revisions of the old-age and disability/invalid pension law, the government has proposed a flexible retirement age between 62 and 65 for men and women. Since 1994, women get credited to their account for each year of childcare. Widows with children are entitled to a pension, but widows without children must be at least 45 and have been married for at least 5 years.

Legal changes have also occurred with regard to domestic violence. Prior to 1992, the legal bases excluded rape that happened within marriage from being subject to litigation. In a 1992 revision, rape and sexual violence within marriage were redefined to be punishable, but only if the

wife is denouncing it. The "Victims Help Law," enacted in 1993, regulates three areas designed to improve the position of victims of violence: counseling and treatment, support throughout the legal procedure and trial, and compensation claims for damages and reparations. This law obliges the cantons to provide counseling facilities, medical, psychological, social, material, and legal assistance. Although this law is not targeting primarily victims of sexual violence, it implies also an improvement for women who experienced sexual violence.

C. General Concepts of Sexuality, Love, Marriage, and Family

The predominant concept in the institutionalized heterosexual relationship is that it should be based on love and last lifelong. In recent years, the diversity of this concept has increased considerably, with a shift to shorter, less-stable relations, with changing partnerships over the lifecycle. This shift is reflected in increases in the divorce rate, single households, and *single educating households*. There is also an increase in the acceptance of other forms of sexualities such as homosexuality and less stigmatization for transsexual individuals.

There is also an increasing trend for a separation of fertility and sexuality. The fertility rate is rather low, around 1.5 children per fertile woman. There is also a relatively high mean age at first marriage, 27.5 years for females and 29.8 years for males. Premarital sexuality is widespread and well accepted. It goes along with the easy availability of contraceptives and widespread sexual education in schools (see Sections 3 and 9 on these topics). Sexual activity is socially accepted also among the younger. This is reflected in the so-called "*Schutzalter*" or protection age, which is set at age 16. The legal marriage age is 18. Despite a relatively high percentage of sexually active teenagers, there is a low rate of unwanted consequences, especially teenage abortions (see also Section 9B, Contraception, Abortion, and Population Planning, Teenage (Unmarried) Pregnancies).

2. Religious, Ethnic, and Gender Factors Affecting Sexuality

ULRIKE KOSTA

According to the last census, 44% of the population in Switzerland is Roman Catholic, and 37% belong to the Protestant church. The number of Muslims has doubled since 1990 because of immigration from Kosovo, Bosnia-Herzegovina, and the Republic of Macedonia. With a population of 311,000, Muslims are the third-largest religious group in Switzerland (4.5% of the total population). The number of Greek Orthodox Church members has also increased greatly (133,000). There are also Jewish communities and Christ Catholic parishes.

The Protestant churches and the Roman Catholic Church have been losing a significant number of members for years. This trend continues and is linked to a process of secularization and changes in values. In the 1990s, the number of persons who indicated they did not belong to any church or religious group rose from 7.4% to 12% of the population.

The Protestant church in Switzerland is characterized by a variety of different regional churches. There are largely cantonal churches, which differ in their theological and organizational character and program.

An empirically conducted ecumenical study in the canton of Basel-Stadt from 1999 showed that more than two thirds of respondents described themselves as "religious in the broadest sense." There exists a great contrast between public (e.g., attending church services) and privately practiced forms of religiousness. Accordingly, religion is practiced primarily in a private setting. Christianity continues to be the determining form of religious faith. A study from 1984 stated a correlation between the religious engagement and the number of children married couples desired. Couples who are very much involved in religion want to have more children than other couples. The study showed no difference about the expected number of children between Catholic and Protestant couples.

Until the 1970s, the sexual morality of the Roman Catholic Church exercised considerable influence on the behavior and attitudes of its believers. The process of secularization has diminished this influence significantly. To this day, the Roman Catholic Church's sexual ethics are determined by the encyclicals of the popes and statements by the national Bishops' Conference. In its encyclicals and other official proclamations, the Roman Catholic Church puts marriage center-stage as the sole place of legitimate sexuality. It considers sexuality an expression of partnership, of human union, and assigns it the aims of personal encounter and procreation. It stresses the natural and central status of marriage and its sacramental character, and rejects all forms of artificial contraception (the pill was prohibited in the encyclical, *Humanae Vitae*, by Pope Paul VI in 1968). On the other hand, some Catholic authorities emphasize the individual responsibility and the quality of the relationship.

The Roman Catholic Church insists on absolute protection of nascent life and so proscribes abortion. According to their "Statement on the Blessing of Same-Sex Unions and the Ordination of Practicing Homosexuals," the Swiss bishops view marriage as an "integrating element of God's plan of creation," yet do not transfer this to partnerships between two homosexuals. The bishops also reject any discrimination of homosexuals. In brief, a deep tension exists between the official sexual morality of the Roman Catholic Church and the attitudes and behavior of the laity.

Like the Roman Catholic Church, the Protestant churches stress protection of marriage and the family. At the same time, they do not accord marriage the same sacramental and central character as the Roman Catholic Church. They also support strong protection of nascent life and reject the use of embryonic life for the purposes of acquiring stem cells, for instance. Switzerland's Protestant churches have also been at the center of years of intensive debate on the subject of homosexuality and same-sex unions.

Although religious values as applied to sexuality are still present in society, it is clear that their influence is diminishing and that sexual behavior is a decision for the individual.

3. Knowledge and Education about Sexuality

SIBIL TSCHUDIN

A. Government Policies and Programs

At present, sexual education is listed as part of the compulsory school's syllabus. After the ninth school year, the basis for sex education is fragmentary and varies from canton to canton. Meanwhile, HIV-prevention education is compulsory. Although parents can veto their children's attendance in sexual education classes, the existence of a legal basis promotes sexual education. Still, the law does not guarantee its systematical realization.

Sexual education has been organized along two lines, the so-called "internal" model and the "external" model. The internal model is predominant in the German-speaking part of Switzerland and in the Ticino canton. Although theoretically responsible for the realization of sexual education, the cantonal offices just give a few pieces of advice to school headmasters and teachers and normally do not do any qual-

ity assessment. It therefore depends almost entirely on the teacher him- or herself how much emphasis is given to the topic. The teacher chooses the lesson content, as well as the number of classes she or he dedicates to sexual education. In the external model, sexual education is considered a special subject by offices and schools. Cantons and communities undertake the responsibility for its realization by engaging well-trained external experts. This procedure guarantees a qualitatively high standing and standardized education program, although only for a few lessons. The disadvantage of this model is the lack of sexual education's integration in everyday school life and the risk that the topic is totally delegated to the external expert by the teacher.

Coexistence of Both Models

In some cantons with the internal model, external experts are additionally engaged quite systematically. The organization of sexual education and HIV prevention is not uniform all over the country on either the political or the administrative and practical level. This renders coordination more difficult and results in a lack of well-defined duties and responsibilities.

By a 1981 federal law, all cantons are obliged to establish an office for Planned Parenthood. The intention was mainly to guarantee adequate counseling in case of unwanted pregnancy, but these institutions also offer contraceptive counseling and sometimes even broader information concerning sexual health.

School health services make various offers for pupils, as, for example, a consultation hour on school grounds. These offers, however, vary from canton to canton. Zurich has a "*Fachstelle für Sexualpädagogik*," with a free sex consultation in person, by telephone, and via a website.

A recent study evaluated sexuality education programs and courses in Swiss schools. The researchers found there is an enormous heterogeneity between Switzerland's 26 federated states. Although the federal government has provided a legal basis for all schools to teach about HIV, the local implementation varies widely. It seems that on the obligatory school level, where students are age 7 to 16, the coverage of HIV/AIDS information is sufficient. At the higher school levels, much less time and effort are devoted to meeting this lifelong education need. In the German-speaking region, sexuality education seems to be less effective than in the French-speaking region. There is no basic sex education in the German-speaking part, which makes it more difficult for the teachers to approach AIDS as a subject.

B. Informal Sources of Sexual Knowledge

Informal sources of sexual knowledge in Switzerland are magazines, telephone hotlines, and the Internet. *Bravo*, a German magazine for teenagers, is widely read in Switzerland. Durchblick has offered information about sex and contraception by experts (gynecologists) for over ten years, first as a telephone hotline, and nowadays mainly as an Internet forum.

4. Autoerotic Behaviors and Patterns

JUDITH ALDER and JOHANNES BITZER

A. Children

In Switzerland, sex education and pedagogy for children generally only start in middle school (after 6th grade); the quantity and quality of sex education as described earlier, depends mostly on the teacher. Before that, sex education is done by parents, with wide differences in the ways parents talk about sexual matters to their children according to their social and religious background. In the past ten years, it can be observed, however, that more parents choose to explain to their children in more-concrete words what sexuality is and how children are created and born. Some children's books about reproduction have been published to help parents provide a child-concerned early sex education. Orientation about autoerotic behavior as part of a normal development process is done unsystematically by pediatricians and child therapists, but usually only if parents have questions about particular issues. There is so far no systematic survey about the autoerotic behavior of Swiss children.

Autoerotic behavior can be observed in young children by the way they touch, caress, massage, and scratch their genitals or rub themselves against, for example, a swing. Behavior like this is mostly done by coincidence, regular and planned masturbatory behavior at kindergarten age (4 to 6) being considered as abnormal. It depends mostly on the caregivers' reactions of whether they believe this behavior is normal but to be carried out in private, or if they view it as immoral and prohibited. Masturbatory behavior can be observed more in boys than in girls, which might be because of the visibility and reactivity of the genitals.

B. Adolescents

No systematic surveys have been carried out on masturbation and other autoerotic behaviors in the general population of Swiss adolescents. There do exist a few Internet services and counseling centers for teenagers, which provide answers to questions about sexuality and family planning. The following information, therefore, cannot to be considered as completely representative for Swiss teenagers, since only interested adolescents contact these services. However, they reflect general observations.

In boys, masturbatory experiences are reported earlier than in girls, with boys starting to masturbate between the ages 11 to 14. Some myths about damaging effects of masturbation can still be encountered (e.g., "Frequent masturbation harms the spinal cord") in boys. In contrast to boys, who talk more openly about masturbatory experiences, girls tend to be more reluctant to talk about masturbation and generally start practicing it later (beginning about 14 years). The typical questions boys 13 to 15 years of age addressed to counselors concern anatomy and the size of the penis, breast stimulation, and masturbation. Girls mostly address questions about menstruation, the time of its onset, and the nature of orgasmic response. With increasing age, the focus of questions becomes very specific; i.e., premature ejaculation, STDs, and homosexuality, but also with a concern for knowledge about normal lovemaking and a worry about not wanting it enough.

C. Adults

Questions about masturbation are not asked systematically in surveys about sexuality. The estimation about experience with masturbation in men lies between around 95%, with about 70% to 85% practicing masturbation on a more regular basis. Still fewer women have experiences with masturbation (50% to 70%). Questions addressed to counselors and physicians generally concern issues of the normality of masturbation parallel to a stable relationship, and sexual fantasies that are in combination with masturbation.

5. Interpersonal Heterosexual Behaviors

JUDITH ALDER

A. Children

Interpersonal sexual behavior manifests around the time of kindergarten in Swiss children (ages 4 to 6). It is represented by a curious, inquiring, and exploratory behavior; boys and girls are interested in the look and size, sometimes

the smell of each other's genitals. The inquiry, however, is mostly done in private, going to the toilet together, for example. Girls and boys then might touch or caress each other's genitals. The interests, however, at this age are still very wide, with some girls and boys not being interested at all.

Role-playing is of central importance for the definition of one's own sex, representing mostly stereotypes even in children with "modern" family structures (e.g., job sharing of parents). In indirect role-play (for example, when playing with dolls) as well as in direct role-play, sexual behavior can be observed when dolls, or boys and girls, respectively, lie on each other. However, children generally name behavior like that as playing "Tarzan" or anything else they know from television or computer games, without having the concept of lovemaking. Doctor's games are another form of interpersonal sexual behavior. Again, on one hand, the main drive is curiosity about differences in anatomy and not sexual excitement. On the other hand, this is a way to be pleasantly touched and tickled by children of the same age, on "neutral" parts of the body as well as the genitals. Caregivers' reactions, again, are of importance for the development of subsequent behavior.

B. Adolescents

In 2003, about three quarters of 14-year-old girls had had some kind of interpersonal sexual contact. In boys, interpersonal sexual behavior starts a bit later, with about two thirds having had some experience by the age of 14. The first contacts are generally through kissing. Group games ("bottle game") are still a frequent way of making first experiences. Other rituals can be observed at parties in dancing games. While boys are more aware about possible sexual reaction, many girls are still surprised and insecure when they lubricate, and do not know it as a sign of sexual arousal. "Dating" often starts before the exchange of caresses and, in the beginning, seems to be more of a definition of a relationship. Dating—"going together"—starts as early as 10 or 11 years. Again, there are wide differences in heterosexual interests at the beginning of puberty.

The legal age for the protection of minors is set at 14 years for consensual sexual relationships. The age difference between the partners is considered as relevant. The age at first sexual intercourse has changed over the past 20 years, to a greater extent for boys than for girls. Boys seem to catch up with girls, with the latter still being somewhat earlier. Intercourse experiences are reported by around 10% of 14-year-olds, while two thirds of boys and girls report intercourse experience by age 17. The step from petting to intercourse, in general, is a small step, with a stronger emphasis on intercourse being done with the right person and is, therefore, a conscious choice and planned behavior.

Relationship changes are frequent in the teenage years and in the 20s, with the tendency to last longer after the age of 18 to 20. Sexual intercourse mostly is a firm part of romantic relationships after the age of 18.

C. Adults

Sexual intercourse before marriage is very common and in most relationships the norm. Dating in general is very casual, young men asking women out as well as vice versa. There are no firm rules about dates or when it is acceptable to initiate sexual contact. Most couples live together for many years before getting married, some moving together when moving out from the parental home. Most young women and men in their 20s, however, choose to first live alone or in communities without bonding as a couple.

With women increasingly following professional careers and having longer education periods, the age at marriage and childbirth has risen significantly in the last ten years. In 2001, women were 28 and men 30.6 years on average when they got married (Bundesamt für Statistik, www.statistik.admin.ch). It was calculated that 58% of women and 53% of men under the age of 50 will get married over the course of time, if the rate of marriage in 2001 remains stable. While in 2001, almost 36,000 couples got married and 15,778 divorces were recorded—45.8% with children under age 18 years—the total population in 2001 was 7,261,210. The current statistics suggest a divorce rate of 38.5%, if the number of divorces remains stable over time. In the same year, 73,509 children were born, with 11.4% of mothers not married at the time of delivery. This number does not represent only the traditional single mother, since more and more couples choose not to get married when they start a family. The child/mother ratio in 2001 was 1.4:1.

In 1999, the Swiss people rejected implementation of a nationwide maternity insurance. This means that there is no obligation of salary payments for women who are on maternity leave. However, a 6-week maternity protection (time after birth where a woman cannot be expected to work) exists. Most governmental institutions and private enterprises, however, do provide 80% to 100% of the employee's salary during an 8- to 16-week period after birth. Also, for mothers who take unpaid maternity leave, there exists a one-year dismissal protection. Fathers do not have any paid parental leave in any institution. In all states, they have the right to one day off from work for the birth, and some states (e.g., Zürich), and some firms, offer a one- to two-week paternal leave after birth.

The interpersonal sexual behavior in the adult years has become more open minded in the past 20 years. Prevention of HIV has helped, to some degree, to open discussions about different sexual practices. Because no data are available on attitudes towards oral or anal practices for heterosexual couples, we rely on clinical observation. While anal sex is most common in gay couples, it is only occasionally used by heterosexual couples. While curiosity for many couples leads to a first tryout, women may experience it as painful and will not want to do it regularly. It is mostly women who will not be ready to try it at all, mostly because of shame feelings or fear of pain and partner reaction. The attitudes on oral sex are more alike in both sexes. Most couples do have experience with oral sex, and women, as men in general, experience it as pleasurable. Even though the attitude is more positive than with anal intercourse, oral sex is not practiced in every sexual contact.

Relationships in Switzerland, in general, are monogamously faithful. Even though most couples consider faithfulness as one of the most important premises of a functioning relationship, many couples experience at least one crisis because of an extramarital sexual contact during the course of time.

Sexuality and the Physically Disabled and the Aged

In recent years, increasing efforts have been made to ameliorate the status of counseling and care for handicapped people regarding sexuality. At Nottwill, one of the large centers for paraplegics in Switzerland, courses are being offered for paraplegics and tetraplegics (quadriplegics) regarding sexuality and intimate relationships. In these courses, basic knowledge about the sexual behavior of males and females is taught, and the influence of the individual dysfunction analyzed. The focus of the courses lies in the development of new approaches to sexuality and sexual intimacy. The teaching includes communicative skills with partners, sensuality training, sensate focus, and so on. Information is also given about the use of new drugs for

erection and orgasmic dysfunction (Viagra, Cialis, etc.). The courses are given in collaboration between urologists, gynecologists, psychologists, nurses, and social workers.

As far as the sexuality of the elderly is concerned, there are also activities in the larger cities of Switzerland in health education and adult educational programs. These programs are offered either by the universities or by other public teaching institutions. These activities are focused on giving information about the organic, endocrine, and psychosocial changes of aging, and in the development of an understanding of sexual needs and behavioral patterns of elderly people. In the institutions (*Alterspflegeheime*), there is a large variety regarding the openness and the active attitude of the caregivers with respect to the sexuality of the elderly.

6. Homoerotic, Homosexual, and Bisexual Behaviors

UDO RAUSCHFLEITSCH

There are no representative data about the number of lesbians, gays, and bisexuals in Switzerland. Since life for homosexuals and bisexuals is by far easier in the big cities, they usually prefer to leave the rural areas and live in the big cities. Here, as in several other countries, we can assume that about 7% to 9% of the men and about 5% to 7% of the women have a homosexual or bisexual orientation. These estimates include those individuals who have homosexual relationships, but have not come out as lesbian, gay, or bisexual.

Since there is quite an open atmosphere concerning homosexuality in Switzerland, it is not too difficult for young people today to have their coming out. Many of them have an early coming out at about 16 years. Difficulties occur only in traditional Roman Catholic or fundamentalist Protestant groups. But until now, there are no announcements at schools in Switzerland about coming-out groups for the young lesbians and gays, although these groups exist in the bigger cities. Information about homosexuality is rarely given at schools. Most of the young (and elder) people get this information by newspapers, radio, TV, and scientific or popular literature. Most of the mass media report positive information and criticize discrimination against lesbians, gays, and bisexuals.

Though there is quite an open, accepting atmosphere in Switzerland, we also find violence against lesbians, gays, and bisexuals. While lesbians are more often attacked by men living or working nearby (as van den Oort reports from Germany), gays are mostly victims of young men who beat and rob them in parks, public toilets, and other areas for anonymous sexual activities. The number of victims who file a report with the police is nowadays higher than it was in former times, when the victims feared (and really experienced) that they were not taken seriously and were blamed or even accused by the police. Even so, quite a number of violent deeds still go unreported, especially if the victims are men who fear to be known officially as being involved in same-sex activities (these victims are often married men). Concerning violence, it is necessary to take into consideration that the different forms of discrimination (verbal discrimination, discrimination in the job area, not having the same rights as heterosexual couples, etc.) are also violent acts, which hurt lesbians, gays, and bisexuals and leave scars in their personality. Professionals who work in the psychosocial field with counseling and psychotherapy have to know about these psychic injuries and their consequences (Rauchfleisch 2001; Rauchfleisch et al. 2002; Wiesendanger 2001).

Coming out is not an easy process even today, since the declaration of being lesbian, gay, or bisexual always includes the risk—or at least, the person who plans her or his coming out fears—that parents, friends, and colleagues at work may be shocked and may break with the homosexual or bisexual person. Moreover, at least in the past, the young lesbians and gays did not have models of other lesbians and gays who could give them a positive view of what it means to be lesbian or gay. This situation has changed during the last ten years, since today quite a lot of lesbians, gays, and bisexuals appear openly with their sexual orientation and their way of living.

Studies on the question of how many young people at which age have their coming out do not exist in Switzerland. But the data from other European countries and the United States lead to the conclusion that the coming out, also in Switzerland, nowadays is usually quite early, as mentioned above, at about the age of 16 years. This means that already during adolescence, lesbians and gays are sure about their same-sex orientation and look for and live a lifestyle according to this orientation.

But these statistical data of an early coming out do not mean that all gays and lesbians have their coming out already during adolescence. There are still women and men (especially bisexuals) who keep their same-sex orientation secret, and even live for some time in heterosexual relations, and have their coming out as same-sex oriented women and men in their 30s, 40s, or even 50s. Those people are in a special situation since they have emotional attachments and obligations to their spouses and children, which make their coming out more complicated than it is for people of younger age. These families especially often need professional counseling during the coming-out process, which is not only an individual step of the homosexual or bisexual person, but a step that all members of the family must undertake (Rauchfleisch 2001; Wiesendanger 2001). This counseling can be done in a few therapeutic sessions with the couple and/or with the whole family, as well as by couple therapy or by family therapy in the narrow sense. Unfortunately, there are not many therapists or centers where families with a lesbian mother or gay father can find professionals who are familiar with these problems. Because of this, the existing self-help groups for lesbian mothers and gay fathers fulfill an important function, since there they find sympathy, support, and advice in their, at times, difficult situation. There also exists a self-help group, Hetera, for wives of gay husbands, where they have the opportunity to talk about their disappointment, their grief, and their feelings of being cheated in different aspects during the time of their marriage.

Especially difficult is the situation for those lesbians, gays, and bisexuals who suffer from psychic illness. In Switzerland, as in many other European countries and in the United States, the majority of professionals nowadays have the opinion that same-sex orientation has nothing to do with psychic health or psychic disease, but that homosexuality as heterosexuality includes the whole range from psychic health to severe disturbance. It is this insight that there is no causal relationship between the sexual orientation and psychic health or disease that led the World Health Organization in 1991 to make the decision to cancel homosexuality as a diagnosis from the *ICD*.

But we know that there are interactions between psychic disturbances and same-sex orientation. On the one hand, we know from empirical studies that discrimination at work has a severe negative influence on the somatic and psychic well-being of a person (Schneeberger et al. 2002) and, as studies from other countries show, being lesbian, gay, or bisexual nowadays still means living in a special situation with specific burdens. Some symptoms (e.g., suicidal impulses, abuse of alcohol, and psychosomatic disturbances) can be understood as reactions to these stressful circumstances.

On the other hand, we must take into consideration that being resistant to stigmatization and offenses in everyday life needs a strong personality that is able to create coping strategies to handle these difficult situations. People who suffer from psychic illness (neuroses, personality disorders, or psychoses), per definition, do not have this strength and, because of this, have many more difficulties in handling the problems in the coming-out process. At times, patients with borderline personality disorders, in particular, use their same-sex orientation as an explanation for all the difficulties from which they suffer in everyday life (Rauchfleisch et al. 2002). It is important for therapists and counselors who work in the psychosocial field to know about these interactions between the same-sex orientation and the different psychic diseases.

There are not many professionals in Switzerland who are very experienced in this field. In the big cities, lesbian, gay, and bisexual therapists have formed groups where they discuss these problems. There is also a national Swiss organization called Medi-Gays, a group for lesbian, gay, and bisexual professionals in medicine and psychology.

Since the Roman Catholic Church as well as fundamentalist groups in the Protestant churches have a strong discriminative policy against homosexuality, lesbians and gays have founded the ecumenical group HuK (Homosexuelle und Kirche—Homosexuals and Church), which fights for acceptance of lesbian, gay, and bisexual Christians. In another group, ADAMIM, founded in the early 1990s, gay priests have found a place to share their experience in church, to draw the public's attention to their difficult situation in church, and to fight for their rights as being accepted members of their church.

There are also two large national organizations, one for lesbians, LOS (Lesbenorganisation Schweiz—Lesbian Organization Switzerland), and one for gays, Pink Cross, which work together when it is necessary to fight for the rights of lesbians and gays. There are also local homosexual groups in the big cities. Moreover, there are groups for lesbians, gays, and bisexuals who are working in different professions (e.g., in medical jobs or as teachers) and sections, formed by Pink Cross, and working for a better situation in church, in the working field, for legal rights, and so on.

Until now, there are only two cantons of Switzerland (Genf and Zürich) where lesbian and gay couples have the opportunity to legalize their partnership. A national law is in the works as of mid 2003, but it is not yet decided. As in other European countries that already have such a law, it will give same-sex couples the same rights as heterosexual (married) couples, but will not include the right for adoption, although long-term studies from other countries show that children who are brought up in lesbian or gay families do not differ from children who are brought up in heterosexual families, i.e., they do not show any specific pathology in their personality or behavior (Rauchfleisch 1997).

7. Gender Diversity and Transgender Issues

UDO RAUCHFLEITSCH

Switzerland at present has no special laws dealing with transsexuality. Though for many people, transsexuality is still something "strange" and "irritating," the acceptance of transgender persons in public has increased during the last 10 to 15 years. This leads to less discrimination and has made it easier for them to find a job and to live an "ordinary" life. Some get married in their new role (heterosexual preference), while others live in a lesbian (man-to-woman) or gay (woman-to man) relationship with a partner. This phenomenon shows that transsexuality is a dimension independent from sexual orientation.

There are some centers in Switzerland at the University Hospitals where specialists of surgery, endocrinology, psychiatry/clinical psychology, urology, and gynecology treat transgender/transsexual persons. The programs are adapted to the way of treatment that developed in other countries, especially in the United States. This modality requires at least one year of an ongoing psychotherapeutic accompaniment, a psychiatric expert opinion, one year of treatment with cross-gendered hormones, and then the operation. Medical insurance companies pay for the psychotherapeutic and medical treatment if a psychiatric expert opinion states that there is an indication for those interventions. But the insurance companies still refuse to pay for epilation and logopedic (voice) treatment before operation, though these interventions are important for a good integration of the transsexual person into the new gender role. After a sex-change operation, it is possible to change the first name in the personal status in all documents.

Experience with transgender/transsexual persons shows that within this group we find the whole range from psychic health to severe psychic disturbances. Severe psychopathology, especially schizophrenia, is a contraindication for treatment with cross-gendered hormones and surgery. Studies on long-term outcome show, in accordance with the international literature about transsexuality, that generally woman-to-man transsexuals have a better prognosis than man-to-woman transsexuals. Moreover, social integration is an important predictor for outcome (Wyler et al. 1979; Rauchfleisch et al. 1998). If the passing (fitting into the new gender role by the body structure) is good, it is easier for the person to be accepted in this role, while it is a more complicated situation for those with a poor passing. On the whole, passing for woman-to-man transgender persons is much better than for man-to-woman because of the strong consequences of the treatment with testosterone (especially breaking of the voice and growing of a beard). Those transsexual persons who have a solid professional education can often stay in their jobs and do not have great difficulties in social acceptance (family, friends, or public). Experiences with the psychotherapeutic accompaniment show that it is important and fruitful that this treatment is offered during the whole process, from the time before medical interventions until the operation, and even for some time afterwards. If there are spouses or children, it is important to integrate them, at least from time to time, into psychotherapy, or recommend them (especially children) for individual psychotherapy or counseling.

8. Significant Unconventional Sexual Behaviors

A. Coercive Sexual Behaviors

Child Sexual Abuse, Incest, and Pedosexuality (Pedophilia)

As in many other countries, child sexual abuse is a crime with a high percentage of unreported cases, especially when it is an abuse in the sense of incest (done by the father or other close family member). This fact can be understood because of the closeness of the perpetrator to the victim. Often the victim does not dare to inform other people because of fears that they will not believe her or him, or the victim feels he or she is guilty for what has happened; there might also be a loyalty conflict because the perpetrator is a person to whom the child is closely attached at the same time as the abuse is occurring, often causing total confusion about her or his own perception. Because of this emotional confusion and because

of the feelings of shame and guilt, it can take many years until sex abuse is consciously recognized and reported to psychotherapists. Eighty to 90% of the victims are girls. The perpetrators are generally up to 90% men from all social levels. To fight sexual abuse of children, an emancipating education and a change of gender-specific power structures is demanded. In Switzerland, children and parents find help in various institutions and places for maltreated and abused children, by emergency telephone hotlines for children, in child-protection centers, and in psychiatric and psychological institutions for children and families.

Pedosexuality

We prefer this term instead of "pedophilia," which by "philia" conceals the aggressive dimension of these deeds. Pedosexuality focuses on the various dynamics and interactions between perpetrator and victim. Similar to incest are those cases where the perpetrator is a leader of Boy Scout groups, a clergyperson, a trainer of sport groups, and so on, who is quite close to the child. Most of the cases of pedosexuality belong to this group. In 2002, both worldwide and in Switzerland, pedosexuality became a public issue when pedosexual crimes committed by Roman Catholic priests decades earlier became a public scandal. It seems that not all these priests are men with pedosexual preferences, but instead chose to abuse children as the way of the lowest resistance ("*Weg des geringsten Widerstandes*"). Though the officials of the Roman Catholic Church, as usual in such cases, tried to talk of "singular cases" and denied any connection with the forced celibacy of priests, it is obvious that the structures and the sexual norms of the Roman Catholic Church are important factors and are directly (causally) related to these pedosexual acts of priests.

In other, far fewer cases of pedosexuality, the victim does not know the perpetrator who tries to get into contact with the child and abuses it.

Sexual Harassment

As in other European countries and in the United States, many women are victims of sexual harassment at their workplace. A study conducted in 1993 (Ducret & Fehlmann) reported that 72% of the women surveyed indicated that they had experienced sexual advances by men against their will or were victims of sexual insults at least once and usually more often. Those affected are more often single women, frequently in insecure positions, with a low self-esteem, and in a professional situation of great dependence and in jobs dominated by men. The perpetrators are "ordinary" men, frequently married, fathers of children, and mostly more than 10 years at the present workplace. As shown by this and other studies, sexual harassment has a very bad influence, not only on the victims (feelings of shame and helplessness, sleeping disorders, anxiety, depression, and disturbances in personal relationships), but also on the working place (lower efficiency of work, bad climate at the place of work, and leaving the job).

A law (*Eidgenössisches Gleichstellungsgesetz*, Arts. 3 and 4), enacted in 1996, declared sexual harassment punishable and obliged the employer to inform the employees about this law and to deal effectively with complaints. Until now, information events were undertaken in many public and private workshops, and in some cantons. Also both Protestant and Roman Catholic authorities have published information about sexual harassment and, as public and private institutions, have identified persons of confidence who, in case of sexual harassment, help women to clarify their situation, intervene at the workplace of the women, and support them if they want to start a legal procedure.

9. Contraception, Abortion, and Population Planning

SIBIL TSCHUDIN

A. Contraception

In the first half of the 20th century, contraception was mainly limited to the use of natural family planning methods such as the one Knaus Ogino devised. The response to questions about family planning was strongly—and might still be slightly—influenced by social factors and religion. That means that contraceptives were more accepted and used in Protestant regions than in Catholic ones, more in cities than in rural regions, and more by better-educated persons than by people of lower social status. With the introduction of the pill on the Swiss market in the early 1960s and the development of more-convenient IUDs, as well as in consequence of the women's emancipation movement, the demand for and use of effective contraceptives has changed drastically. Nowadays, its use is widely accepted. Birth control is still mainly left to women. After the detection of HIV/AIDS, and certainly because of information and large advertising campaigns during the last decade, the awareness of this problem and the acceptance of condom use has grown considerably.

In a survey carried out in 1996, a representative sample of 1,000 women between ages 15 to 45 were asked about the actual contraceptive method they used. The results showed a predominance of oral contraceptives (OC) by 31%, followed by condoms (17%), IUD (6%), tubal ligation (6%), vasectomy (5%), natural family planning methods (5%), coitus interruptus (2%), and depot-injections, diaphragm, and spermicides (1% each). Twenty-two percent indicated they used no contraceptive at all. Of this 22%, 18% were pregnant or intended to get pregnant; the remaining 4% would have been upset by an unwanted pregnancy. Young women (age group 20 to 25 years) use the pill in an even higher percentage of about 50%. Contraceptives are not covered by health insurance and must be paid for by the consumers themselves. This is an important factor that limits their use, especially by the young, people with low income, and asylum-seeking immigrants. Whereas condoms can be purchased easily in drugstores and supermarkets, the pill can only be bought in pharmacies on prescription.

B. Teenage (Unmarried) Pregnancies

In comparison with some other European countries, the pregnancy and birthrate of teenagers (age 15 to 19 years) is relatively low. In 1998, 3.9 per 1,000 teenagers gave birth to a child in Switzerland, while the rates in 1997 for the U.K., Sweden, and Netherlands were 30.1, 7.2, and 4.3 per 1,000, respectively. The estimated abortion rate for teenagers in Switzerland was 6.1 per 1,000 in 1998, indicating that three of five teenage pregnancies end by artificial abortion. The estimated pregnancy rate for the age group of 15 to 19 years is about 10 per 1,000. Teenagers can make the decision on their own, and if they fear that it could be seriously harmful to them if their parents were informed about the unwanted pregnancy, their wish for secrecy will be taken into account. Single mothers are given an assistance or guardianship for their children only if they are not of age or express a need for assistance. Various institutions offer help to the young mother, if there is not sufficient support by the teenager's parents and family.

C. Abortion

In the 19th century, legislation concerning artificial abortion was a responsibility and duty of the cantons. From 1893 to 1938, nationwide regulation of this issue within the federal penalty legislation was discussed and a federal law

was worked out. In 1942, it came into force and reduced the more liberal management of abortion in some cantons to medical indication. That meant abortion was only legal if severe danger for the pregnant woman's life or health was feared. Otherwise, abortion was illegal and punished by prison or fine. The new legal limitation did not lead to a reduction of the number of legal abortions (about 15,000 per year in those times). But the following decades and the changing and more and more liberal attitude of Swiss people towards abortion led to a reduction in illegal abortions at first, and after the introduction of the pill, to a reduction of legal abortions as well. In the 1960s and 1970s, a so-called "abortion tourism" (mainly from Catholic and conservative cantons to more-liberal ones) was common, and the women often were made to feel guilty when seeking help in case of unwanted pregnancy. In the 1980s and 1990s, the law was interpreted very liberally. Unofficially, women were now allowed to decide themselves, and their decision was legitimated by the physician's expertise attesting to the risk of psychological sequelae if the woman were forced to keep the unwanted pregnancy. Since 1988, no woman has been punished by law for illegal abortion.

In 1971, Swiss women finally got their right to vote. Soon afterwards, an initiative to exempt abortion from punishment was launched, and then withdrawn in favor of the so-called "*Fristenregelung*" (time-limited permission that means legalization of abortion on demand of the pregnant woman within the first 12 weeks of pregnancy). In 1977, however, this law and a later law enlarged to a social indication were barely rejected by a plebiscite. Before the paragraphs concerning abortion in the penal code could be revised, a federal law charging the cantons to establish a center for planned parenthood offering counseling for free was launched in 1981 and put into operation in 1994. After years of debates and discussions, the second initiative to introduce the "*Fristenregelung*" was clearly accepted by more than 70% by plebiscite in 2002. This act legalized the practice of most cantons during the preceding two decades, and put an end to the varying, and therefore unjust, handling by the cantons. Abortion is now legal on demand of the woman when executed during the first 12 weeks of pregnancy.

The methods used are medical abortion by *mifepristone* and *misoprostol* until 49 days of pregnancy, and vacuum aspiration and curettage until 12 weeks of gestation. Medical abortion can only be offered by a physician, who can execute a curettage in case of failure of the method. The operation can be carried out in public hospitals, normally under general or epidural anesthesia, or in private practice, usually executed under local anesthesia. Private clinics generally refuse to carry out artificial abortions.

In any case, the following prerequisites must be met:

- Written demand of the pregnant woman;
- Pregnancy under a maximum of 12 weeks of gestation;
- Counseling concerning risks, complications, and possible sequelae by the physician performing a medical or surgical abortion;
- Counseling of adolescents under the age of 16 years in a specialized office;
- All abortions must be reported anonymously to the responsible health authority; and
- Beyond 12 weeks of gestation, abortion can be performed if there is a medical reason. This reason must be more severe the more the pregnancy is advanced. During the second trimester, abortion because of psychosocial or psychiatric reasons is exceptional. Most abortions at this state of pregnancy are executed on demand of the woman or couple after detection of severe fetal malformations or chromosomal aberrations. Up to 14 weeks of pregnancy, a vacuum aspiration is the method used; afterwards, abortion is induced by *mifepristone* and *misoprostol*, occasionally followed by a curettage because of incomplete release of the placenta. The costs of any abortion procedures in the above-mentioned contexts are carried by the obligatory health assurance.

10. Sexually Transmitted Diseases and HIV/AIDS

JOHANNES BITZER

A. Sexually Transmitted Diseases

Since the 1920s, there has been a political effort to control sexually transmitted diseases by reporting cases to state institutions. Registered prostitutes are legally required to be examined at regular intervals for venereal diseases.

The Legal Framework

In 1999, a modification regarding the reporting of sexually transmitted diseases was established in Switzerland. The new legal dispositions abolished the necessity for the physicians to report classic infections like gonorrhea, chlamydia, syphilis, and chancroid. In addition, the new law interrupted the automatic registration performed by the laboratories of *Treponema pallidum*. These new regulations seem to be appropriate regarding the assessment of infections. The new regulation says the following: Obligatory declaration refers to HIV and AIDS, laboratory declaration refers to HIV-positive tests, gonorrhea, chlamydia trachomatis, and hepatitis B and C. In addition, the following infections have to be declared (reported) by physicians: HIV, AIDS, and hepatitis B and C.

The Epidemiology

The incidence of the different infections is changing. Gonorrhea has diminished and syphilis seems to be increasing.

There are very few specialized STD clinics, because these are usually integrated into the dermatological department of university hospitals. Thus, patients with STDs are usually seen either in practices of general practitioners, gynecologists, or urologists, or at the outpatient departments of the dermatology, gynecology, and urology units. There are, however, specialized HIV clinics, which are usually directed by infectiologists (internal medicine). Several dermatological outpatient departments in Switzerland have decided to survey other STDs. Their list includes: orchitis in men, rectitis, cervicitis, chlamydia, gonorrhea, syphilis, chancroid, genital herpes, genital condylomata, pelvic inflammatory disease, and *Trichomonas*. Unfortunately, the data gathered by the six outpatient university departments are not representative for the Swiss population.

For the general population, there is a declaration system called *Sentinella*. Between 150 and 250 general practitioners are cooperating on a voluntary basis to report infectious diseases. Since 1995, 30 gynecologists have been included.

In 1998, gynecologists have participated in a prevalence study on chlamydia in women under 35 years of age. From this study, it has been extrapolated that the numbers given by the laboratories represent only 5% of the total reservoir of chlamydia infections of women between 20 to 35 years. It is therefore estimated that chlamydia infections have spread out in Switzerland, with 2,400 infection cases in 2000. This means, that chlamydia is the most prevalent sexual STD infection in Switzerland. Compared with AIDS, the detection and tracing of other STDs is not optimal. This

provides a reason for reconsideration, especially regarding the resurgence of classical STDs in all European countries.

The laboratory reports do not permit an in-depth epidemiological analysis. On one hand, the available data are incomplete, and on the other hand, they do not mention the total number of tests. This makes it impossible to ascertain whether an increase in positive test results is because of an increase in infections or to an increase in the number of tests.

B. HIV/AIDS

Overview

HIV- and AIDS-prevention programs are quite widespread in Switzerland. Two major organizations are involved in public education and programs.

The AIDS Hilfe Schweiz, l'Aide Suisse contre le SIDA (aids@aids.ch) is a private association founded in 1985 and financed by Bundesamt für Gesundheit (BAG—the Federal Administration of Health). This organization has 21 cantonal and regional subcenters. The secretariat of the organization, based in Zurich (Konradstrasse 20, 8005 Zurich; case postale 1118, 8031 Zurich), develops specially tailored programs for HIV prevention especially for homosexual and bisexual men, female and male sex workers, drug consumers, and young people. This secretariat also coordinates the action of the other centers, which are financed by the cantons. The local or cantonal centers' services include medical information, legal advice, personal counseling, networking, and group formation.

A second regular information service is the SIDA Infodoc Swiss (www.infodoc-gf.ch). This organization is responsible for the collection of bibliographic information. SIDA Infothek publishes regularly a journal called *Aids Infothek*, which comments on the actual issues and also reviews recent publications.

The general approach in family planning consultations is to provide counsel for prevention of unwanted pregnancy in combination with protection against sexually transmitted diseases, especially HIV. This is accomplished by promoting the use of condoms. Tests can be made anonymously and free of charge at the Aidshilfe institutions. Testing is also available at the outpatient departments.

HIV-infected persons are obliged by law to inform their sexual partners about the risk. On the other hand, HIV-positive prostitutes are not obliged to inform their clients. Clients of sex workers are responsible for protecting themselves.

Partner tracing is not obligatory, nor are possibly infected persons obliged to be tested for HIV. HIV testing can be only performed with the informed consent of the person. Testing by institutions and hospitals for protection of medical personal without informed consent of the patients is not allowed. The general policy is to encourage people to get tested, but all the efforts are dealt with on a voluntary basis because coercion is thought to push people into isolation and anonymity that prevent them from collaborating with the health system. Infected persons are strongly encouraged to inform their partners. They are advised about the legal consequences of infecting another person in the presence of knowledge of one's own infection. Further obligations are not regulated by law.

HIV Prevention Programs

For the past 14 years, since 1989, the Institute for Social and Preventive Medicine of the University of Lausanne has performed various studies regarding the global strategy of prevention of HIV infections. Global evaluation surveys, as well as specific studies in specific populations, have been performed. The last report on the global evaluation of 1996 to 1998 shows the following results:

- Public awareness of the need for ongoing HIV prevention and consciousness of risk-reduction behavior remain at a high level. The results of HIV-prevention education are steady and persistent. There is no diminution of preventive behavior in recent years and the number of new infections has continuously declined. It can be seen that there is no longer a major difference in the different regions of Switzerland, and preexisting differences between cities and rural areas and between different groups of education have diminished. There is also general agreement that the confederation has to continue health education on this issue to make it part of normal life.
- A major element of HIV prevention is a solidarity, which manifests itself on the level of solidarity with affected persons, solidarity with the manifestly ill persons, especially regarding their jobs and their insurance, and solidarity with other countries affected by the infection.
- A special program for women's health and prevention of AIDS was set up between 1994 and 1998, making it possible to form groups of experts in reproductive and sexual health to integrate women's health into gender-sensitive programs and activities at universities and hospitals.
- There is, however, still a lack of uniformity between the different cantons in Switzerland. Another study has focused on the sexuality and sexual behavioral of HIV-positive persons (published in 1998). The infected persons suffer from various psycho-effective problems, like diminution of self-esteem, fear of being rejected, the difficulties of maintaining protected intercourse, the denial of the disease, the deterioration of physical well-being, and the questioning and doubts about maternity or paternity.
- From this study, it was concluded that, besides the medical care, more intensive psychological care is necessary. Furthermore, health personal should be informed about the special emotional needs of HIV-positive persons.

Another study of the needs of HIV-positive persons found that the quality of information and of counseling is too heterogeneous across the country. There are no guidelines regarding information-giving and patient education. Moralizing continues. The insurance companies do not pay for artificial insemination for HIV-positive males who want a child, but without the risk of infecting their partner with unprotected intercourse. Psychological support during pregnancy is insufficient. There is a need for continuous education for obstetricians and midwifes. There are still too many tests performed without informed consent.

Finally, a third study has evaluated sexual education at schools. As in other areas, this study showed an enormous heterogeneity between the different regions. Although there is a legal basis for all schools to teach about HIV, the practice is very different. It seems that on the obligatory school level, the coverage of the subject is sufficient, whereas at the higher school levels, it is much less. In the German-speaking region, sexuality education seems to be less effective than in the French-speaking region. There is no basic sex education in the German-speaking part, which makes it more difficult for the teachers to approach AIDS as a subject.

[*Update 2002*: UNAIDS Epidemiological Assessment: By the end of 2001, a cumulative total of 25,637 cases of HIV infection was reported in the country. The number of newly diagnosed AIDS cases has declined since 1995. This development is associated with improved therapy (highly active antiretroviral therapies, HAART). Injecting drug us-

ers and men who have sex with men each contributed approximately 25% to the reported AIDS cases in 2000 and 2001. The proportion of cases in the heterosexual transmission group had been steadily increasing until 1999, and seems to have stabilized since then at around 45%. As a result, the proportion of cases in women has also increased over the years to over 30%.

[The number of death reports for persons with AIDS increased until 1994 and has since declined. In 1999, approximately 120 persons with HIV or AIDS were reported to have died. This number is less than 20% of the number reported for the peak year 1994. Death reports are not complete for 2000 and 2001, but it is estimated that the decline in AIDS-related mortality is continuing, although at a slower rate.

[The number of newly diagnosed HIV infections has also been declining in Switzerland between 1992 and 1999 to 2000 and appears to be stabilizing. Heterosexual contacts have been the dominant transmission route since 1990 (over a third of all newly diagnosed HIV infections, over 50% since 1997). Men who have sex with men make up approximately 25%, and injecting drug users approximately 15% of reported positive HIV tests in 2000 and 2001. Among heterosexually infected cases, the proportion of cases with nationalities from countries with a generalized epidemic is increasing, although the absolute number of cases in this group has been more or less stable in the second half of the last decade.

[The estimated number of adults and children living with HIV/AIDS on January 1, 2002, were:

Adults ages 15-49:	19,000	(rate: 0.1%)
Women ages 15-49:	6,000	
Children ages 0-15:	300	

[An estimated less than 100 adults and children died of AIDS during 2001.

[No estimate is available for the number of Swiss children who had lost one or both parents to AIDS and were under age 15 at the end of 2001. (*End of update by the Editors*)]

11. Sexual Dysfunctions, Counseling, and Therapies

JUDITH ALDER

The definition of sexual dysfunction followed in Switzerland is in agreement with the international classifications of mental disorders *ICD-10*, chapter F52 (sexual dysfunction not in relation to a medical factor), and *DSM-IV* (sexual and gender identity disorders). However, in the general population, there is a lack of definition of what "normal sexual behavior" is. This is particularly true in the lack of public knowledge about what is the "normal" range of frequency for sexual activity and what types of sexual behavior are considered within the "normal" range. In general, a sexual dysfunction is diagnosed only after a longer period of its persistence and not shortly after the development.

An impairment of sexual behavior/response that has the following features is understood as sexual dysfunction:

- Disorder of sexual drive or satisfaction;
- Lack of the physiological reaction needed for satisfactory sexual interaction;
- Inability to experience and control orgasm; or
- Painful intercourse.

A recent Swiss survey of sexual dysfunction in women shows that lack of libido is the most-often-named sexual problem (41%), followed by orgasmic disorders (19%), dyspareunia (painful intercourse) (12%), vaginal spasms (10%), sexual aversion (8%), and excitement disorder (1%) (Buddeberg et al. 1994). In men, the most frequent sexual dysfunction is erectile dysfunction (41.7%), followed by early ejaculation (30.6%), lack of libido (9.7%), painful intercourse (2.8%), and sexual aversion and delayed ejaculation (both 1.4%) (Buddeberg et al. 1994). In general, sexual dysfunction certainly is not something people talk about when they are confronted with it. Even women during menopause rarely have an exchange about the changes and problems in sexuality they experience during these years.

Availability of Diagnosis and Treatment

People with sexual problems generally consult first their family physician or gynecologist. Many patients who do not mention the problem to their doctor will not receive treatment for a long time. Questions about sexual functioning are still not part of a routine history taking. Only a few men would consult a urologist in the first place; they generally wait until their general practitioner physician refers them. If the problem is recognized, diagnosis by physicians generally is mostly adequate. However, if the problem is related to addictive behavior or medication, it may not be assessed carefully enough. Sexual problems in the first place are still looked upon from a somatic perspective and more so for men than for women. Only if a medical treatment is unsuccessful will the patient be referred for specialized counseling. However, there is a clear shortage of therapists who have special skills in sexual counseling, and it is generally rather difficult to find therapy places for patients with a sexual dysfunction. There are only a few centers in the larger cities that offer special counseling and therapy for sexual dysfunction. And these generally have waiting lists.

Training and Certification of Therapists

A recent study assessed knowledge of and sensitivity to the sexual side effects of antidepressants in general practitioners and psychiatrists (Kunz et al. 1998). The response rate (12.5%) of the contacted physicians was very low, demonstrating at least partly the lack of relevance that healthcare providers give to sexual matters in counseling for other psychological problems. Only one half of physicians responding judged their competence in sexual medicine as fair or good. Differences in sexual history taking were observed between general practitioners and psychiatrists, the latter addressing more frequently sexual medicine-related questions. The results emphasize the importance of knowledge and competence in sexual medicine for general practitioners and psychiatrists, both showing interest in continuing education on this topic. Diagnosis and treatment of sexual dysfunction is part of most curricula in psychology and—later on—psychotherapy specialization. These curricula include sexual dysfunction as one part of the training among the other mental disorders. There are only a few private institutes, Zentrum für Agogik and Höhere Fachschule Luzern being two, which offer a specialization course in sexology and sexual counseling. However, there is no official regulation or certification for those providing sexual counseling in Switzerland.

12. Sex Research and Advanced Professional Education

JOHANNES BITZER

There is no Swiss professorial society for sexological research and sexology. There are, however, different professional associations that deal with sexual issues. These include the Swiss Society for Psychosocial and Psychosomatic Medicine, especially the Division of Psychosomatic Obstetrics and Gynecology; the Swiss Society for Fertility, Sterility, and Family Planning; the Swiss Society of Urology; and the Swiss Society of Gynecology and Obstetrics. In recent years, efforts have been made to integrate sexolo-

gy in the curricula for training medical students. Until now, there is not yet a specific training program, which could be compared to other training programs designed to teach certain skills (*Fertigkeitsausweise*).

In 1998, a collaboration between the institutes of Basel, Zurich, and Lausanne for social and preventive medicine made a survey analyzing 140 publications regarding reproductive and sexual health: 23% of the publications were routine statistics, 12% repetitive studies, 61% isolated studies, and 5% ongoing studies. The largest amount of studies, 40%, concentrated on STDs and HIV, followed by unwanted pregnancies 33%, contraception 29%, sex education 14%, sexual behavior 8%, deliveries 8%, and violence 6%. This analysis showed that there is a lack of epidemiological data regarding the country as a nation in almost all areas, including unwanted pregnancies, STDs, violence, contraceptive behavior, and so on.

A quite-positive development can be found in the recent and current research projects undertaken by several research groups in Switzerland:

- The Institutes of Social and Preventive Medicine in Switzerland are focused on epidemiological research.
- The Institute in Zürich (Schmid, Gutzwiler) has done major research projects on sexual and reproductive health of the Swiss population. Furthermore, they have made surveys regarding sexual behavior especially in the older age group. Another focus of research of this group is HIV and AIDS prevention.
- The Institute in Lausanne (Dubois-Arber, Spencer) performed several evaluation studies on HIV/AIDS prevention, unwanted pregnancies, and teenager sexuality. Another focus of their research is violence and especially sexual violence. (Hofner et al.).
- Another publication was made in 2001 by the Institute of Social and Preventive Medicine of Lausanne. The study focused on the sexual health of the canton Waadt. The study focused mainly on postcoital contraception and a knowledge of contraceptive methods.
- The Institute in Basel (E. Zemp, U. Ackermann-Liebrich) is focusing especially on women's health issues. This includes research on family planning services, maternity care, mammography, etc.
- Research on teenager health was extended by P. A. Michaud and F. Narring.
- Several research projects on violence and especially sexual violence have been performed by different research groups (Godenzi, Felber, Gilloz).
- Research on contraception and sexuality is being performed by various university groups (J. Bitzer et al., M. Bianchi-Demicheli, etc.).
- The group of C. Buddeberg at the Zürich Institute of Psychosocial Medicine has published on several issues: Sexual counseling skills, and sexual behavior of elder females and males (M. Schmid-Mast, C. Buddeberg, F. Gutzwiller).
- The group of Johannes Bitzer at the Division of Social medicine and Psychosomatic Gynecology has done research on sexual dysfunction, counseling, and adolescent and perimenopausal sexuality.
- Another important institution is the Professor Willi Pasini Institute of Sexology at the psychiatric university hospital of Geneva. The work is now continued by Dr. Dominique Chatton, a psychiatrist.
- Several groups have done prevalence studies on STDs (Feuz et al., Lauper).
- One of the most important areas of research in Switzerland is the study of sexual and reproductive health performed by Karen Klaue and Brenda Spencer with the collaboration of Hugues Balthasar. This study was financed by the Office Fédéral de la Santé Publique, Berne, and was carried out at the Institut Universitaire de Médecine Sociale et Préventive, Lausanne. The background of the study is the important political initiative, called Postulate of Genner of June 2000, which demands that the government produce a survey on the report how the sexual health of the Swiss population could be improved. The study was performed from the December 1, 2001, to June 3, 2002. One of the major objectives of the study was the integration in coordination of different services and programs like mother and child healthcare, family planning, and AIDS help, prevention, and protection, with a special focus on groups like teenagers, men, and women apart from their role as mothers.
- Gender studies have also become an important part of the research and academic activities in Switzerland. The approach is multidisciplinary and includes the sensitivities and nuances of researchers in different disciplines like medicine, social signs, linguistics, history, and so on, to include in their research gender-specific questions and what is called gender mainstreaming.
- A competence center for gender studies was founded in 1998 in Zurich. In Lausanne, there is a chair for gender studies. There is a Swiss society for women and gender research, founded in 1996.

There is no official specifically sexological journal devoted to publication of sexological research. Research results are usually published in German or English journals.

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