



NORWEGIAN MINISTRIES

Strategy

Acceptance and coping

National HIV strategy (2009-2014)





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Preface

In the preface to “Responsibility and Consideration” – the strategic plan that was launched in 2001 and that is now being replaced with this new HIV strategy – it is stated that *“we can describe the development of the HIV situation in Norway as a transition from an emergency to an everyday situation.”* The HIV epidemic in Norway did not reach the proportions that many people feared it would in the 1980s.” This is still true. The HIV epidemic has not reached the proportions that we feared. However, we have witnessed a situation similar to an outbreak among men that have sex with other men in Oslo during the last five years, and the number of newly diagnosed HIV-infected persons reached its highest level of the last few years in 2008 with nearly 300 cases. This amounts to a doubling of the number of new yearly HIV cases relative to the situation a decade ago. A study now exists that compares the current living conditions of persons living with HIV with the situation seven years ago when the previous HIV strategy was launched. The study shows that the progress in the development of medicines has improved the physical health of people living with HIV, but a similar improvement has not taken place with regard to openness, knowledge about HIV and attitudes to HIV as a phenomenon in the society. In many areas – especially the psychosocial – it feels just as difficult to be HIV positive today as it was seven years ago.

This trend gives cause for concern and reminds us how important it still is to stay focused and pursue the same course of action with regard to HIV. Through this strategy and the fact that six ministries are now united behind it, the Norwegian Government wants to strengthen the effort to combat HIV. Our aim is a society that accepts and copes with HIV in a way that both limits new infection and gives persons living with HIV good living conditions.

Prevention of HIV-infection is a complex, complicated task. It involves matters such as the prevention of communicable diseases, sexuality and social inequality in health. Ensuring good living conditions for people living with HIV is important from both a preventive and a rights perspective. In order to succeed in the ongoing work, it is necessary for us to base our thoughts and work on a number of different perspectives.

Among other things, this involves discussing sexuality and the driving forces that contribute to a

further spread of HIV. It involves openness about HIV. The psychological costs of keeping one’s HIV status secret are often great for both the individual and the society. Through openness, the disease can be demystified and new generations of HIV positive patients will have an easier time than the previous ones. Last but not least, it involves knowledge. Knowledge about the ways in which HIV infects and the ways in which HIV does not infect. This is important in order to avoid the spread of HIV, discrimination and social exclusion. The strategy is based on important general principles, such as: human rights, the gender perspective, equal access to information and public services and the independent responsibility that all of us have to protect ourselves from infection and to avoid infecting other people. The strategy focuses special attention on groups that are at-risk for more than one reason, persons who have HIV or are exposed to a great risk of HIV infection and who encounter barriers in their lives of a psychological, social and financial nature. The strategy is designed at a comprehensive level and is meant to consist of a framework that gives it a direction and provides a basis for follow-up of effective, knowledge-based measures.

In the formulation of this strategy, emphasis has been given to involving HIV positive persons, representatives for HIV positive persons and civil society. Broad participation and active co-determination will also be important principles in the implementation of this strategy.

Oslo, Norway, 4 June 2009

Minister of Labour and Social Inclusion

Minister of Children and Equality

Minister of Health and Care Services

Minister of Justice and the Police

Minister of Education

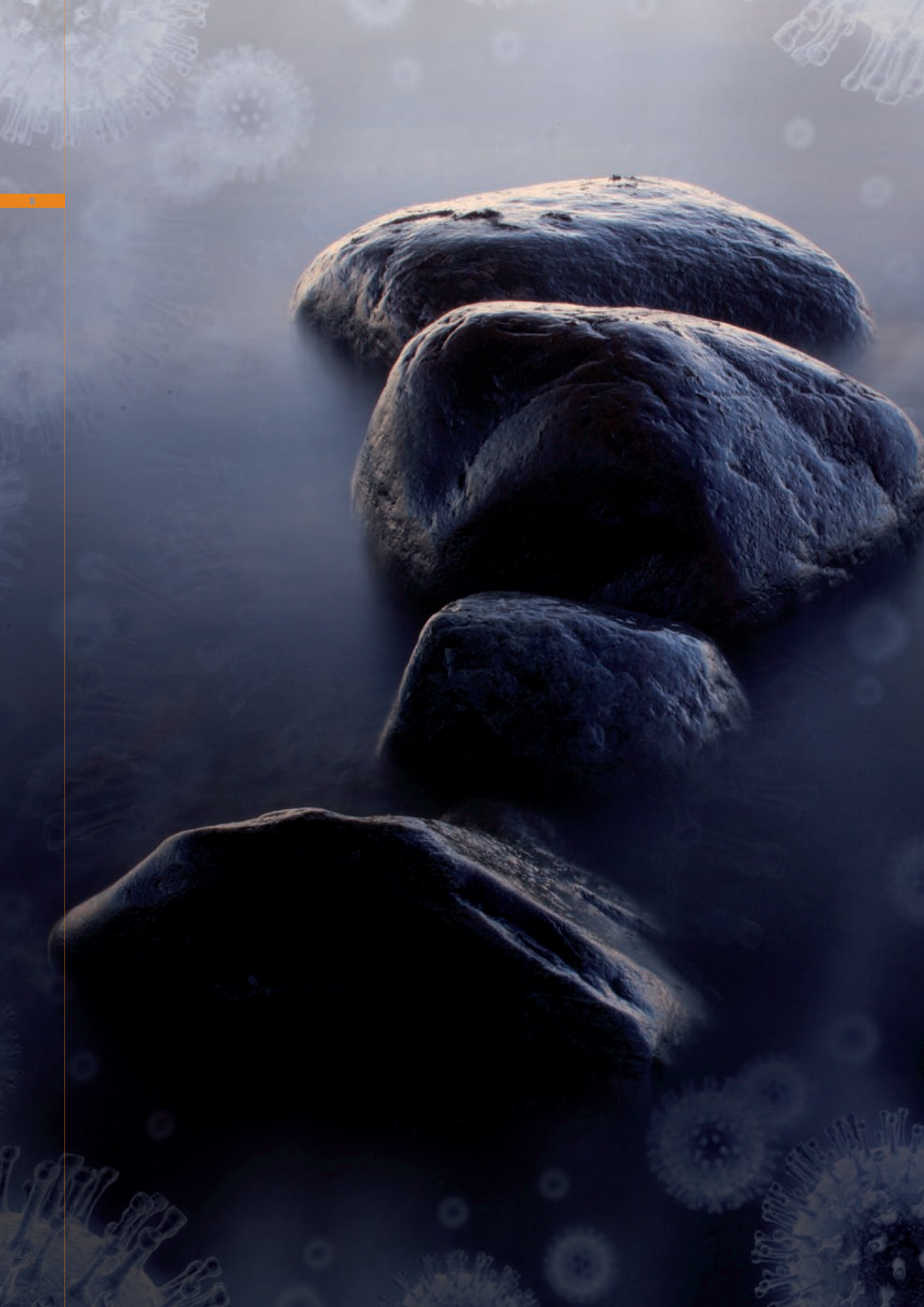
Minister of the Environment and International Development

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1. Introduction and background

1.1 Background

Since 2002, the national HIV effort has mainly been followed up within the framework of the health authorities' "Responsibility and Consideration - Strategic plan for preventing the spread of HIV and sexually transmitted diseases". Among other things, this was based on experiences from the preventive work that had been carried out through action plans since 1985. The strategic plan was based on four guiding principles: *The measures should encroach as little as possible on personal freedom*; efforts should be targeted at groups with a high risk and prevalence of HIV and at the general public; the authorities should cooperate with civil society; and society should show solidarity with persons with HIV and AIDS. The strategic plan had two general objectives and 19 specific objectives with relevant measures that were aimed at the population, target groups and individuals.

A considerable effort has been made to evaluate the strategic plan and summarise new knowledge about HIV.

- Econ Pöyry has conducted an evaluation of the strategic plan, which concludes, among other things, that even though the activities that were carried out were in accordance with strategies and measures in the plan, many of the objectives were not achieved. This especially applies to the groups men who have sex with men (MSM) and immigrants. In many ways, the challenges that the strategic plan described concerning the situation for HIV positive persons are still just as relevant today. There is a need to further develop strategies, give more priority to the efforts and get more of the sectoral authorities involved.
- A survey of public attitudes and knowledge conducted by the Institute of Applied Social Science (Fafo), *"Fortsatt farlig å kysse"* ("Still dangerous to kiss?") (2008) shows that in some areas there is insufficient knowledge about HIV in the population and that this can have an impact on HIV positive persons' life situation.
- In the spring of 2009, Fafo published the results of a new study of living conditions among people living with HIV in Norway: *"Fra holdninger til levekår. Liv med hiv i Norge i 2009"*. (From attitudes to living conditions. Living with HIV in Norway in 2009.) Compared with the previous study from 2002, this report shows progress with regard to somatic and physical factors. In many areas, especially the psychosocial, it is felt to be just as difficult to be HIV positive today.
- The Norwegian Knowledge Centre for the Health Services has carried out an international knowledge review of the things that must be done in order to increase the use of condoms among boys and young men. It shows that it is difficult to designate individual measures that have an effect by themselves and that measures supporting

- increased use of condoms must cover more aspects of sexuality and be targeted and recurrent.
- Agenda has evaluated the Norwegian Directorate for Health and Social Affairs' national scheme providing free condoms to adolescents, young adults and particularly at-risk groups. The scheme is well-known among the target groups of adolescents and young adults, but distribution schemes should be established that are more accessible than the current ones, e.g. distribution via the Internet.
 - A qualitative preliminary study among Africans in Norway (Institute of General Practice and Community Medicine, University of Oslo, 2008) concluded that most of the respondents had very little or incorrect knowledge about HIV and that little relevant information on this topic has reached them since their arrival in Norway.
 - Agenda, which has evaluated the two biggest recipients of subsidies throughout the whole planning period, HivNorway and Gay & Lesbian Health Norway, points out that much good, targeted work is done in these organisations, but that both of them would benefit from further narrowing and refining their core areas so that the work shall have sufficient effect.
 - In response to an assignment from the Commission to propose a comprehensive anti-discrimination legislation, Fafo has prepared a summary of research on discrimination against lesbian, gay, bi-sexual and HIV positive individuals.

Econ Pöyry emphasises in its evaluation that the previous strategic plan shows a good understanding of the problem and clearly presents objectives and furthermore that the relationship between objectives and measures is manifested in a good way. They think that the plan was not specific enough with regard to measures and responsibilities and that it was difficult to measure the efforts. The funds that were allocated for follow-up were limited relative to the ambitions. Econ Pöyry emphasises that in order to succeed in preventing the spread of HIV it is necessary to narrow the focus of the work. They think that it is important to focus on whether the measures that are implemented are targeted precisely enough in the sense that those who are at-risk come in contact with the measures.

The trend in the number of infected persons shows that the challenges associated with fighting new infection are greatest for the groups men who have sex with men (MSM) and certain groups of refugees, asylum-seekers and members of reunified

families in Norway. In future efforts, there will be a special need for improving the preventive efforts aimed at these groups.

Insufficient knowledge about the ways in which HIV *does not* infect can help prolong prejudices against HIV positive individuals and create a basis for stigmatisation and discrimination. The fact that only a few individuals feel that they are able to be completely open about their own HIV status affects their quality of life and also their ability and opportunity to make conscious choices related to the risk of infection.

Medical developments in the last 10-15 years have given most persons with HIV good prospects of living a long, good life. In addition to the challenges of preventing new infection and ensuring that a steadily larger group of patients get good medical follow-up, the developments also entail that it is important to help ensure that persons living with HIV get good opportunities to live their lives free of shame, stigmatisation and discrimination. Both Norwegian and international experience and research indicate that this challenge requires strong leadership and a clearly interdisciplinary approach.

1.2 Organisation of the work

The Norwegian Directorate of Health was given the assignment of evaluating the strategic plan, *Responsibility and Consideration*, updating the basic facts and knowledge about HIV and making proposals for a new national strategy. Starting with this documentation, a conference was held with participation from civil society, research circles and public authorities. The main objective of the conference was to come up with proposals for the work on this HIV strategy. A draft of the strategy has also been submitted to the National AIDS Council. Following these meetings, a number of actors have submitted specific written proposals.

The work on the strategy has been rooted in an interministerial steering group at the state secretary and senior official level, chaired by the Ministry of Health and Care Services, with representatives from the Ministry of Labour and Social Inclusion. The Ministry of Children and Equality, the Ministry of Justice and the Police, the Ministry of Education and Research, the Ministry of Foreign Affairs and the Ministry of Health and Care Services.

1.3 Content

This strategy furthers and strengthens the efforts that have been implemented through previous action and strategic plans. In chapter three, two national general objectives have been specified for this strategy. In addition, eight specific goals are specified that are further divided into strategic moves, where the actors who have follow-up responsibility are specified.

A presentation of facts is included as an appendix, which gives a more detailed description of the actors who play a role in the efforts to prevent the spread of HIV, the regulatory framework and a more detailed description of the situation in this area in Norway.

1.4 Roles, responsibility and relevant regulations

Objectives and strategies in “Acceptance and Coping” involve actors at all administrative levels and many sectors of society; six ministries and their underlying agencies and activities, including the regional and local levels, play a role in the follow-up of the strategy. Civil society and voluntary organisations are also affected. The UN’s special body for HIV/AIDS, UNAIDS, emphasises that civil society plays an extremely crucial role in the global and national fight against HIV and in ensuring that good care is given to persons living with HIV. In addition to obvious leaders in civil society and the general public, the involvement of persons living with HIV in the work is a highly significant factor. Relevant actors and their roles are described in greater detail in the presentation of facts in the appendix, cf. chapter 1 of the appendix.

Furthermore, there is an extensive body of regulations that establish frameworks, e.g. for actors’ and services’ obligations in the efforts to combat HIV and the rights of HIV positive persons.

The most relevant acts in this context are:

- Act relating to control of communicable diseases (Communicable Disease Control Act)
- Act relating to municipal health services (the Municipal Health Services Act)
- Act relating to the specialist health service, etc. (the Specialist Health Services Act)
- Act relating to patients’ rights (the Patients’ Rights Act)

- Act relating to health personnel etc. (the Health Personnel Act)
- Act relating to day care institutions (the Day Care Institutions Act)
- Act relating to primary and secondary education (the Education Act)
- Act relating to working environment, working hours and employment protection, etc. (the Working Environment Act)
- Act relating to a prohibition of discrimination on the basis of disability (the Anti-discrimination and Accessibility Act)
- Act relating to social services etc. (the Social Services Act)
- General Civil Penal Code (the Penal Code)

The relevant legislation, including acts and regulations, is described in greater detail in the presentation of facts in the appendix, cf. chapter 2 of the appendix.

1.5 Follow-up

The strategy is a tool for strengthening and coordinating the effort within the sectors that the six ministries represent. The intention is for the interministerial working group that has devised the current strategy to continue its work as a steering group in the follow-up of the strategy at the senior official level. A coordinating group will be established at the directorate level. Important tasks for the coordinating group will include assessing the ongoing implementation of the strategy and establishing a reporting and/or evaluation system, including assessing whether a follow-up evaluation of the effort and the achievement of objectives during the strategy period should be implemented.

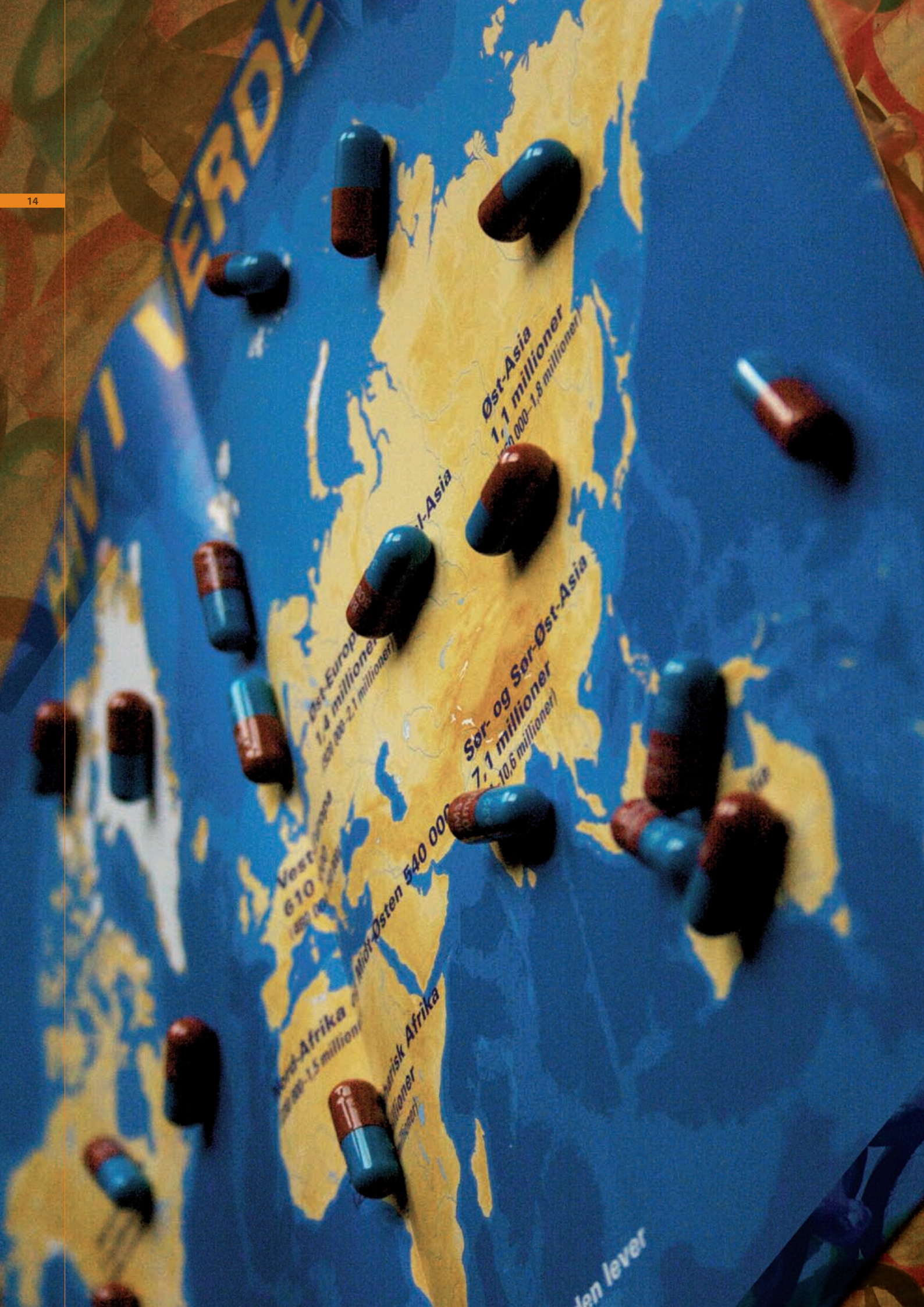
The strategy’s general objectives and specific objectives and the individual strategic moves that are summarised are primarily achieved at a comprehensive strategic level because of the need to be able to regularly change or improve the numerous individual measures that are continued or are to be implemented in the strategy period. A comprehensive strategy will help both the responsible authorities and certain individuals and organisations in civil society to achieve a more in-depth understanding of the complex challenges that they face in their work. The experiences of recent years show that changes in the HIV and AIDS picture in Norway and the rest of the world often occur rapidly. The coordinating group headed by the Directorate of

Health will draw up annual plans to ensure a knowledge-based and relevant prioritising and targeting of the effort after it is underway.

For the most part, the strategy will be followed up with allocations under the disposition of the six ministries, relevant management tools, grant schemes and Storting documents.

The list below presents a summary of the abbreviations of the ministries; cf. the list of those responsible for follow-up associated with the strategic moves in chapter 3 and a summary of relevant agencies and/or actors under the ministries that will have follow-up responsibility on behalf of the authorities.

The Ministry of Labour and Social Inclusion	MLSI
The Directorate of Labour and Welfare	NAV
Directorate of Integration and Diversity	IMDi
The Norwegian Directorate of Immigration	UDI
The Ministry of Children and Equality	MCE
Norwegian Directorate for Children, Youth and Family Affairs	Bufdir
The Equality and Anti-discrimination Ombud	LDO
Ministry of Health and Care Services	MHCS
The Norwegian Institute of Public Health	NIPH
The Norwegian Directorate of Health	Helsedir
Norwegian Board of Health Supervision	Htil
Regional health authorities	RHF
Municipal health service	
Ministry of Justice and the Police	MJP
The Norwegian Correctional Services	
The Norwegian Police Directorate	POD
Ministry of Education and Research	MER
Norwegian Directorate for Education and Training	Udir
Ministry of Foreign Affairs	MFA
The Norwegian Directorate for Development Cooperation	NORAD



Nord-Afrika
100-15 millioner

Sør-Afrika
10 millioner

Midt-Østen
540 000

Vest-Europa
610 millioner

Øst-Europa
14 millioner
(50-80-2,1 millioner)

Sør- og Sør-Øst-Asia
7,1 millioner
(10,6 millioner)

Øst-Asia

Øst-Asia
1,1 millioner
(100-1,8 millioner)

len lever

2. HIV in Norway – Certain trends and special challenges

Since the previous strategic plan was issued, there are certain trends that present new challenges and that are important for the work in the upcoming strategy period. The more specific problem areas are described in more detail under the individual specific objectives in chapter 3.

2.1 New infection

The number of newly diagnosed HIV positive persons in Norway during the last ten-year period doubled from about 150 cases at the close of the 1990s to nearly 300 cases in 2008. This is primarily due to an increase in the number of HIV positive immigrants who have come to Norway and to an increase in HIV infection among men who have sex with men in Norway during the last 10 years. There has not been any confirmed increase of HIV that has been transmitted heterosexually among persons born in Norway. Among injecting substance abusers, the number of diagnosed cases has remained at a stable low level. There has still been very little HIV infection detected among youth. It is not very likely that there will be major changes in the epidemiological situation in the coming years. The infection patterns and the challenges for prevention will to a great extent be the same as before; i.e. the main effort in the future will continue to be aimed at the groups that are especially at risk of being infected: men who have sex with men and certain groups of immigrants.

Men who have sex with men are the group that is exposed to the greatest risk of HIV infection in Norway, and they have a prevalence of HIV infection that is 70 times as high as the prevalence for heterosexually active men. In Oslo, the situation for this group since 2004 has been very much like an outbreak, and an increase in HIV infection has also been witnessed now among men who are infected homosexually in other parts of the country and on trips abroad. There is reason to fear enduring high HIV figures in this group in the coming years unless we succeed again in bringing about an extensive behavioural change with regard to safer sex and the use of condoms, corresponding to the trend that we observed during the 1980s and 1990s.

Refugees, asylum seekers and members of reunified families who are infected prior to their arrival in Norway will be the other large group of HIV-infected persons in Norway in the coming years. The number of HIV positive immigrants who arrive in Norway is determined by the number of refugees, asylum seekers and members of reunified families who come from regions with an especially high prevalence of HIV. The majority come from areas of conflict in eastern Africa, most often from Ethiopia, Somalia and Eritrea. Most of the HIV positive immigrants from Asia are Thai women who have come to Norway in connection with family reunification.

It is assumed that about 1000-1200 HIV positive persons of non-Norwegian background live in Norway. The health service shall ensure that these persons are quickly met with well-adapted preventive measures against communicable diseases and necessary medical follow-up so as to avoid the spread of HIV. At the same time, we have to ensure that a large immigrant population is sufficiently well-informed about HIV, outside of the health service as well, in order to meet the increasing risk of infection both internally in the immigrant communities in Norway and on trips back to their country of origin.

The gender distribution among refugees, asylum seekers, and members of reunified families with HIV reflects the global picture. The percentage of women among those living with HIV has remained stable at about 50 per cent for many years, but the percentage of women is increasing in many countries. This is true, for example, among countries south of the Sahara in Africa.

In the general population in Norway, HIV has remained at a stable low level for many years. Since the number of persons living with HIV is steadily increasing, the risk of infection will continue to increase among heterosexually active persons as well, both in Norway and on trips abroad. The risk of infection from heterosexual contact is low, so the conditions are not present for a rapid spread of HIV among heterosexually active persons in Norway. However, the low perception of threat with regard to the risk of HIV infection and the low use of condoms increases the vulnerability considerably.

Norwegian youth will probably continue to be at little risk of HIV infection through heterosexual activity. There is little HIV in the youth age-group and hence low infectivity. Limited sexual contact with groups with a high prevalence of HIV will still limit the spread of infection among most youth.

Among injecting substance abusers, the number of HIV cases has remained at a stable low level since the end of the 1980s. However, the high prevalence of hepatitis B and C in the group shows that substance abusers are still vulnerable to the transmission of infection via blood, and the HIV situation must be regarded as threatening and unpredictable. Experiences from Finland and Sweden show that HIV can spread rapidly and extensively again if the virus gains a foothold in circles where hypodermic needles are shared.

2.2 Attitudes in the population and living conditions of persons living with HIV

In the spring of 2009, the Institute of Applied Social Science (Fafo), a research foundation, published the main report from the project it conducted in 2008/2009 concerning living conditions among HIV positive persons in Norway. In 2008, Fafo published the first report, *Fortsatt farlig å kysse?* (Still dangerous to kiss?), which consisted of a national representative survey of attitudes in the population and a summary of information about living conditions and HIV. The findings from the survey of attitudes constitute an important framework for interpreting many of the findings that are presented in the main report *Fra holdninger til levekår. Liv med hiv i 2009* (*From attitudes to living conditions. Living with HIV in 2009*).

The study of living conditions is based on two types of data. First of all, a questionnaire was conducted among those living with HIV in Norway who know that they are HIV positive. Since there is not any register from which a representative sample can be drawn, attempts were made through a number of channels to reach out to as much of the population as possible. Nevertheless, it turned out that the number of respondents was disappointingly low. A total of 271 persons filled out and submitted the form, which amounts to less than 10 per cent of everyone currently living with HIV in Norway. The second source of data was in-depth interviews with 25 HIV positive persons (15 men and 10 women). The informants were recruited with the aim of reaching out to a group of persons of varied background with a representative sample of the most important groups of infected persons as well as of age, gender and geography. Even after combining data from the two sources, a representative sample of data was still not achieved, but the report is still based on a substantial amount of material containing much information.

Among other things, Fafo concludes that the medical developments in recent years have made considerable progress. Anti-viral drugs and treatment regimes have radically improved the outlook for HIV positive persons being able to live long, good lives with the absence of any symptoms and complaints, so they have a positive effect on the living conditions of HIV positive persons.

People's living conditions are not just solely affected by the individual's physical health. At least equally

important are the knowledge, the attitudes and the openness with which HIV positive persons are met in the society. Living conditions are defined in an interaction between individual factors and conditions and the opportunities people have to realise them in different arenas such as the labour market, the educational system and in their encounters with public services.

Despite the progress in the medical advances, Fafo's data shows that a similar development has not occurred with regard to openness, knowledge about HIV and attitudes to HIV in the society.

This contrast - between better prospects for the individual to live a longer life on the one hand and other people's knowledge, attitudes and reactions on the other - has been an important point of departure for this study of living conditions and is also strongly emphasised in "Acceptance and Coping".

A summary of the main findings from the living conditions project is presented in chapters 3.2 and 3.3 of the appendix.

2.3 Norway's fulfilment of international obligations

In its evaluation of the strategic plan, Econ Pöyry has assessed the extent to which the strategic plan "Responsibility and Consideration" and its follow-up complied with the international declarations that Norway has endorsed. Among other things, they drew the following conclusions:

- "Responsibility and Consideration" is based on the guidelines for strategies in the UNGASS declaration of 2001, but has only been partially implemented.
- The strategies aimed at discrimination against and stigmatisation of HIV positive persons are among the areas that have been least addressed in "Responsibility and Consideration".
- There remains much to be done with regard to offering a broad range of preventive programmes to at-risk groups, especially to immigrants from high-risk areas and to men who have sex with men.
- At-risk immigrant women's vulnerability to HIV infection and the attention devoted to this problem have not been dealt with properly.
- The focus on giving youth sufficient information and training about HIV and modes of infection has not been well enough handled.

- The specific objectives associated with information and prevention in the previous strategy are not quantifiable, and it is difficult to measure how many people in the various target groups have received information and which groups have come in contact with preventive measures.

Cf. chapter 3.4 of the appendix for a more detailed discussion of the declarations and a summary of Econ Pöyry's evaluation concerning Norway's compliance.



3. National objectives and strategic moves

The comprehensive aim of this strategy is that at the end of the strategy period, Norway will be a society that accepts and copes with HIV in a way that both limits new infection and gives persons living with HIV good conditions for social inclusion in all phases of their lives.

The aim is twofold with one focus on prevention of new infection and another on living conditions for persons living with HIV. Although no effort must be spared to ensure that as few people as possible are infected with HIV, we must recognise that tens of millions of people in the world are living with HIV. To ensure that more of those living with HIV in Norway feel that they have good living conditions despite HIV in the form of good and well-adapted services, opportunities for openness and fellowship and freedom from fear of discrimination and social exclusion is in itself a crucial preventive strategy for avoiding the spread of HIV.

In addition to a main objective, the strategy has two operative general objectives and eight specific objectives. The specific objectives are important supporting objectives for achieving the general objectives. Under each of the specific objectives, a number of strategic moves are listed. Taken together, this amounts to a framework that gives direction and creates the foundation for follow-up in the form of knowledge-based, effective measures. A shadow document to “Acceptance and Coping” will be

drawn up, which discusses indicators for each individual strategic move so that it will be possible to measure the degree to which it is achieved in accordance with general objectives and specific objectives underway. The latter is also important in order to fulfil the reporting obligations associated with the international declarations. For each strategic move, the person who is responsible for the follow-up of measures at government level is listed. It is assumed that the individual expert authorities will be responsible for implementing and reporting on measures within their respective areas of responsibility. This entails that a ministry and/or its underlying agencies will follow up a strategic move with measures if the measures are within their scope, even if the ministry is not initially included on the list of parties with follow-up responsibility in the strategy.

General objective:

- I. New infection with HIV shall be reduced – especially in groups with high vulnerability to HIV.
- II. Everyone living with HIV shall be ensured good treatment and follow-up regardless of age, gender, sexual orientation and/or practice, domicile, ethnic background and personal finances.

Specific objectives:

- 1) Increase the knowledge about and awareness of HIV and AIDS in the population.

- 2) Reduce stigmatisation and discrimination associated with HIV.
- 3) Reduce new infection - especially among at-risk groups.
- 4) Reduce hidden sources of error - early detection of HIV infection; testing, surveys, diagnostics and appropriate counselling
- 5) Remove barriers to access to medical treatment and a comprehensive treatment programmes based on good teamwork among the health service actors involved.
- 6) Ensure the participation of HIV positive persons in the labour force.
- 7) Further promote international cooperation and efforts, and follow up international obligations in the efforts to combat HIV and AIDS.
- 8) Help improve research on the prevention and treatment of HIV and monitoring and evaluation of prevalence, risk factors and effects of measures.

3.1 Specific objective 1: Increase the knowledge about and awareness of HIV and AIDS in the population

Just as in other western countries, there are more and more people in Norway living with HIV. At the same time, the spread of HIV in Norway is defined as a “concentrated type”. The prevalence of HIV is concentrated in certain social groups, such as individual groups of immigrants, men who have sex with men, men who have sexual contact abroad and substance abusers. That means, however, that there are individuals living with HIV in all age groups, in both genders, and in various ethnicities and social groups throughout the country.

There is reason to believe that the general awareness of HIV has decreased somewhat in recent years. There are many theories about the reasons for this development: the de-dramatisation of HIV and AIDS in the public space, new medicines for HIV, information overload, new patterns of sexual practices and a general lack of knowledge are examples of possible causes. The answer is probably a combination of these factors.

A high level of knowledge about HIV in the general population is crucial to preventing new infection, but also in order to create the best possible framework around people living with HIV. Fafo’s study of attitudes to and knowledge about HIV indicated a high level of knowledge in the popula-

tion about the ways in which HIV infects, but a lower level of knowledge about the ways in which HIV does not infect.

The sex life and behaviour patterns of youth have altered since the turn of the millennium. Youth are more satisfied with their sex life; they have sex earlier, more sex, more experimental sex and sex with more partners. This is a general trend in Norway and in the rest of Europe. However, altered sexual behaviour patterns create new risk areas that require good skills in relational and sexual situations. Youth encounter sexuality in new arenas – on the Internet, on mobile phones and through increased travel. One risk of the new sexual behaviour patterns is infection with sexually transmitted infections through unprotected sex. The prevalence of Chlamydia among adolescents and young adults is increasing in all European countries. In an active sex life with multiple partners, a condom is the only thing that protects the user against sexually transmitted infections. However, Nordic and European research shows that the use of condoms is still not good enough. One main challenge is to give adolescents and young adults good training in putting theoretical knowledge about sexually transmitted infections into practice in their own sex life.

School is the arena where instruction about sexuality, the human body and health should be given to all children and youth in Norway. Nordic studies and summaries of knowledge show that knowledge and communication and skills training about sexuality are not very comprehensive and targeted in dealing with the aspects of sexuality that are best – and those that are most difficult to deal with. Only the targeted, comprehensive programmes have proven to be effective. The studies particularly emphasise that instruction in the schools is not very skills-oriented and that teaching about important topics occurs too late – after children and youth have already passed the stage when they needed it. The studies also show that the instruction is still not sufficiently aimed at including gender and minority perspectives so that it can reach the groups where the effort may have the greatest effect in evening out social health differences that have impacts on sexual practices.

A number of proficiency objectives have been set for the basic instruction where sexually transmitted infections, including HIV and AIDS, are relevant topics. The Norwegian Directorate for Education and Training is currently preparing a new resource

book related to the instruction about sexuality and relationships. The Directorate has hired a number of external expert groups to provide contributions to this resource book. The point of the resource book is to give emphasis to and operationalise the relevant proficiency objectives that touch upon the topics of sexuality and relationships in the Knowledge Promotion Reform for basic schooling.

There is little HIV among adolescents and young adults in Norway at present. However, the increase in Chlamydia infection among the youth population is an indicator that the efforts to further increase the use of condoms should be intensified.

In recent years, a relatively large number of men have been infected with HIV and other sexually transmitted infections in connection with holiday trips abroad. As grounds for this infection, it is often stated that they have had unprotected sex with sex workers in countries where the prevalence of HIV is high. This may indicate that many adult men have little awareness of the risk of HIV infection.

There is considerable expectation that everyone must be able to make the right choices in sexual situations and then act according to those choices. This is especially true with regard to the use of condoms and the practicing of safer sex. Knowledge about HIV is a necessary condition for being able to make rational choices with regard to one's own sexual practices. There is not necessarily a relationship between knowledge and action. Nordic studies show that the majority of adolescents and young adults have a high level of knowledge about topics related to sexuality – e.g. about contraception and what must be done to practice safe sex – but that that knowledge is not followed up with correct actions. The reasons why parents and caregivers' are unable to achieve a proper dialogue with their children about sexuality are often related to insufficient language and communications skills in this area.

Relevant strategic moves:	Follow-up responsibility
Further develop age and gender-specific methods for improving sexual autonomy and for training in behavioural skills in sexual situations.	MHCS, MER
Initiate new, knowledge-based methods for spreading information about HIV and safer sex in various communication channels.	MHCS
Encourage civil society, organisations and religious communities to engage in community work on HIV.	MHCS
Further develop and integrate (knowledge-based) information about sexual health that also includes HIV.	MER, MHCS

3.2 Specific objective 2: Reduce stigmatisation and discrimination associated with HIV

In addition to illness and other health-related challenges related to infection, people living with HIV and others who are affected by HIV have also been subject to stigmatisation and discrimination in the time that has passed since the HIV virus was identified. Employment is often referred to as an arena in which HIV positive persons experience discrimination. Yet there is also unreasonable discrimination in the health, care and welfare services, especially in the parts of the services that rarely come in contact with HIV positive persons.

The concepts of stigmatisation, discrimination and social exclusion are related; they are based on prejudices and a lack of knowledge. The degree of stigmatisation associated with HIV/AIDS and discrimination against HIV positive persons in the society is often related to the general level of knowledge about HIV in the population. Fafo's study of attitudes to HIV revealed insufficient knowledge about the ways in which HIV does not infect. In itself, this can result in increased fear and hence increased stigmatisation of and discrimination against HIV positive persons. Clarifying the rights to which HIV positive persons are entitled, can help reduce the stigmatisation and discrimination they experience.

The stigmatisation problem related to HIV also involves degrees of self-stigmatisation or exagger-

ated fear of being stigmatised. Fafo's study of living conditions in 2009 supports this impression as well. This applies to both the HIV positive individuals themselves and also to social and ethnic groups with an especially high prevalence of HIV. As a result of this awareness of negative perceptions of one's own "self", or one's own group, the group, or its members, will often tend to internalise those negative perceptions. This internalisation can result in an unfavourably negative self-image, which may lead in turn to low self-esteem and little ability to cope with one's own life.

In Norway, HIV is associated to a very large extent with groups that are especially at-risk for HIV: men who have sex with men, certain groups of immigrants with immigrant women particularly at-risk, sex workers and injecting substance abusers. These are minority groups who are essentially more at risk of stigmatisation and discrimination, regardless of their HIV status. The efforts to combat stigmatisation and discrimination should put great emphasis on measures aimed at those who belong to more than one at-risk group.

Relevant strategic moves:	Follow-up responsibility
Targeted increase of knowledge about HIV among health and care workers and employees in the employment and welfare services.	MHCS, MER
Include discrimination and marginalisation of HIV-infected persons as a topic in programmes aimed at improving the quality of services and likewise in the evaluation and monitoring of those services.	MHCS
Regular public-opinion campaigns to reduce the stigmatisation associated with HIV.	MHCS
Support organisations in civil society that work to promote rights of persons living with HIV and others who are affected by HIV.	MHCS, MJP, MFA
Help counteract social exclusion mechanisms that work against HIV positive persons in minority communities.	MHCS, MLSI

3.3 Specific objective 3: Reduce new infection - especially among particularly at-risk groups

Sexually at-risk minority groups are often less skilled in and have fewer possibilities of asserting their autonomy, and they often have worse sexual health than the majority of the population. This is the case for particularly at-risk ethnic and sexual minority groups, people with reduced functional capacity, groups at-risk of abuse and certain at-risk groups with mental health and substance abuse problems. A new group is young people who are infected with HIV. Strategic preventive efforts with regard to sexually at-risk groups have been conducted under the direction of both the action plan for the prevention of unwanted pregnancies and abortions and the previous strategic plan for preventing the spread of HIV and sexually transmitted infections. Evaluations show that the strategies must be focused even more specifically in the coming years.

As with the trend in the rest of the world, HIV and AIDS in Norway are very unevenly distributed among different groups in the population. The same can be said about the level of knowledge about HIV. Research and experiences indicate that the knowledge about HIV is low in some cases among immigrants from countries that have an especially high prevalence of HIV, whereas there is reason to believe that the level of knowledge about HIV among men who have sex with men is higher than in the general population. Knowledge alone, however, is of limited value if it is not supplemented with other policy instruments.

In sexual situations, hence situations where there is a potential for infection, it may involve the ability to negotiate in and cope with the situation, the absence of intoxication, positive self-esteem and easily accessible protection such as male and female condoms.

A crucial common trait among the groups of ethnic and sexual minorities is that the risk of infection; i.e. the number of individuals who are HIV positive in the groups, is very much higher in some cases than in the population at large.

Men who have sex with men

Among men who have sex with men (MSM), information campaigns about safer sex and the use of condoms have been kept at a steady intensive level for many years, and the level of knowledge

about the modes of infection with HIV has traditionally been high. Nevertheless, it is among MSM that we have seen the biggest increase in new infection in recent years. This is also reason to believe that the assumption about information overload in MSM circles is serious since this group in particular has been a target group for HIV/AIDS information for many years. This in turn can have a diminishing effect on the intensity of the targeted information to new generations of MSM among various actors in the field of HIV prevention.

Both Norwegian and international research has documented considerable risky behaviour among MSM in recent years. This is in good agreement with the finding that over 60 per cent of newly diagnosed MSM list unprotected anal sex with a casual partner as the source of infection. If new infection is to be reduced among MSM, there must be a significant change in behaviour with regard to increased use of condoms among MSM who have sex with casual or unknown partners.

Research has discovered that in some MSM circles there are a number of people who are not properly informed about the current prevalence of HIV and other sexually transmitted infections. Data from the Norwegian Institute of Public Health and a number of experiences from clinical practice show that a substantial number of men who are diagnosed with HIV also have other sexually transmitted infections. Some men living with HIV have also been diagnosed with sexually transmitted infections such as gonorrhoea and syphilis, which indicates the practicing of unsafe sex. This shows that the group is in need of more information about the current situation and the high risk of infection with both HIV and other sexually transmitted infections. This also applies to information about how drug treatment of HIV affects the risk of infection.

The emergence of contact points on the Internet is mentioned in many international studies as a contributory factor to the increase in the spread of HIV among MSM. The reason for this may be that the ease of establishing contacts potentially increases the accessibility of many casual sex partners in circles with a high risk of infection. At the same time, it is also noted that the same contact points on the Internet are an important source for spreading necessary information about sexual health and protection strategies to the target groups.

Relevant strategic moves:	Follow-up responsibility
Develop and make use of new, active interventions that address the connection between received information and behaviour, with the aim of changing risky behaviour among MSM.	MHCS
Increase the awareness of double discrimination issues among MSM along with links between high consumption of intoxicating substances and the risk of HIV infection.	MCE, MHCS
Easy access to condoms and lubricants.	MHCS
Increase the test frequency among MSM.	MHCS
Implement guidelines for post-exposure prophylaxis (PEP); make relevant target groups aware of this offer.	MHCS
Improve the programme offering psychological and guidance services to MSM.	MHCS

Certain groups of immigrants

Among certain groups of immigrants from countries that have an especially high prevalence of HIV, the risk of infection internally in the group may be almost as great as the risk in the country of origin. In addition, there will be a number of living condition variables that indicate the likelihood of poor sexual health, such as level of education, degree of self-determination over one's own life and sexuality.

One third of HIV positive persons in Norway at present were infected before their arrival in Norway, and about half of these persons are women. HIV positive persons with an immigrant background, both men and women, report that it is difficult to be openly HIV positive in their own group. Taking into consideration that it is the support and confidence of friends and family that are most important for mental health among immigrant women, they appear to be an especially vulnerable group.

The immigrant groups in Norway are very heterogeneous, but studies indicate that many of those who are infected, including those who are in communities with a risk of infection, have too little knowledge about the modes of infection and about sexual health in general.

One question in Fafo's study of living conditions from 2009 was only asked to persons who have come to Norway in the last five years. The question dealt with the relationship with the asylum and

refugee authorities. The majority of respondents gave positive feedback, but about one out of three did not feel that the HIV test upon arrival was voluntary, and a relatively large number said that HIV and AIDS was not something that was discussed at the reception centre for asylum seekers.

For some, the barriers to seeking help from public authorities can be great. Language, insufficient insight into Norwegian government systems, uncertain residency status and mutual misunderstandings between patients and personnel are some of the barriers that are pointed out in research and experience. As a result, some individuals may come late for testing and any treatment that may be necessary for HIV infection. The barriers to receiving and offering adequate guidance about infection when HIV infection has been confirmed may also be high.

Among the group of immigrants in which immigrant women have poorer material living conditions than men, the gender perspective is especially important. Preventive strategies and follow-up measures must have a clear gender perspective that particularly takes into consideration that many women are highly at-risk of contracting HIV. Among other things, this may involve a lack of sexual autonomy, a lack of self-determination with regard to the use of contraceptives, biological factors and their personal economic situation. Experiences from female-oriented measures in Norway show that the use of female condoms by some individuals gives them somewhat more control over their own sexuality and functions as a protective strategy.

In a survey of African women in Norway, it was found that HIV particularly affects this group's ability to have their own children, when information about pregnancy and HIV does not reach them. In many cases, immigrant women will be more excluded from employment or only marginally employed than their partners, a factor that further contributes to their isolation.

In Norway, it is estimated that there are about 30-40 children and adolescents living with HIV. A case of mother-to-child transmission has not been confirmed in Norway for many years, and the children and adolescents to whom it applies were primarily infected before their arrival in Norway. There is little or no systematic knowledge about this group. In the expert groups, concern has been expressed about the extent to which children and adolescents

with HIV and their nearest relatives receive adequate follow-up of the psychosocial aspects of living with HIV.

A certain increase in new infection has been confirmed in certain immigrant communities in recent years, but the reason why the group "infected prior to arrival in Norway" is largest in the HIV statistics is that Norway receives a large number of refugees from countries with a high prevalence of HIV.

There is a growing international awareness about the relationship between tuberculosis and HIV infection. Globally, it was estimated that there were 9.3 million cases of tuberculosis in 2007, 1.4 million (15 per cent) of which were also HIV positive. Of these cases, 79 per cent were from the Africa region and 11 per cent were from the Southeast Asia region. The World Health Organisation estimated in 2008 that HIV-positive persons have a twenty times greater risk of developing tuberculosis than HIV-negative persons in countries that have a generalised HIV epidemic. In countries with a lower prevalence of HIV, HIV-positive persons have between 26-37 per cent greater risk of tuberculosis than HIV-negative persons.

There is very little knowledge about sexual minorities in the Norwegian immigrant population. Individual reports and international research indicate, however, that there is a significantly greater vulnerability to HIV among men who have sex with men and transpersons in this group. This is partly due to cultural norms about sexuality and partly to insufficient knowledge about modes of infection and risk factors.

There are few organisations and circles that work specifically with HIV prevention and living conditions for HIV-positive individuals among immigrants in Norway. Several individual measures have been laid down. At the same time, there are a number of organisations and circles that may be interested in and have the potential and policy instruments to contribute to the work.

Relevant strategic moves:	Follow-up responsibility
Improve the communication of information to and the coping strategies for especially at-risk immigrant groups.	MHCS, MLSI
Support targeted measures aimed at groups that are especially at-risk for HIV, such as certain groups of women and men who have sex with men.	MHCS
Initiate knowledge-based, effective measures for increasing the use of male and female condoms.	MHCS
Work to ensure equivalent public services to all groups, including health services and other public assistance programmes.	MHCS
Urge religious communities and voluntary organisations to conduct preventive work in the immigrant population as well.	MHCS, MLSI
Establish training and follow-up programmes for children, adolescents and young adults living with HIV.	MHCS

Other groups at-risk to HIV

The number of newly infected persons with HIV as a result of injecting drug abuse has remained at a low, stable level. However, the high prevalence of hepatitis B and C in the group shows that substance abusers are especially at-risk for the transmission of infection via blood, and the preventive measures must therefore be maintained.

The number of inmates in Norwegian prisons amounts to about 3,400 persons at any given time. It is assumed that about 60 per cent of the inmates in Norwegian prisons have substance abuse problems, and about half of these inmates had injected drugs with hypodermic needles. Starting in 1997, a scheme was introduced out of consideration for the prevention of communicable diseases where inmates were given access to disinfectants such as chlorine and/or chloramine so as to be able to clean used needles and needle tips. International experience from a number of European countries that have given inmates access to sterile needles and needle tips indicates that this is a measure that prevents the transmission of infection via blood in prison and which has not resulted in an increased use of intoxicating substances among drug addicts, in increased disciplinary problems nor in an increase in the use of needles and needle tips as weapons. In 2009, the Norwegian Directorate of Health studied this matter in an assignment from the Ministry of Health and Care

Services and concluded by recommending the implementation of a scheme in the prisons that at least includes the exchange of used needles and needle tips. The Ministry of Health and Care Services has sent out the study for a broad round of consultation in the health and justice sectors.

Infection from prostitutes to buyers of sexual services in Norway has not been reported in recent years. However, a substantial increase in the number of sex workers who test positive for HIV has been reported in recent years. This is due to the increase in the number of foreign prostitutes, especially from African countries, which began in the first half of the 2000 decade.

Internationally, sex workers and injecting substance abusers are highly at-risk for HIV, and in many countries they are the largest social groups living with HIV. There is reason to believe that the targeted preventive efforts in these communities have made a strong contribution to keeping the development under control in Norway.

Subsequent to the introduction of a ban on the purchase of sexual services in January 2009, there is an increasing concern that the preventive efforts targeted at prostitutes will be weakened. It has become more difficult to have a good overview of and gain admittance to prostitution circles. In addition, it is reported that individual sex workers no longer want to receive condoms and lubricants as they did before out of fear that the consumption of large quantities of these will be used by the police as indicators of the sale of sexual services.

In recent years, there has been a steady increase in the number of Norwegians who are infected on holiday trips abroad. This applies in particular to men who have unprotected sex on holiday in countries with a high prevalence of HIV.

Relevant strategic moves:	Follow-up responsibility
Continue harm-reducing measures for substance abusers, e.g. low threshold health care, needle rooms.	MHCS
Ensure that injecting substance abusers are offered an HIV test during detoxification and in treatment institutions.	MHCS
Improve programmes involving sexological advice to substance abusers in treatment.	MHCS

Evaluate recommendations concerning harm-reducing measures for inmates in prisons after a broad round of consultation in the health and justice sectors.	MHCS, MJP
Prevent unintended prevention-oriented consequences of the criminalisation of the purchase of sex services.	MHCS, MJP
Intensify preventive measures aimed at persons travelling abroad.	MHCS, MFA

3.4 Specific objective 4: Reduce hidden sources of error - early detection of HIV infection; testing, surveys, diagnostics and appropriate counselling

In the event of HIV infection, the prognosis can be improved considerably by early diagnosis and by commencing treatment prior to symptoms of the disease. Early diagnosis is also important in order for the individual to be able to avoid transmitting the disease further - HIV is most infectious in its early stages. By getting underway early with treatment, the outlook for good benefits from treatment will also be greatly improved. The current testing methods are safer and more specific than ever. They are free for the patient and are available in almost all parts of the health services.

The European Centre for Disease Prevention and Control (ECDC) estimates that between 20 and 30 per cent of all HIV-positive persons in Northern and Central Europe are not aware of their HIV status. In Denmark, it is estimated that the hidden sources of error amount to between 15 and 25 per cent. The Norwegian Institute of Public Health estimates that between 300 and 500 persons in Norway are HIV-positive without being aware of it. Some studies have shown that in a population of HIV-positive individuals, the 20 per cent who were not aware of their HIV status accounted for more than 50 per cent of new infection of others.

It is necessary to have more targeted measures in order to improve the testing frequency in many parts of the population. That applies to the groups that are especially at-risk of HIV, but also to others who may have been in at-risk situations. Substance abusers are especially at-risk of transmission of infection via blood and the HIV situation must be regarded as unpredictable. Frequent testing for HIV in this group will ensure good monitoring and

facilitate rapid intervention if there should once again be an outbreak of HIV in these circles.

Both sexual minorities, such as MSM, and certain groups of immigrants experience barriers to the accessibility of testing and counselling. In many situations, a patient may find it difficult to share information with medical personnel about possible risky situations, which makes it difficult for the medical personnel to assess whether an HIV test ought to be offered. It may also be the case that health personnel are hesitant to offer an HIV test to a patient out of fear of disturbing or offending the person in question. In the international context, increasing importance is being attached to ensuring that health personnel ought to take the initiative more often and recommend an HIV test to their patients.

For refugees and asylum seekers, it is the health service in the transit centres for refugees that is supposed to immediately detect diseases requiring treatment or conditions among asylum seekers and refugees that need rapid help.

Quota refugees and members of reunified families settle directly into the municipality without going through a reception centre. The municipality in which they settle is responsible for providing offers of a medical examination and relevant information and guidance. A regular GP shall be appointed as soon as possible after settlement in the municipality.

For many immigrants, interpreters are necessary in order for them to utilise health services, and they are often necessary in order to obtain adequate medical assistance. All patients are entitled to necessary information about their state of health and the content of the medical assistance that is provided. The information should be adapted to the recipient's individual circumstances such as age, maturity, experience and cultural and language background. (Cf. Sections 3-2 and 3-5 of the Patients' Rights Act.)

Health personnel are responsible for coherently organising the information and ensuring as much as possible that the patient has understood the content and meaning of the information. The municipality must ensure the assistance of qualified interpreters in the primary health services and with specialist physicians in private practice when such help is needed. The specialist health service in hospitals and outpatient clinics must obtain assistance from

interpreters themselves. Reports from expert groups and organisations indicate that in consultations that deal with HIV it will often be most desirable to use telephone interpreters out of consideration for anonymity.

In 2003, the Norwegian Board of Health Supervision conducted inspections of the municipal health services in reception centres for refugees and asylum seekers. Major shortcomings in routines for testing and other follow-up were discovered in some centres. According to the Norwegian Directorate of Health guide to the above-mentioned services, newly arrived refugees and asylum seekers shall be offered a test for and guidance about HIV. A number of reports indicate that so far this has not been adequately implemented. Persons who are granted residence in Norway through family reunification should avail themselves of the ordinary health services, and at present there is little systematic knowledge about the extent to which members of reunified families are offered testing for HIV.

Relevant strategic moves:	Follow-up responsibility
Spread knowledge about the importance of early testing to at-risk groups in the population	MHCS
Introduce an offer of a quick test to especially at-risk groups, e.g. in collaboration between the health service and voluntary organisations.	MHCS
Improve the health service's tracking of and guidance about infection after a diagnosed HIV infection.	MHCS
Ensure good access to testing and counselling for groups that find the health systems relatively inaccessible or poorly adapted to their personal situation.	MHCS
Evaluate new indications for routine HIV testing in the services.	MHCS
Study and improve routines for testing for tuberculosis and HIV in cases of family reunification.	MHCS
Ensure necessary assistance in the prevention of communicable diseases for persons without a legal residence permit.	MHCS, MJP

3.5 Specific objective 5: Remove barriers to access to medical treatment and comprehensive treatment programmes based on good teamwork among the health service actors involved.

The introduction of new medicines to treat HIV at the end of the 1990s has reduced the morbidity and mortality that is associated with HIV and AIDS, increased the quality of life and increased the prospects of a long life for those who have been infected with HIV.

That means that each year there will be more people living with HIV, and that HIV must be considered in the perspective of an entire lifetime to a greater extent than it was before. For the health services, this development entails, among other things, a change in the use of the services – from a large amount of hospitalisation to an increased focus on follow-up in the first-line service.

At the same time, the situation is such that very many patients with HIV get their primary medical follow-up in the specialist health service. The complexity of the treatment regimes, including interactions among the medicines and the development of resistance, means that the specialist health service has overriding responsibility to ensure the maximum effectiveness of the treatment.

However, it is important to have a good collaboration between the specialist health service and the regular GPs so that the benefits of the treatment shall be maintained. Patients with HIV also have a need for good, accessible health services at the municipal level for complaints and disorders that are not necessarily related to the HIV infection.

More recent research indicates that HIV patients may have an increased risk of certain illnesses, such as diabetes, cardiovascular disease, high blood pressure and depression. These are conditions that the regular GP has the main responsibility for following up.

Obduction studies show that 30-40 per cent of HIV-positive persons in Africa die of tuberculosis. Among HIV-positive children, one out of every five deaths is due to tuberculosis. We do not have any Norwegian data for co-infection with HIV and tuberculosis because the two diseases are reported in two different ways. Nevertheless, there are

grounds for assuming that there is some degree of co-infection, especially among Africans, with regard to HIV and tuberculosis. For the patient and doctor, it is important to know whether a HIV-positive person is also infected with tuberculosis because in most cases tuberculosis can be easily treated and because tuberculosis in an HIV infected patient can take a more serious course than for persons who are not HIV-infected. On the other hand, it is important to know whether a tuberculosis patient is also infected with HIV, partly because this will affect the way that the tuberculosis is treated. It is important in Norway as well to consider these two infections in connection with each other to a greater extent than before. This is true both in relation to the individual patient and from a social medical perspective.

The oldest person who was diagnosed with HIV in Norway in 2008 was 76 years old. Altogether there are over 700 persons over age 50 living with HIV in Norway. International studies show that older HIV-positive persons report non-HIV-related health problems to a greater extent than others in the same age class. These findings give reason to believe that the same applies to older HIV-positive persons in Norway as well. The people providing the services must have sufficient knowledge to meet the group's care needs.

It is uncertain to what extent the health services provide an adequate programme of regular, repetitive conversations about the prevention of infection and a programme of other training about how to live with a chronic infectious disease. However, the health trusts have a statutory obligation to see that patients who are diagnosed with an HIV infection and any relatives they may have are offered a programme with this kind of training.

At present, there are not any instructions or guidelines about how good teamwork in the medical follow-up of HIV patients should be ensured by interactions between the levels in the health services.

Aksept – the centre for everyone affected by HIV, which is run by the Church City Mission in Oslo, has 25 years of experience in arranging for a good psychosocial follow-up of individuals and families living with HIV. In recent years, they have gained experience and developed methodologies relating to African groups. In 2009, the centre is developing a school practice scheme with the aim of ensuring

that the experiences and methods can be transferred to and adapted in municipalities throughout the country.

Relevant strategic moves:	Follow-up responsibility
Develop and implement guidelines and instructions for good practices in the treatment of HIV infection.	MHCS
Assess the establishment of a scheme with HIV coordinators as a link between the primary health service and the specialist health service as the tuberculosis coordinators function at present.	MHCS
Improve the integration and teamwork between the treatment of infectious diseases and services for mental health and substance abuse.	MHCS
Develop a comprehensive training programme for living with HIV under the direction of the Centres for Learning and Coping.	MHCS
Make more use of the statutory scheme with an individual plan for HIV-positive patients for safe, optimal teamwork between health and welfare services.	MHCS
Develop methods that ensure a good transfer of empirical knowledge and methodologies for the psychosocial follow-up of HIV-positive persons.	MHCS

3.6 Specific objective 6: Ensure the participation of HIV positive persons in the labour force

HIV/AIDS were initially identified as a very serious health problem for the individual and the society, but it became quickly clear that for many people HIV has an enormous impact on the individual's possibilities of having a social life, education and employment.

Most people living with HIV are in the economically productive phase of their life. HIV infection may entail a loss of productivity for the society because of reduced working capacity as a result of the disease and in some cases because of discrimination in employment.

Through the Anti-discrimination and Accessibility Act, HIV-positive persons are ensured legal protection against discrimination and harassment, e.g. on

the job. This also entails that HIV-positive persons can be given an offer of free guidance concerning their rights in employment and the right to a free hearing of an appeal if they think that their rights have been violated. HIV-positive persons also have rights pursuant to the general provisions in the Working Environment Act. Among other things, the Working Environment Act specifies requirements that the working environment shall be "fully satisfactory", cf. chapter 4 of the Working Environment Act. Requirements are also specified for the psychosocial working environment, e.g. employees shall not be subject to harassment or other undue conduct. Under certain conditions, the employer has a responsibility and a duty to arrange the work situation for the employee where that is necessary. Furthermore, the Working Environment Act has provisions in chapter 13 that include a prohibition against discrimination. This prohibition against discrimination applies to all aspects of employment, including the advertising of an available position, hiring, pay and working conditions and termination. The Act also imposes restrictions on an employer's right to request health information when hiring, cf. Sections 9-3 and 9-4 of the Working Environment Act and on an employer's right to lay off an employee, cf. Section 15-7 of the Working Environment Act. In a judgment from 1988 (Norwegian Supreme Court Report Rt. 1988, p. 959), the Norwegian Supreme Court maintained that an unjustified fear of infection among colleagues was not an objectively justified ground for dismissal.

The International Labour Organisation (ILO), the UN's specialised agency for labour issues, established a separate HIV/AIDS programme for employment in 2000. The objective of the programme is to understand and respond to the impacts of HIV/AIDS in employment and to support the actions and/or measures of the authorities and employer and employee organisations in this area. The programme has the following three priority target areas: research and analysis concerning HIV/AIDS-related issues in employment, information, communication and counselling through various fora (e.g. publications and trade meetings at the global, national and regional levels) and professional cooperation with projects in over 50 countries in cooperation with employees, employers and the authorities.

In 2001, the ILO issued "Code of practice on HIV/AIDS and the world of work". Important topics in this codex are rights, non-discrimination, equal

status, confidentiality, prevention and support and care. In order to focus attention on this topic in the national and international plans and increase the importance of this codex, HIV/AIDS in labour issues was put on the agenda of the ILO's Labour Conference in June 2009 with the aim of coming up with a recommendation.

The results from Fafo's studies of living conditions in both 2002 and 2009 among persons living with HIV show that a substantial number of these people face challenges related to labour issues and that the problems with openness have not become any less serious. In 2002, over half of the respondents stated that they were employed – either full-time or part-time. Employment is experienced as positive for some, but demanding, partly because only a minority of them are open about their HIV diagnosis. A prevailing explanation for a possible worsening when it comes to openness is that it is more difficult to announce that you are HIV-positive when you are going to live a long time with HIV.

The Norwegian findings were confirmed by a number of international studies. The challenges partly involve a general fear of telling people at the workplace about one's HIV status, which will obviously have negative consequences with regard to necessary adjustments in the job situation if there should be any. Difficulties with gaining admission to the labour market are also reported, and many people have abandoned or lowered their job ambitions as a result of an HIV diagnosis.

Fafo's survey of attitudes and knowledge showed, for example, that 60 per cent of those asked think that HIV-positive individuals have a duty to be open about their HIV status at the workplace and that the employer must have an opportunity to delegate HIV-positive persons to perform other tasks, e.g. out of consideration for a possible fear of infection among colleagues. Fafo concludes that HIV-positive persons' prospects of a long working life create a need for stronger protection against dismissal, for protection against discrimination in hiring and for the organisation of the working environment taking discrimination into consideration. In some cases, there may also be a need for specific information campaigns that are intended to prevent negative discrimination in the workplace.

Relevant strategic moves:	Follow-up responsibility
Follow up the coordinating responsibility for the recommendation from the ILO concerning HIV/AIDS and labour issues.	MLSI, MCE, MHCS
Increase knowledge about HIV in the labour sector in cooperation with the employer and employee organisations and private and/or non-governmental organisations.	MHCS
Operationalise and clarify the parts of the legislation that should ensure the rights of HIV-positive persons in employment matters.	MCE, MLSI, MJP
Urge companies with many employees to develop a workplace policy with regard to HIV.	MHCS
Standardised programmes for HIV-positive persons in order to quality assure comprehensive and equal follow-up regardless of place of residence.	MHCS
It must be ensured that relevant knowledge about HIV and AIDS is covered in the educations for the various professions.	MHCS
Develop information measures concerning HIV intended for the workplace.	MHCS

3.7 Specific objective 7: Further promote international cooperation and efforts, and follow up international obligations in the efforts to combat HIV and AIDS.

For about 30 years, HIV and AIDS have spread drastically to become a global pandemic. Well over 30 million people live with HIV, and between 20 and 30 million people have died of the disease. Over two thirds of those living with HIV and AIDS live in Africa south of the Sahara. Although the treatment programme has become better throughout the world, we have not managed to diminish the gap when it comes to access to treatment. There are still more people who are infected than there are new persons who gain access to AIDS medicines (a ratio of five to two). It is estimated that about 30 per cent of those who need treatment will get this treatment (2008). Eleven million people are sick with both HIV and tuberculosis. Tuberculosis is the most frequent cause of death among HIV-positive persons, and treatment of these co-infections is both medically and practically demanding.

Women constitute a steadily increasing percentage of HIV-positive persons. The epidemic has levelled off to some extent in its scope, especially in Africa south of the Sahara, whereas in other parts of the world it is still increasing. In the world outside Africa, it is injecting drug users (IDU), men who have sex with men (MSM) and sex workers who are most at-risk of infection. Discriminating laws and social stigmatisation make it difficult to reach out to these groups, not least in Africa, where there so far has been little focus on MSM and IDU. This leads to hidden sources of error and shows that there is a need for better monitoring of the epidemic with regard to at-risk groups.

The absence of infectious diseases such as HIV is a global common good, which is dependent on cooperation among individuals, local communities and nations. The fight against HIV and AIDS is therefore a key priority in Norwegian aid and foreign policy.

Through the UN's Millennium Summit in 2000, the millennium development goals were approved. These set goals for economic and social development. Through Norway's international work, we shall help meet the international millennium development goals, where specific objective six is partly concerned with HIV and AIDS.

- Stop the spread of HIV/AIDS, malaria and other fatal diseases.

In 2001, the UN's General Assembly Special Session passed a "Declaration of Commitment on HIV/AIDS" (UNGASS 2001), which defined specific goals and time frames for ensuring action, support and funding for the HIV response. Likewise, the member states of the World Health Organisation Europe signed a binding partnership agreement to fight HIV/AIDS in Europe and Central Asia in Dublin in 2004 (the Dublin Declaration 2004).

Norway is obligated to help reach the goal of achieving universal access to HIV prevention, treatment, support and care as much as possible by 2010. This goal was launched in 2005 and confirmed in the political declaration at the High-Level Meeting in New York on HIV and AIDS in June 2006 (UN reference A/Res/60/262 Annex, Political Declaration on HIV/AIDS). In order to achieve these goals, international solidarity and a joint effort are needed in order to ensure the funding of services, measures, medicines and equipment.

One of the things that the international declarations have in common is that they set up specific goals and common measures for achieving them. Key topics are:

- Leadership and responsibility at all levels, and the need for strong partnerships among nations and among actors in the public, private and voluntary sectors, including persons living with HIV themselves.
- Strengthen ties: both thematically (not least with regard to sexual and reproductive health and tuberculosis) and between organisations and initiatives. Upscaling of treatment programmes must help improve the health systems as much as possible at all levels.
- Prevention – with a special focus on groups with a high risk of infection. Measures aimed at adolescents and young adults, with special emphasis on conveying information and developing youth-friendly services. Relationship between HIV infection and other sexually transmitted infections.
- Living with HIV – focus on universal access to treatment and care. Fighting stigmatisation and discrimination and safeguarding of human rights. Upscaling of voluntary and confidential HIV testing and good quality counselling. Important to ensure work in various sectors and with numerous actors, including civil society. Workplaces are important arenas for prevention and social inclusion, and employer and employee organisations are key actors with regard to HIV-positive persons' living conditions.
- Internationally, it is important to have a gender perspective in the efforts to combat HIV, because the epidemic and its consequences often hurt women in particular.

Norway supports the international efforts to fight the HIV epidemic both through broad multilateral efforts in accordance with comprehensive guidelines from the UN and by concentrating on individual priority topics where Norway can play the role of an advocate. In December 2006, the Ministry of Foreign Affairs issued a position paper on Norwegian HIV and AIDS policy, developed through a dialogue with Norwegian actors and as a follow-up of the international obligations issued by the UN. The position paper has the following thematic priorities:

- Women, gender and power. Sexual and reproductive health and rights.
- Particularly at-risk groups (men who have sex with men, persons who sell sex, injecting substance abusers, etc.).
- Youth.

- Legislation relevant to the AIDS area
- Local community and local democracy from an AIDS perspective.
- Health personnel and health system.
- Prevention of infection from mother to child.

It is an international goal that the legislation shall help reduce people's risk of becoming HIV-positive and that the rights of HIV-positive persons shall be ensured. This has been taken into account in Norwegian HIV and AIDS policy for development cooperation.

In order to help facilitate a coordination of the national measures with the international AIDS policy, the Ministry of Foreign Affairs and the Ministry of Health and Care Services appointed a joint Norwegian National HIV and AIDS Council in 2007. The Council meets two times a year and is chaired alternately by a Minister or State Secretary from MHCS or MFA respectively. The Council has members from affected government agencies and from civil society, including representatives for people living with HIV and from organisations that work on international development cooperation and with youth. The Council is a platform for discussing key topics and challenges related to the epidemic abroad and at home and for a dialogue with the political leadership in both ministries, but it has no decision-making authority. In addition to the HIV and AIDS Council, the Norwegian Agency for Development Cooperation (NORAD) has supported the coordination of a professional network for HIV and AIDS, Aidsnett, which consists of experts and interested parties from voluntary organisations, from government administration and from research circles.

Relevant strategic moves:	Follow-up responsibility
Further develop a strong focus on HIV and AIDS in international development policy.	MFA
Continue to raise Norway's clear voice in international fora with regard to HIV and human rights.	MFA
Focus on rights of at-risk groups, and ensure a link between sexual and reproductive rights and HIV in the international efforts.	MFA
Continue to make solidary contributions to the funding of the global HIV efforts.	MFA
Gather international experience related to the effect of various forms of regulation and criminalisation on HIV infection.	MFA

3.8 Specific objective 8: Help improve research on the prevention and treatment of HIV and monitoring and evaluation of prevalence, risk factors and effects of measures.

A good system of epidemiological monitoring is crucial for identifying issues related to risk factors for various demographic groups and defining priorities for the effort. The data function as work tools for both preventive actors and planners of measures and for the dimensioning of health and care services.

The monitoring of HIV in Norway is based on anonymised reports from the diagnosing doctor. Among other things, the report shall provide information about the assumed mode and place of infection. This is called first generation epidemiological data.

Data about knowledge, attitudes and behaviour in the general population and among especially at-risk groups in the population are crucial for being able to plan and implement knowledge-based preventive strategies. Periodic and systematic gathering of this type of data (second generation epidemiological data) provides opportunities to forecast trends in HIV infection, evaluate and monitor preventive efforts, degrees of stigmatisation and discrimination that persons living with HIV encounter, as well as participation in employment, etc.

In order to fulfil the international obligations that Norway has assumed with regard to monitoring of and reporting on HIV/AIDS (UNGASS 2001 and Dublin 2004), both first and second generation data are needed. Norway has committed itself to regular reporting of a number of indicators that apply to the population's level of knowledge about HIV, especially measures for at-risk groups, for damage reduction and for the response of various sectors to the HIV epidemic. At present, there is insufficient data for a very high percentage of indicators, and the reporting from Norway is insufficient. The main reason for this is that systematic population and sample surveys that deal with HIV indicators are rarely conducted, and that personnel resources for this work have not been dimensioned.

Areas with a special need for research knowledge include:

- Children and youth living with HIV.
- Prevention among migrants.

- Summaries of effective measures aimed at the group MSM.
- Risk factors and protective factors among especially at-risk groups.
- Elderly persons living with HIV.

Based on current penal regulations, which have been subject to considerable debate, there is also a need for more research-based knowledge of a criminological and medical nature. For one thing, there is a need to improve the basic knowledge about unintended effects of current regulations, including the extent to which current regulations discriminate against HIV-positive persons and/or have a negative effect on the individual's behaviour, protective strategies and willingness to be tested.

For another thing, current knowledge about the risk of transmission of infection from unprotected sex with an HIV-positive person with a low or indeterminate number of cells is limited. It is up to the court to assess how great the risk must be in order for the offence to come under the General Civil Penal Code. Criminal liability is not incurred if there is appropriate use of condoms. Thus, the degree of risk of transmission of infection through unprotected sex is not only a general health issue, but also a matter of importance for the assessment of whether the matter will lie within or outside of the lower limit of criminal liability for risk.

Relevant strategic moves:	Follow-up responsibility
Further develop the current system of monitoring.	MHCS
Encourage the doctors to fulfil the duty to report HIV infection.	MHCS
Monitoring of key indicators for the population's sexual health and behaviour, and likewise in groups that are especially at-risk for HIV.	MHCS
Conduct regular surveys among groups that are highly at-risk for HIV in order to reveal hidden sources of error.	MHCS
Encourage Nordic and/or European cooperation with regard to research, monitoring and basic knowledge about the HIV field.	MHCS
Arrange annual and/or biennial research conferences for the exchange of experience and development of knowledge during the planning period.	MHCS

Initiate and implement "follow-up" evaluation of efforts and achievement of objectives underway in the planning period.	MHCS
Evaluate the choice of method and if possible try to be able to obtain better information about possible unintended effects of current penal sanctions related to HIV.	MHCS, MJP
Systematise existing and initiate new research-based knowledge about the risk of transmitting infection from persons under effective treatment.	MHCS



Appendix

– Presentation of facts for the strategy

1. Distribution of roles

The strategy's objectives and strategic moves affect many sectors of society and involve actors at all levels of government administration and civil society. The most relevant actors and their tasks and authority are described below.

1.1 Public authorities

The Ministry of Labour and Social Inclusion (MLSI) is responsible for labour market policy, working environment and safety policy, integration and diversity policy, immigration and asylum policy, Sami and minority policy, pension policy and welfare and social policy.

In the working environment area, one of the main objectives is to help promote safe and inclusive employment for all, where importance is attached to preventing injuries, illness, accidents and social exclusion. The authorities' main policy instruments in this work are to develop regulations, provide supervision and carry out the development of knowledge and methods.

Ministry of Children and Equality (MCE) administers key parts of the equality and anti-discrimination legislation and has overall coordinating responsibility for equality and anti-discrimination policy, including the policy with regard to lesbian, gay, bi-sexual and transpersons (lgbt). MCE is the

coordinating ministry for the action plan "Bedre livskvalitet for lesbiske, homofile, bifile og transpersoner 2009-2012" (Better quality of life for lesbian, gay, bi-sexual and transpersons 2009-2012), where the government has specified important principles with regard to sector responsibility and integration (mainstreaming) of policy and knowledge about lgbt in all sectors and government agencies. The plan includes over 60 measures, including several that directly or indirectly affect the efforts to prevent the spread of HIV and that can contribute to improved quality of life among men who have sex with men, including HIV-positive persons in this group.

The Ministry of Health and Care Services (MHSC) has overall responsibility for seeing that the population gets good, equivalent health and care services regardless of factors such as their place of residence and personal finances. The Ministry administers health and care services through an extensive body of laws, annual allocations (about NOK 110 billion in 2007) and by means of government agencies, activities and enterprises. Furthermore, the Ministry of Health and Care Services has sector responsibility and advocacy for the public health work in other sectors. Public health work is the society's aggregate effort to improve factors that promote health, diminish factors that entail a health risk and protect against external threats to health. Furthermore, the public health work should help promote a more equal social distribution of factors that affect health.

The Ministry of Justice and the Police (MJP)

works to reduce criminality, promote security, safety, openness, democracy and the Criminal Justice Systems solution of problems and service to the public. One of its main objectives is to ensure the security of the society and the individual. Among other things, the Ministry of Justice and the Police should help ensure quality in the legislation.

The Ministry of Education and Research

(MER) is responsible for developing the comprehensive policy for day nurseries, education, lifelong learning and research.

The Ministry of Foreign Affairs (MFA) works to promote peace and security, an international rule of law, an economically just world order and sustainable development. MFA is supposed to ensure that Norway “speaks with one voice only” at all times in accordance with the main features of Norwegian foreign policy. Therefore, MFA has an important coordinating and advisory function with other ministries. As a superior ministry, MFA is a preparatory and executive body for foreign policy matters, foreign economic matters and development matters.

The Directorate of Labour and Welfare administers the Norwegian Labour and Welfare Administration, which is responsible for the implementation of labour market, national insurance and pension policy. The Norwegian Labour and Welfare Administration shall help achieve the general objectives of the reform of the Norwegian Labour and Welfare Administration relating to getting more people in employment and activity and fewer on assistance, making things easier for the users and adapted to the user’s needs, and developing a comprehensive, effective labour and welfare administration. On the basis of these general objectives, the administration shall:

- help create an inclusive society, inclusive employment and a well-functioning labour market
- attend to the needs of disadvantaged groups and combat poverty, e.g. by encouraging employment and participation
- ensure income during unemployment, pregnancy and birth, sole responsibility for children, illness and injury, disability, old age and death

The Norwegian Institute of Public Health is the Norwegian Government’s institute for the prevention of communicable diseases pursuant to Section 7-9 of the Communicable Disease Control Act. Important tasks include monitoring infectious

diseases, conducting research in the area of prevention of communicable diseases, ensuring an adequate stock of vaccine and/or preparedness and providing guidance to institutions and the population on measures for the prevention of communicable diseases. In accordance with regulations concerning the prevention of communicable diseases in the health service, the Norwegian Institute of Public Health shall maintain an overview of the prevalence of infection in institutions, prepare statistics and offer assistance in the clarification of outbreaks. Furthermore, the Institute shall conduct education activities, hold courses and update information about the prevention of communicable diseases.

The Norwegian Directorate of Health is the national authority on the prevention of communicable diseases and has authority pursuant to Sections 7-10 of the Communicable Disease Control Act to issue a number of orders. Examples of this are the authority to impose temporary duties to report and give notification, require surveys, require vaccination and make quick decisions about a number of matters. The Directorate of Health is responsible for implementing approved policies in a great number of preventive areas, including HIV and sexually transmitted infections. The Directorate administers the Ministry of Health and Care Service’s grant funds in the field of HIV.

The Norwegian Directorate for Education and Training shall help achieve the sector objectives for basic training so that children, adolescents and adults throughout the country can get a good, adequate basic training adapted to the conditions and needs of each individual. The Directorate’s main tasks are:

- promoting the development of quality in basic training,
- promoting the assessment of quality, analysis and documentation of basic training,
- performing administrative tasks related to the basic training.

NORAD is the Norwegian Agency for Development Cooperation under the Ministry of Foreign Affairs. The agency shall provide expert advice on effective follow-up of the Government’s action plan for combating poverty and the work on the UN’s millennium development goals. The agency shall develop and provide independent professional expertise, contribute actively to professional discussions and be at the international forefront in certain fields.

The linking of organisational knowledge and professional advice should help raise the level of NORAD's services by increasing its overall experience. NORAD's Norwegian partners include aid and humanitarian organisations, companies, trade unions, cultural circles, research circles, embassies, government agencies and institutions.

The Directorate of Integration and Diversity (IMDi) is the Ministry of Labour and Social

Inclusion's executive body for the Government's integration and social inclusion policy and is an important contributor to the development of policy in this field. IMDi's most important tasks are to:

- help the municipalities settle refugees who are granted residence in Norway in keeping with the aims of the settlement scheme and in a way that maximises the possibility of rapidly finding employment,
- take the initiative and cooperate with the private sector and organisations in order to increase immigrants' participation in the labour force and community affairs
- ensure a rapid transition from an introductory programme to employment or education,
- help develop and implement the integration and social inclusion policy,
- be a resource centre for the municipalities and other partners that work with integration and social inclusion
- take the initiative with sectoral authorities concerning opportunities and barriers that various groups of immigrants are facing and assist them with advice and guidance,
- help prevent and combat forced marriage.

IMDi's work shall help the expert authorities attend to their sectoral responsibility.

The Norwegian Police Directorate is a directorate under the Ministry of Justice and the Police. The Norwegian Police Directorate is responsible for the professional administration, management, follow-up and development of the Norwegian Police Service, including the 27 police districts and the key services. The National Police Immigration Service, PU, is a service under the Norwegian Police Directorate. PU is responsible for registering all who seek asylum in Norway, identifying asylum seekers and removing persons who have illegal residence in Norway or have received a refusal of their application for asylum. Through the registration of asylum seekers, one of PU's responsibilities is to gather

information from the applicants about their own state of health.

The Norwegian Directorate of Immigration (UDI) shall implement the refugee and immigration policy in the Ministry of Labour and Social Inclusion's area of responsibility. UDI's main tasks include processing applications pursuant to the Immigration Act and the Norwegian Nationality Act, including applications for family reunification, visa, residence permit, work permit, citizenship and asylum and are responsible for the operation of government reception centres for asylum seekers, including the establishment and closing of reception centre places. UDI shall also provide expert-based assistance to the development of a body of regulations and policy in this area.

Pursuant to the Act relating to the public supervision of health services, the **Norwegian Board of Health Supervision** has the overall professional supervision of the health service in Norway. Pursuant to Section 7-10a of the Communicable Disease Control Act, the Norwegian Board of Health Supervision has general responsibility for ensuring that the municipal, county and central government activities are in accordance with laws and regulations.

The regional health authorities (RHF) shall ensure that persons with a permanent domicile or residence in that health region are offered specialist health service in and outside of institutions. Among other things, RHF shall help ensure that the services offered are adapted to the patients' needs and are accessible to the patients.

Each **municipality** shall ensure necessary health services for everyone who lives or has temporary residence in that municipality. Through its health service, each municipality shall promote public health and well-being and good social and environmental conditions and seek to prevent and treat illness, injuries or bodily defects.

The Norwegian National HIV and AIDS Council was established in December 2006 as successor to MFA's former AIDS forum. Key aspects of the concept include the desire for a relationship between the Norwegian and international efforts to prevent the spread of HIV and AIDS and the importance of consultation with affected and involved parties. Another important concern is to make people more aware that HIV is a political

challenge that this government is investing in through political involvement and leadership. The Council was established with an advisory, but not a decision-making mandate. It is the political administration's use of the Council that gives it its justification and professional standing. The meetings are alternately arranged and chaired at the political level by the Ministry of Health and Care Services and the Ministry of Foreign Affairs. The Council is broadly composed of a number of public and private sector organisations. HRH Crown Princess Mette Marit participates as an observer.

1.2 Low-threshold schemes and voluntary organisations

As previously, the actors that are relevant in preventing the spread of HIV include both ordinary health services and voluntary organisations. Here we describe actors that have special roles to play in this work.

The Olafia Clinic in Oslo offers counselling, examination and treatment of sexually transmitted infections and HIV. The Olafia Clinic, which belongs to the South-Eastern Norway Regional Health Authority, comes under Rikshospitalet University Hospital and is supposed to be a resource centre in the area of sexual health. Olafia approaches those who have the greatest risk of sexually transmitted infections and is a low-threshold scheme. The Olafia Clinic cooperates actively with Gay & Lesbian Health Norway, among others, to improve the health of homosexuals through various measures aimed at men who have sex with men.

Brynsenglegene in Oslo runs an outpatient clinic open in the evening for the testing and treatment of sexually transmitted infections for men who have sex with men. The Norwegian Directorate of Health requested that Brynsenglegene open this programme in 2005 in connection with the increase of new infection with HIV among men who have sex with men. The programme is open one evening a week and is free of charge.

The Centre for Social Medicine in Tromsø, Norway is a public-sector actor that has worked especially with following up HIV-positive persons and that has conducted projects aimed at immigrants. They have a programme that covers the whole Northern Norway Regional Health Authority. Many of the people they follow up are immigrants,

and many are women. They work with psychosocial issues, have individual follow-up and arrange group trips and courses. Much of their activity involves providing information about living with HIV, prevention of infection and having children. Most of the people that they have contact with were infected heterosexually.

The Pro Centre in Oslo is an assistance programme for women and men involved in prostitution, which is partly run by the City of Oslo, but which receives central government funds for functioning as a resource centre and a separate health service for sex workers. The Pro Centre's health services focus on sexual and reproductive health and on substance-abuse-related health issues. The Pro Centre conducts preventive efforts against infection through guidance and the distribution of condoms at the actual centre and through outreach services to sex workers on the street and in the indoor market. The majority of the users at the Pro Centre are of foreign origin. Most of the users come from Africa, Eastern Europe and Thailand; i.e. countries with a high prevalence of HIV.

Gay and Lesbian Health Norway is a key actor in preventing the spread of HIV among men who have sex with men (MSM). Gay & Lesbian Health Norway is a voluntary organisation, formerly under the authority of the National Association of Lesbians and Homosexuals (LLH), but is now an independent organisation. Gay & Lesbian Health Norway conducts health-promoting and preventive efforts aimed at women who have sex with women and men who have sex with men. Gay & Lesbian Health Norway generates research-based knowledge about the life situation and health of persons with same-gender sexuality, both on its own and in collaboration with other institutions. Its form of working is based on the peer principle, where the point of departure is that the most effective way to influence attitudes and behaviour is through an open dialogue with one's peers. In keeping with the peer principle, Gay & Lesbian Health Norway has employed openly HIV-positive persons and young staff members who are openly gay or lesbian. Gay & Lesbian Health Norway has measures aimed at individuals, groups and communities.

HivNorway is a national interest organisation for HIV-positive persons, which has no affiliation with any political party or religion. HivNorway's task is to safeguard the rights and interests of HIV-positive

persons in the society and to help promote a greater understanding of the situation of HIV-positive persons and to combat fear, prejudice and discrimination. The organisation works to protect the rights and interests of HIV-positive persons, contribute to preventive efforts and provide follow-up programmes to HIV-positive persons. HivNorway is a programme for everyone and includes individual counselling related to guidance and work to protect rights, seminar activities and efforts to spread information through conferences, the media, etc. HivNorway's efforts to spread information are aimed at HIV-positive persons, professional personnel and the general public through lectures, web sites and general use of the media. The organisation publishes the quarterly magazine, POSITIV.

Aksept is a psychosocial support centre for anyone who is affected by HIV. The centre has an open house for people living with HIV/AIDS, an outpatient clinic and a stationary care unit that is open round-the-clock. Aksept offers HIV-positive persons a programme of various activities, conversations and counselling with regard to living with HIV. Aksept offers 24-hour accommodation for HIV-positive persons who need recreation and rehabilitation. Aksept is a social meeting place that also offers a therapeutic programme and cultural activities. Aksept is also involved in disseminating relevant information. Aksept is funded by the City of Oslo and is operated under the direction of the Church City Mission. Users from other parts of the country can make use of Aksept as needed. The Church City Mission also conducts extensive work for and with people living with HIV in a number of other cities. This is partly organised through the project "Living with HIV" in Stavanger, Bergen and Trondheim.

Primary Health Care Workshop (PMV) in Oslo has measures for preventing the spread of HIV among immigrants. PMV works with health-promoting activities in a broad perspective. Many of these activities are group-based. They have an HIV/AIDS group, and they also include information about HIV in a number of other group activities. They spread information, try to debunk myths and attempt to reduce the stigmatisation associated with HIV.

PION - Prostitutes' Interest Organisation in Norway – was founded in 1990 and works to protect prostitutes' interests and social and civil rights. PION conducts preventive health care and information campaigns in the prostitution communities and provides individual legal advice and guidance. PION

publishes the magazine *Albertine* and disseminates information about prostitution. In its efforts to prevent the spread of HIV and sexually transmitted infection, PION performs outreach services in the prostitution community.

HOMOPOSITIV is a self-help organisation for, by and with HIV-positive homosexual and bi-sexual men. The purpose of the organisation is to support efforts to improve the quality of life for homosexual and bi-sexual men by helping to provide real opportunities so that the individual can live his life according to his own wants and needs. The organisation works hard to promote network-building and inclusive activities for HIV-positive men of all ages. Empowerment is an important concept in HOMOPOSITIV's activities. In this context, empowerment means that the HIV-positive person actively uses his own resources and abilities to cope with the challenges of being HIV-positive.

The National Association of Lesbians and Homosexuals (LLH) is a nationwide organisation that works politically and socially to enable lesbian, gay, bi-sexual and transpersons to live openly without fear of being socially excluded, discriminated against or harassed. The organisation has local organisations in all counties and works to develop community-based methods for preventing the spread of HIV.

2. Relevant regulations

There is an extensive body of regulations that governs actors' and services' obligations and rights relative to the target areas in this strategy. The following is a description of certain Acts and regulations with the emphasis on relevance to the efforts to combat HIV.

Act relating to control of communicable diseases (Communicable Disease Control Act)

The purpose of the Communicable Disease Control Act is to protect the population from communicable diseases by preventing their occurrence and hindering them from spreading through the population, and by preventing such diseases from being brought into Norway or carried out of Norway to other countries. The Act shall ensure that the health authorities and other authorities implement the measures necessary to control communicable diseases and coordinate their efforts to control such diseases. The Act shall safeguard the legal rights of individuals who are affected by the measures to control communicable diseases pursuant to the Act.

Act relating to municipal health services (the Municipal Health Services Act)

This Act shall ensure that the nation's municipalities shall provide necessary health service to everyone who lives or has temporary residence in the respective municipality. The municipality's health service includes public organised health service that does not come under the authority of the central govern-

ment or county administration and private health enterprises that are run in accordance with an agreement with the municipality. Through its health service, each municipality shall promote public health and well-being and good social and environmental conditions and seek to prevent and treat illness, injuries or bodily defects. It shall spread information about and increase interest in the things that the individual him/herself and the general public can do to promote their own well-being and health and public health.

Act relating to the specialist health service, etc. (the Specialist Health Services Act)

The purpose of this Act is partly to promote public health and prevent disease, injury, disorders and disabilities and to help provide equal services adapted to the patients' needs and accessible to the patients.

Act relating to patients' rights (the Patients' Rights Act)

The purpose of this Act is to help ensure the population equal access to good quality medical assistance by giving patients rights with the health service. The Act shall help promote a relationship of trust between patient and health service and maintain respect for the individual patient's life, integrity and human dignity.

Act relating to health personnel etc. (The Health Personnel Act)

The purpose of this Act is to help promote patients' safety and quality in the health service together with confidence in health personnel and the health service. The Health Personnel Act applies to all types of health personnel. It is a basic condition that all health personnel shall be authorised according to a definite procedure. With authorisation comes responsibility to adequately perform one's tasks, which entails that requirements are specified for a high professional and ethical standard among those who are authorised. The main objective of authorisation is to take care of patients' safety.

Act relating to working environment, working hours and employment protection, etc. (the Working Environment Act)

The purpose of the Working Environment Act is to ensure safe employment conditions and equal status in employment and ensure a working environment that provides a basis for health-promoting and meaningful work. The Working Environment Act applies to all employees with the exception of those involved in shipping and fishing, which are regulated in separate regulations. The Act contains special provisions concerning the duties an employer and employee have with regard to ensuring an adequate working environment.

Act relating to National Insurance (the National Insurance Act)

The purpose of the National Insurance is to provide financial security by ensuring an income and compensating for special expenses in the event of unemployment, pregnancy and birth, sole responsibility for children, disease and injury, disability, old age and death. The National Insurance shall contribute to an equalisation of income and living conditions throughout the whole life of the individual and among groups of persons. The National Insurance shall help promote help to self-help with the aim of enabling the individual to be able to provide for him/herself and manage in the best possible way on a daily basis.

Act relating to day care institutions (the Day Care Institutions Act)

The Day Care Institutions Act shall ensure children under compulsory school age good opportunities for development and activities in close dialogue and collaboration with the children's parents. The personnel in the day care institution shall meet

children and parents with different backgrounds and develop an inclusive and supportive environment.

Act relating to primary and secondary education (the Education Act)

One of the purposes of education is that the pupils and apprentices shall acquire knowledge, abilities and attitudes so as to be able to cope with their lives and take part in employment and fellowship in the society. Through Section 9-2 of the Education Act, pupils in primary school and secondary education are entitled to necessary guidance on education, vocational programmes, career choices and social matters. Pupils in difficult situations, such as young people living with HIV, may have a need to speak openly and confidentially with an adult about this. The school guidance service should be a place where pupils can go in such a situation. Together with the school health service, for example, this service must also help facilitate competence building.

Act relating to a prohibition of discrimination on the basis of disability (the Anti-discrimination and Accessibility Act)

The purpose of this Act is to promote equality and equal worth, to ensure equal opportunities and rights to participation for everyone in the society regardless of functional capacity and to prevent discrimination on the basis of reduced functional capacity. The Act shall help facilitate the dismantling of socially created disabling barriers and prevent new ones from being created. The Act applies to all areas of society with the exception of family life and other matters of a personal nature. The Act ensures HIV-positive persons legal protection against discrimination and harassment, e.g. on the job.

Act relating to social services etc. (the Social Services Act)

The purpose of this Act is to promote economic and social security, to improve the living conditions for disadvantaged persons and to help promote greater equal worth and equality and prevent social problems. In addition, the Act shall help give each individual an opportunity to live and dwell independently and to have an active, meaningful existence in fellowship with others.

General Civil Penal Code (the Penal Code)

Section 155 of the Penal Code has the purpose of protecting the society against the spread of communicable diseases that are hazardous to public health. This provision imposes penalties on those who have

good reason to believe that they are infected with a communicable disease that is hazardous to public health and who wilfully or negligently transmit that infection or expose someone else to the risk of becoming infected. The maximum penalty is up to 6 years imprisonment for a wilful violation and 3 years for a negligent violation. The Communicable Disease Control Act's definition of a "communicable disease that is hazardous to public health" is also applicable for the Penal Code. The content of the concept may alter with time, depending, for example, on the treatment possibilities for various diseases and the possibilities of preventing the transmission of infection.

3. More detailed discussion of the HIV and AIDS situation in Norway at the end of 2008

3.1 HIV infection

HIV testing became available in Norway in 1985, and anonymised reporting of HIV infection was introduced in 1986 with retroactive effect. Since then, 4,086 HIV-positive persons have been confirmed in Norway (tab. 1), 2,748 men and 1,338 women.

The number of diagnosed HIV positive persons in Norway during the last ten-year period doubled from about 150 cases at the close of the 1990s to nearly 300 cases in 2008. This is primarily due to an increase in the number of HIV positive immigrants who have come to Norway from countries with a high prevalence of HIV and to an increase in HIV infection among men who have sex with men in Norway. In the last ten years, no definite increase in heterosexual HIV infection among persons born in Norway has been confirmed. Among injecting substance abusers, the number of HIV-infected persons has remained at a stable low level. There has still been very little HIV infection confirmed among heterosexual youth.

In practice, only sexual infection and infection through the use of unclean injection equipment among substance abusers now have any significant effect on the HIV situation in Norway. Only one case of infection through blood transfusion has been confirmed in Norway after 1986, and HIV infection of children in connection with pregnancy and birth has not occurred in Norway since 1999.

Since the HIV monitoring is based on anonymity, there is not any data showing how many of the HIV-positive persons are living with their HIV infection in Norway at present. Of the 4,086 reported HIV-positive cases, 618 have been reported to have died from AIDS, some have died of other causes, and others have travelled out of the country. The Norwegian Institute of Public Health assumes that around 3,500 persons with an HIV infection are currently living in Norway, 300-500 of which do not know that they have HIV (hidden sources of error).

The nature of the HIV epidemic in Norway has changed very little in the last 25 years with regard to infection patterns and the groups that are most affected. More than 90 per cent of HIV-positive persons in Norway are still from the original at-risk groups of men who have sex with men, immigrants from high-endemic areas, Norwegian men who have sexual contacts in high-endemic areas and injecting substance abusers. The virus has gained very little access to the rest of the population. This is mainly due to the fact that HIV has relatively low contagiousness through sexual contact and hence mainly has the potential to spread in groups that have a great deal of casual and unsafe sex and/or sexual contacts in communities that have a high prevalence of HIV or sexual practices that have a higher risk of infection (anal sex).

Risk category	<99	99	00	01	02	03	04	05	06	07	08	Total	%
Heterosexual	641	92	131	105	151	153	163	134	164	141	185	2060	50,4
-residence Norway	289	27	38	27	28	34	43	33	42	41	46	648	-
-immigrants	352	65	93	78	123	119	120	101	122	100	139	1412	-
Homosexual (MSM)	699	36	32	39	30	57	70	56	90	77	92	1278	31,3
Injecting drug use	430	12	7	8	16	13	15	20	7	13	12	553	13,5
Received blood products	46											46	1,1
Mother-to-child	18	4	3	2	2	5	1	5	6	9	4	59	1,4
Others/unknown	37	3	2	3	6	10	2	4	9	8	6	90	2,2
Total	1871	147	175	157	205	238	251	219	276	248	299	4086	100

Table 1

HIV infection notifications in Norway 1984-2008 by risk category and year of diagnosis.

Source: The Norwegian Surveillance System for Communicable Diseases (MSIS)

3.1.1 Homosexually infected persons

Among men who have sex with men, there has been a rapid increase in the number of HIV cases since 2003, and the number of yearly confirmed HIV cases in the group has more than doubled since the 1990s. A similar trend has been observed in both the USA and a number of other western countries. Of the 442 HIV cases reported since 2003, about 60 per cent were infected in Oslo, 10 per cent in the rest of Norway, and 24 per cent abroad, while for 6 per cent of the cases, the place of infection was unknown. In the last three years, there has been a clear increase in homosexual HIV infection outside of Oslo. The situation with infection among men who have sex with men is still distinguished by the fact that many of them are infected by casual or anonymous sex in Norway or on holiday trips abroad. In the period 2003-2008, 66 per cent of the newly diagnosed patients reported that they were infected by a casual partner and 16 per cent by a steady partner, while in 18 per cent of the cases the relationship to the person who had infected them was unknown. The median age at the time of diagnosis has remained around 36, and there are no definite signs that more young homosexual men are now being infected.

In the last five years, 15-20 per cent of the HIV cases among homosexual men have been immigrants infected after their arrival in Norway.

3.1.2 Heterosexually infected persons

The majority of heterosexually infected persons that are now confirmed to be HIV-positive in Norway are persons of foreign origin who were infected before their arrival in Norway. In order to get a better

picture of the HIV epidemic among heterosexuals, the heterosexually infected persons are divided into two groups according to whether they had permanent residence in Norway when they were infected or whether they were infected before their arrival in Norway.

Infected while domiciled in Norway

Since 1985, a total of 648 HIV cases have been confirmed in this group: 410 men and 238 women. The number of HIV-positive persons has undergone a slight increase in the last ten years from about 30 cases per year around 2000 to 46 cases in 2008. Until recently, most of the cases in this group (85 per cent) have been persons with a Norwegian background, but the percentage of immigrants infected while they were residing in Norway has increased in recent years, especially among women, and now constitutes about one third of the heterosexually infected cases. Among persons born in Norway, the number of confirmed infected persons and infection patterns have altered little in recent years. As a rule the women are infected in Norway, usually by their steady partner who is unaware of his HIV infection. The men are usually infected through casual sex abroad, and for many years Thailand has been reported as the most frequent source of infection by far.

In the last ten years, the median age of men at the time of diagnosis remained around 45 whereas it was around 35 for women. Few have been infected heterosexually by substance abusers or by bi-sexual men. There have still been very few confirmed cases of HIV infection among heterosexual youth in Norway.

Infected before arrival in Norway

This group consists of persons who were born abroad and who were infected with HIV before they arrived in Norway for the first time. Most of them came as refugees, asylum seekers and family reunification immigrants and the number of HIV-positive persons in this group has increased in recent years in step with the number of immigrants arriving in Norway. Since 1985, a total of 1,412 HIV cases have been confirmed in this group: 844 men and 568 women. The number of HIV-positive persons has increased in the last 10 years from about 80 cases a year around 2000 to 139 cases in 2008. The majority are from areas of conflict in East Africa, most frequently from Ethiopia, Somalia and Eritrea. Most of the HIV positive immigrants from Asia are Thai women who have come to Norway to marry a Norwegian husband. The median age for the cases reported in the last 10 years has been 34 for men and 30 for women.

3.1.3 Injecting substance abusers

The incidence of HIV among substance abusers in Norway has remained at a stable low level in the last ten years with about 10-15 cases diagnosed annually. Of the 123 HIV cases confirmed in the last 10 years, 70 per cent were men. The median age has remained steady around 35 for both women and men. About 20 per cent of the cases have been immigrants infected before their arrival in Norway. Of the cases infected in Norway, 60 per cent state that they were infected in Oslo.

3.1.4 Infection from mother to child

Since 1985, 59 perinatally infected children have been reported. The routine offer of HIV testing of pregnant women in Norway and the use of antiviral prophylaxis for mother and child in connection with birth have resulted in a greatly reduced risk of infection for the child. The last child with congenital HIV infection in Norway was born in 1999. Of children with HIV infection, most of the 41 cases reported in the last 10 years have come to Norway together with asylum-seeking parents, usually from Africa.

3.1.5 AIDS

Since the first AIDS cases were diagnosed in Norway in 1983, a total of 958 AIDS cases have been reported: 744 men and 214 women, 618 of which have been reported dead. The number of reported AIDS cases and AIDS deaths reached their peak in the 1990s with 74 AIDS cases in 1994 and 72 AIDS deaths in 1992.

After modern HIV treatment became available in 1996, the incidence of AIDS has been gradually reduced to around twenty cases a year, and the number of registered deaths due to AIDS has decreased to under ten a year. However, the greatly improved prognosis in the event of AIDS has also caused the AIDS diagnosis to lose much of its original clinical and epidemiological importance. Doctors have therefore become more reserved in giving the patients AIDS as a diagnosis, nor do they report the cases to the Surveillance System for Communicable Diseases (MSIS). The reported cases of AIDS and the number of deaths are thus minimum figures.

3.2 Knowledge about and attitudes to HIV

The nationally representative survey *Fortsatt farlig å kysse? (Still dangerous to kiss?) - information about attitudes to HIV that was conducted by the Institute of Applied Social Science (Fafo) in 2008 - shows that the general knowledge about how HIV infects is for the most part very good. The greatest lack of knowledge in the population is related to the ways in which HIV does not infect. There is a fairly significant percentage of the population who think that HIV infects by kissing a HIV-positive person and by drinking from the same glass as a HIV-positive person.*

To survey knowledge and attitudes in the population, Fafo has conducted a survey of knowledge and attitudes. A summary of the results is presented in the table below

Results from the survey of attitudes and knowledge "Fortsatt farlig og kysse" (Still dangerous to kiss?), Fafo 2008, Distribution of responses concerning HIV, per cent, total n = 1002

Statement	Agree	Dis-agree	Do not know
You can be infected by HIV by having sex without a condom	98 %	1 %	2 %
You can be infected by HIV by kissing a HIV-positive person on the mouth	24 %	65 %	15 %
You can be infected by HIV by drinking from the same glass of water	13 %	75 %	12 %

Persons who are HIV infected are obligated to inform their employer and colleagues of their HIV status	60 %	35 %	5 %
Employees who are HIV-positive must accept that their employer changes their job tasks out of consideration for their colleagues	50 %	43 %	7 %
It is okay for HIV-positive persons to have parental responsibility	88 %	7 %	5 %
I would not let someone who is HIV-positive take care of my own children	34 %	58 %	8 %

* Fully agree and partly agree come under the same category; fully disagree and partly disagree come under the same category

In general, the level of knowledge in the population appears to be good. To questions related to infection and/or the use of condoms, an overwhelming majority answer correctly (98 per cent). Nevertheless, previous sexual surveys and not least the number of infected persons show that far too many still do not use a condom when they know that they ought to do so.

There is a lower level of knowledge about the ways in which HIV does not infect. Twenty-four and thirteen per cent respectively answered that you can be infected by kissing or drinking from the same glass as an HIV-positive person. In addition to a relatively large percentage who answered incorrectly, there were also many who answered “do not know”, especially among the youngest respondents (ages 15-24).

The Norwegian results agree to a great extent with the results from similar surveys in the rest of the world, which UNAIDS conducted in 2008. While nearly 100 per cent of the adolescents and young adult respondents in Norway knew that you could be infected with HIV by having sex without a condom, the UNAIDS data show by comparison that about 70 per cent of the young men and about 55 per cent of the young women had this knowledge in other countries.

In the study *Fortsatt farlig å kysse (Still dangerous to kiss?)*, the family and job are used in particular as arenas for measuring the population's attitudes, and key indicators are parental responsibility, childcare

and safety in the workplace. The study shows that 88 per cent of the respondents thought it was okay that HIV-positive persons have parental responsibility, but 34 per cent would not let a HIV-positive person mind their own child. Sixty per cent of the respondents thought that HIV-positive persons had to be obligated to inform their employer of their HIV status, and 50 per cent thought that HIV-positive persons had to accept altered job tasks out of consideration for their colleagues' safety. Eighteen per cent would have avoided contact with a colleague if they found out he/she was HIV-positive.

The study shows a strong relationship between knowledge and attitudes. The attitudes become more positive with knowledge and more positive with age up to a certain limit. It is among the youngest and the oldest that we find the most problematic attitudes, and it is especially in the group of 15-24 year-olds that we find the most restrictive attitudes to HIV-positive persons' rights and opportunities to participate in society.

The study may indicate that HIV-positive persons have limited opportunities for personal and professional development through social inclusion in employment and in the society in general. Fafo's survey of knowledge about research on HIV shows that the Norwegian findings confirm those of a number of international studies. The challenges partly involve a general fear of telling people at the workplace about one's HIV status, which will obviously have negative consequences with regard to necessary adjustments in the job situation if there should be any. Difficulties with gaining admission to the labour market are also reported, and many people have abandoned or lowered their job ambitions as a result of an HIV diagnosis.

These results may mean that in order to combat fear and stigmatisation, there is a need to improve the knowledge about HIV in the population in general and among young people in particular. They may also indicate a need for stronger protection against dismissal, for protection against discrimination in employment and for an arrangement of the working environment with a view to discrimination.

3.3 The living conditions of persons with HIV

In the spring of 2009, Fafo published the results of a new study of living conditions among people living

with HIV in Norway: The report *"Fra holdninger til levekår. Liv med hiv i Norge i 2009"* (From attitudes to living conditions. Living with HIV in Norway in 2009) follows up a previous study of living conditions from the beginning of the 2000 decade and is based on qualitative interviews and a quantitative questionnaire of HIV-positive persons. A total of 271 persons filled out the questionnaire, and if we use the estimate of the number of persons living with HIV in Norway at present, this amounts to a response rate on the order of magnitude of 10 per cent. In this sample, homosexual men, for example, are overrepresented and heterosexuals and injecting substance abusers are underrepresented. These factors mean that the report is not representative; it says something about the living conditions and the life situation of those who have answered the questionnaire, but not the population of HIV-positive persons as a whole. In light of the survey of attitudes and qualitative interviews, however, the study still provides an important understanding of relationships, experiences and insights into living as an HIV-positive person in Norway in the year 2009.

Compared with the situation in 2001/2002, the results show improvement with regard to somatic and physical factors related to the HIV diagnosis. The psychosocial factors are challenging for HIV-positive persons in most cases, and that has not changed since the previous study. There is also an indication of change in personal strategies with regard to living with the disease: It looks as if HIV-positive persons would like HIV to not play a major role in their lives; this is especially true of newly infected persons.

Fifty-five percent of those who answered the question say that during the last few days that have felt well and energetic and been happy and content all or most of the time. Even more (60 per cent) say that they feel happy and content all or most of the time. Compared with Fafo's previous study of living conditions in 2002, this amounts to an increase. In 2002, 47 and 51 per cent respectively stated that they experienced these two conditions all or most of the time.

The study shows that 27 per cent of the HIV-positive persons have been in contact with a psychologist one or more times in the past year, and another 54 per cent say that they have needed psychological counselling and treatment in connection with being HIV-positive. The qualitative data may indicate that despite the fact that it is easy to get a referral from a

doctor, it is difficult to gain admittance with a psychologist and that even with admittance it may be difficult for the HIV-positive person to find the necessary expertise. The study indicates a great demand for programmes that focus on the psychological needs.

If we consider the need for psychological services in light of openness about the diagnosis and reported isolation, it enhances the picture of the HIV-positive persons' feelings of loneliness and alienation on the one hand: about half of the respondents feel isolated. About 40 per cent of the respondents have not told anyone, or fewer than 5 persons, that they are HIV-positive. The main reason is that family and friends would be afraid of the HIV-positive person (43 per cent); after that comes a fear of rejection (26 per cent) and feelings of shame (27 per cent). It is worth noting in connection with this that respondents from immigrant communities in particular speak of difficulties being open in their own community.

Many are confronted with negative attitudes and ignorance with regard to HIV, and this is experienced as a burden. There are also many in Fafo's sample who do not mention any such burden, and 53 per cent say that they have encountered predominantly positive reactions from their surroundings after they have announced their HIV diagnosis. For some people, it appears that the burden primarily involves their own fears of other people's reactions more than people's actual reactions: only 23 per cent say that they feel that others to a great or some extent keep their distance from them, whereas fully 37 per cent say that they perceive themselves as contagious to a great or some extent and therefore keep their distance from others. On this basis, it is conceivable that there is a potential for greater self-knowledge among HIV-positive persons and that prevention of self-stigmatisation is an important gateway in the efforts to improve their living conditions.

Men who have sex with men (MSM) are the group that comes out best in many of the living condition indicators that are used in the study. Also in this group of respondents, however, there is a high percentage who report that they have financial problems that are partly related to the HIV diagnosis. The group of homosexually infected persons is the group that is most open about their HIV status. Nevertheless, there is also a high percentage in this group who limit their openness to a small group of

persons. Many of the informants that define themselves as homosexual say that contacting HIV entailed a new “coming out” process. With regard to health, this group distinguishes itself by a relatively large use of psychological services compared with the other groups. Many make active use of the Internet to build a network and say that it is a place where it is easier to talk about their HIV status. However, HIV-positive homosexual men with an immigrant background, for example, say that they encounter a number of prejudices on these web sites.

In the group women and men who are infected heterosexually, two-thirds were infected before their arrival in Norway and have an immigrant background. The picture of the living conditions of this group is therefore characterised by the high number of persons with an immigrant background. Not least women with an immigrant background score relatively poorly when it comes to material conditions. HIV positive persons with an immigrant background, both men and women, report that it is difficult to be open in their own ethnic group. Among the respondents, this is the group that claims to be the least open about their HIV status to their surroundings. Only one out of four of the respondents is living in a steady heterosexual relationship. Many of the informants are reluctant to get involved in a relationship. Many are in despair because they do not get any assistance to have children, and they want this kind of programme.

The report shows that gender appears to be a significant factor with regard to income and personal finances and with regard to sexuality. Women have consistently lower income and worse personal finances and are not as concerned that their sex life should function optimally; they maintain that sex is no longer so important - trustworthiness and intimacy are more important. When it comes to relations with family and friends, it also appears that the women attach more importance to these relations and to the fact that support from and the confidence of their family and friends are very important for their mental health.

The report on living conditions calls attention to the fact that the groups that have the highest prevalence of HIV in Norway are marginalised in other ways besides just HIV. That is true, for example, of homosexual men and MSM, persons with an immigrant background and substance abusers.

There appear to be many common challenges and issues shared by these groups. With regard to material living conditions, there are a relatively large number of disability pensioners. This is probably not surprising given that the study focuses on a group with a health problem. It looks as if HIV-positive persons used to be more or less automatically given a disability benefit. In the sample, about half of the respondents are employed, and one fourth of them are disability pensioners. Some of these disability pensioners could have coped with and wanted part-time employment, but they experience barriers in their encounters with the Norwegian Labour and Welfare Organisation (NAV). Many state that they have a need for accommodations at the workplace that are not followed up. With the change that the anti-viral medicines have brought for HIV-positive persons' state of health, it is quite conceivable that there is a lag in the system, which means that relatively many receive, for example, disability benefits. Fafo concludes that it will be a challenge to follow up the workfare programme in the social policy and achieve a socially inclusive labour market for HIV-positive persons.

The workplace is a challenge for openness. The survey of attitudes, “*Fortsatt farlig å kysse*” (Still dangerous to kiss?), revealed a certain amount of scepticism to working together with HIV-positive persons. The study of living conditions shows that relatively few of the respondents who are employed are open (34 per cent) and furthermore that relatively many of those who have been open have experienced negative reactions to their openness. Some informants say that they have been discriminated against or that attempts have been made to exclude them from the workplace. In general, it appears that among both respondents and informants there is only a limited openness. However, there is not any indication of similar problems with openness with their personal networks, friends and family. On the contrary, many of the informants say that they have been given considerable support from family and friends and that this has been crucial for their mental health.

The most positive findings concern somatic health issues. The medicines have become better and have fewer side effects. However, the health services still face challenges with regard to knowledge about and attitudes to HIV. This is especially true of the generalists, such as the regular GPs or the professional staff at NAV, where there are reports of

insufficient knowledge about the psychological and social factors related to HIV.

The variable that most clearly affects openness is the time of diagnosis. The longer a person has known that he or she is HIV-positive, the greater the openness. Anxiety about openness appears to be more closely related to anxiety about stigmatisation and the consequences that openness may bring about than to actual experiences with being rejected because of HIV status. The percentage of persons who have contact with networks, organisations and bodies offering psychosocial support are about equal in all of the groups. Those who have contact with a network and/or organisation often have contact with more than one such, and they give positive feedback about the help they have received. Some of them are also critical, mainly in two respects: one is that these communities are too focused on misery; the other is that HIV-positive persons themselves have too little influence in the organisations, and this is especially mentioned with respect to HivNorway.

Many of the respondents are concerned with sexuality and report problems with regard to it. Among the informants in the qualitative part of the study, Section 155 of the Penal Code is regarded as a substantial difficulty. This section contributes to a poorer quality of life and has a destructive effect on couples and also with regard to daring to establish new relationships. This is somewhat less clear in the questionnaire, even though over half of the respondents say that the Penal Code worries them.

3.4 Norway's international obligations in the HIV area

Since 2001, Norway has endorsed the following declarations under the direction of the UN and the EU:

3.4.1 Declaration of Commitment on HIV/AIDS "Global crisis - global action" (UNGASS – A/RES/S-26/2 - 27 June 2001)

With this declaration, Norway has made the following main commitments:

- Promote greater national, regional and international leadership in the struggle to prevent the spread of HIV/AIDS
- Prevent the transmission of HIV infection
- Increase the scope of and improve universal access to care, support and treatment.

- Ensure human rights and fundamental liberties for everyone.
- Give priority to vulnerable and at-risk groups
- Provide special care for orphaned children who are affected by HIV/AIDS.
- Limit the social and economic effects of HIV/AIDS and invest in sustainable development.
- Increase the commitment in research and development with regard to immunisation and treatment.
- Develop and implement national strategies for prevention, care and treatment of HIV/AIDS in areas suffering from conflict and hurt by disasters.
- Ensure financial contributions and other necessary resources in the efforts to combat HIV/AIDS.
- Maintain and monitor the progression of the HIV/AIDS efforts at the national, regional and international levels.

3.4.2 Political Declaration on HIV/AIDS (UNGASS – A/RES/60/262 - 2 June 2006)

With this declaration, Norway has made the following main commitments:

- Halt and begin to reverse the spread of HIV/AIDS, malaria and other fatal illnesses by 2015, as approved in the UN's millennium development goals.
- Increase the scope of and improve universal access to prevention, treatment, support and care by 2010.
- Promote the links between various national plans and strategies, including plans for HIV/AIDS, sexual and reproductive health and the reduction of poverty.
- Promote information, communication, training and guidance, especially among young people, about sexual behaviour, control of one's own body and how to protect oneself against infection.
- Prevent HIV infection from mother to child.
- Eliminate all forms of discrimination against persons living with HIV/AIDS and other at-risk groups.
- Emphasise the disparities of power between the genders and women's right to good health and step up the fight against abuse of women.
- Emphasise the relationship between tuberculosis and HIV.

3.4.3 The Dublin Declaration on Partnership to Fight HIV/ AIDS in Europe and Central Asia (24 February 2004)

With this declaration, Norway has made the following main commitments:

- Increase the awareness of leaders in the public and private sectors, including the pharmaceutical industry, the media and civil society.
- Establish a national HIV/AIDS partnership forum with special participation from civil society and persons living with HIV/AIDS.
- Promote increased coordination and partnership among countries in Europe and Central Asia, regional networks of civilian actors and affected parties, and European and international organisations.
- Ensure that financial and technical resources are provided.
- Promote universal access to information, guidance and services.
- Prevent HIV infection from mother to child.
- Counteract the special vulnerability to infection of women and young girls.
- Eliminate discrimination against and stigmatisation of persons living with HIV/AIDS.
- Ensure universal access to prevention, treatment and care, along with the monitoring and exchange of best available practices.
- Increase the commitment in research and development.

3.4.4 The Vilnius Declaration on Measures to Strengthen Responses to HIV/AIDS in the European Union and in Neighbouring Countries (17 September 2004)

With this declaration, Norway has made the following main commitments:

- Prepare, implement and evaluate plans and strategies and monitor the progression of the HIV and AIDS efforts.
- Promote participation by and increase the awareness of civil society and voluntary organisations.
- Promote universal access to prevention, treatment, care and support, including information, education and guidance.
- Promote gender equality and the right to sexual and reproductive health, including women's and young girls' special vulnerability to HIV infection.
- Increase the commitment in research and development.
- Follow up with relevant legislation and necessary funding.
- Promote increased cooperation and contact between the public and private sectors and national and international actors and affected parties.

3.4.5 The Bremen Declaration on Responsibility and Partnership – Together against HIV/AIDS (13 March 2007)

With this declaration, Norway has made the following main commitments:

- Ensure political leadership in the fight against HIV/AIDS and hold leaders responsible at the national, European and international levels.
- Protect human rights and prevent discrimination against and stigmatisation of persons living with HIV/AIDS and other at-risk groups, including injecting substance abusers and their partners, men who have sex with men, young people, women, migrants, children, inmates in prisons and persons who are involved in the sex trade.
- Promote universal access to prevention and treatment in order to reduce the damaging effects of HIV/AIDS, including cooperation to ensure access to affordable medicines and the exchange and implementation of best available practices.
- Prevent HIV infection from mother to child.
- Promote sex information and guidance, especially among young people.
- Strive for cooperation with a broad range of partners, both public and private sector and national and international.
- Increase the commitment in research and development of new technology and in investment in the public sector with regard to vaccination and other funds for the purpose of preventing HIV infection.

3.4.6 Norway's fulfilment of international obligations

In its evaluation of the strategic plan, Econ Pöyry has assessed compliance with the declarations that Norway has endorsed. Among other things, they conclude that the strategies on which the HIV/AIDS work shall be based according to the UNGASS Declaration are the same strategies on which the strategic plan is based. Econ Pöyry is familiar with these strategies, but raises questions about the extent to which they have been implemented.

In the Norwegian context, it is probably the strategies aimed at discrimination against and stigmatisation of HIV-positive persons that have been least fulfilled in the current efforts. When the Dublin Declaration states that at least 80 per cent of those who belong to at-risk groups shall be covered by a broad range of preventive programmes, it is not very likely that such is the case in Norway. Econ Pöyry points out that there remain things to be done with

regard to at-risk groups such as men who have sex with men and immigrants from high-endemic areas. The international declarations have a strong focus on women's vulnerability to become HIV infected. In Norway, this applies first and foremost to immigrant women from certain communities. According to Econ Pöyry, these women are not well taken care of by the current efforts.

There is also considerable focus on ensuring that young people shall be given sufficient information and training; this is also an important goal in the strategic plan where it is stated that young people shall be given information and training about HIV and modes of infection. However, Fafo's study (2008) of knowledge about HIV, for example, shows that young people are a group that has only limited knowledge about HIV and modes of infection.

Through the strategic plan, Norway has established national goals for reducing new infection in at-risk groups and preventing new infection in other groups. This is in keeping with the declarations. However, the specific objectives related to information and prevention in the strategic plan have not been quantified. Econ Pöyry emphasises that it is difficult to measure the number of people in the various target groups who have received information and come in contact with preventive measures. Econ Pöyry thinks it ought to be assessed whether it is possible to measure these efforts in a better way than the present one.

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