



Plan of Action for Combating  
**the HIV/AIDS Epidemic**  
**1996–2000**



**THE NORWEGIAN MINISTRY OF HEALTH AND SOCIAL AFFAIRS**



# Foreword

In 1996 the Norwegian Ministry of Health and Social Affairs (SHD) published a new Plan of Action for the HIV/AIDS epidemic for the years 1996-2000 (order number I-0875 B, Norwegian Bokmål version). The present version is shorter and is currently being printed in Arabic, English, Farsi, French, Spanish, German and Urdu. The Ministry hopes that these publications will reach as many people living in Norway as possible, including those who speak and read languages other than Norwegian.

HIV/AIDS-preventive programmes have been run by both public and Non Governmental Organisations (NGOs) in Norway since 1984. The underlying principle for these programmes has been a voluntary and self-motivated cooperation between the different people involved, and a great deal has been achieved. Nevertheless the public is constantly reminded that HIV infection is all around us and that young people are dying of AIDS. No vaccine has yet been produced that will prevent infection, and there is no way of curing a person who has developed AIDS.

Combating the HIV/AIDS epidemic is therefore just as important today as it was in 1984. Two principal objectives for this programme are set out in the Plan of Action for Combating the HIV/AIDS Epidemic 1996-2000:

1. The number of people who become infected by HIV during the period 1996-2000 must be less than during the period 1990-1995.
2. People with HIV and AIDS must have a better quality of life and a longer life expectancy than was the case between 1990 and 1995.

The main aim is to work actively for the fulfilment of these principal objectives. In addition to protecting young people, people travelling abroad, people from other countries who are unfamiliar with the Norwegian language and those who come into contact with HIV and AIDS, these initiatives are intended to prevent infection among such vulnerable groups as: men who have sex with men, injecting drug users, people who buy and sell sexual services, and people from countries with a higher HIV prevalence than Norway. People who are HIV positive are very important to the preventive programme and it will be a priority to involve them more actively. A great deal can now be done to improve the quality of life and treatment options for people with HIV and AIDS. This will be given full attention during the period of the Action Plan.

The Norwegian Ministry of Health and Social Affairs,  
October 1997.

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# Chapter 1

## *Plan of Action for Combating the HIV/AIDS Epidemic. Objectives and initiatives for the period 1996-2000*

### INTRODUCTION

Management by objectives and results is the method by which programmes are carried out within different sectors of central government administration. The Ministry of Health and Social Affairs (SHD) also uses these principles in the HIV/AIDS preventive programme so as to clarify the objectives which the authorities have established and to indicate which procedures should be used in order to achieve these objectives.

The objectives listed below are based on the conclusions in chapters 3 and 4 and summarise the plan of initiatives to combat the HIV/AIDS epidemic. The principal objectives (1 and 2) represent the overall targets of the Plan of Action. The specific objectives indicate those elements most critical to the fulfilment of the principal objectives. It is not always possible to use direct methods for checking if the specific objectives have been reached. The intended results should therefore give an indication that the specific objectives have been reached or are in the process of being reached. The actions are concrete measures which will achieve the specific objectives and not just the intended results.

Below each action a name (or names) is printed in bold to show who should assume overall responsibility for implementing and coordinating the action, together with the proposed collaborating groups (in brackets).

### PRINCIPAL OBJECTIVES

*1. The number of people who become infected by HIV during the period 1996-2000 must be less than during the period 1990-1995.*

*2. People with HIV and AIDS must have a better quality of life and a longer life expectancy than was the situation during the period 1990-1995.*

### SPECIFIC OBJECTIVES

#### Specific objective 1.1

The cases of new HIV infection among men who have sex with men must be lower than for the period 1990 - 1995.

#### **Intended result:**

Reduce by 25 per cent the cases of new infection among men who have sex with men in relation to the period 1990-95.

#### **Action:**

Identify the factors that are associated with increased risk of HIV infection. (See also specific objective 1.10)

- **SHD** (Norwegian research establishments, NGOs)

Combat or reduce the range of factors which are associated with increased risk of HIV infection.

- **SHD** (Norwegian Board of Health (Helsetilsynet) NGOs)

Improved availability of condoms.

(See also specific objective 1.7)

- **Norwegian Board of Health** (municipalities and NGOs)

Better counselling concerning HIV testing.  
(See also specific objective 1.6)

- **Norwegian Board of Health** (National Institute of Public Health (Folkehelsa), doctors)

Improved contact tracing of infections after HIV has been diagnosed.

- **Norwegian Board of Health, National Institute of Public Health**, (doctors)

Increase the cooperation of people with HIV in the HIV preventive programme.

- **Norwegian Board of Health** (support groups for people with HIV)

### Specific objective 1.2

The cases of new HIV infection among injecting drug users must not increase as compared with the period 1990 -1995.

#### Intended result:

The number of injecting drug users becoming infected must not increase as compared with the period 1990-95. This means that there must not be more than 10-15 cases per year.

#### Action:

Ensure that there is adequate availability of clean syringes, needles and condoms in all appropriate locations throughout the country.

- **Norwegian Board of Health** (municipalities (outreach workers), chemist shops and NGOs)

Improve the overall health service care for drug users so as to strengthen their health, and also improve the treatment of STDs (sexually transmitted diseases). (See also specific objective 1.8)

- **Norwegian Board of Health** (municipalities)

Prioritise those who are HIV positive when admitting drug users to treatment centres.

- **SHD, Norwegian Board of Health** (municipalities)

Strengthen HIV preventive measures in connection with drug users with other cultural backgrounds.

- **SHD, Norwegian Board of Health** (municipalities, organisations for immigrants)

### Specific objective 1.3

The cases of new HIV infection among heterosexuals must decrease as compared with the period 1990 - 1995.

#### Intended result:

The number of people becoming infected through heterosexual contact must not be greater than

during the period 1990-95. This means that there must not be more than 30 cases per year.

#### Action:

Make those who travel abroad an important target group for HIV preventive measures. Improve cooperation on preventive measures with the hotel and tourist industries, the Defence Authorities, NORAD [Norwegian Agency for Development Cooperation] and companies which send employees abroad. (See also specific objective 1.9)

- **Norwegian Board of Health, National Institute of Public Health** (NORAD, the tourist industry and others)

Increase awareness among young women of the risks of HIV and sexually transmitted diseases, for example in connection with the prevention of unwanted pregnancy.

- **SHD, Norwegian Ministry of Children and Family Affairs (BFD)** (Helsetilsynet, Folkehelsa, Norwegian Ministry of Education, Research and Church Affairs (KUF), municipalities, school health services, health services for young people, doctors)

Strengthen measures aimed at men who pay for sex, especially abroad. (See also specific objective 1.9)

- **Norwegian Board of Health, National Institute of Public Health** (NORAD, Prostituertes interesseorganisasjon i Norge (PION) [Support group for prostitutes in Norway], Helseutvalget for homofile (HU) [Health Committee for Homosexuals], the tourist industry)

Ensure that people who sell sex have adequate understanding of how to protect themselves, their partners and their clients against infection.

- **Norwegian Board of Health** (municipalities, PION, HU etc.)

Ensure that non-native speakers in Norway have adequate information of how to protect themselves and others against HIV/AIDS. (See also specific objective 1.9)

- **SHD, Norwegian Board of Health** (Norwegian Ministry of Justice, Norwegian Ministry of Local Government and Labour, Directorate of Immigration (UDI), Contact Committee for Immigrants and the Norwegian Authorities (KIM), municipalities, the Olafia Clinic in Oslo, immigrant organisations etc.)

### Specific objective 1.4

There should be no case of HIV infection resulting from medical use of human material.

#### Intended result:

Human products which are used in medical applications must continue to be clear of HIV.

#### Action:

Ensure that Norway continues to be self-sufficient in blood and blood products which are used in medical applications.

- **Norwegian Board of Health, National Institute of Public Health** (Transfusjonsrådet [Blood Transfusion Council], blood banks, hospitals)

Continue to undertake virus inactivation of blood and blood products.

- **Norwegian Board of Health, National Institute of Public Health** (Transfusjonsrådet, blood banks, hospitals)

Ensure that there is minimal risk of HIV infection among donors of blood and human materials.

- **Norwegian Board of Health, National Institute of Public Health** (Transfusjonsrådet, blood banks)

Perform HIV testing of donors of blood and human material, using procedures that are always in accordance with the best international guidelines.

- **Norwegian Board of Health, National Institute of Public Health** (bloodbanks, microbiology laboratories)
- Ensure that the use of blood, blood products and human material is for recognised medical indications.
- **Norwegian Board of Health** (hospitals)

### Specific objective 1.5

Monitoring the HIV/AIDS epidemic is to be continued.

#### Intended result:

The systems for mapping HIV/AIDS should provide at least as good an overview of HIV prevalence and incidence of new infection, together with the number of diagnosed AIDS cases, as they did during the period 1990-95.

#### Action:

Continue to monitor HIV/AIDS using the Meldings-system for smittsomme sykdommer (MSIS) [System for reporting notifiable diseases].

- **National Institute of Public Health** (doctors, microbiology laboratories)

Carry out inspections of HIV testing activities.

- **Norwegian Board of Health** (HU, the Olafia Clinic, Statens institutt for alkohol- og narkotikaforskning [National Institute for Alcohol and Drug Research])

Gain more insight into the spread of the epidemic by making better use of available data.

- **SHD, National Institute of Public Health, Norwegian Board of Health**, (research establishments)

### Specific objective 1.6

The number of HIV tests carried out on people from vulnerable groups must be higher than during the period 1990-95.

#### Intended result:

There should be a 25 per cent increase in HIV testing among vulnerable groups as compared with the period 1990-95.

#### Action:

Get the message through to those people who may be exposed to HIV about the importance of agreeing to have an HIV test.

- **Norwegian Board of Health** (all health-care workers, the Olafia Clinic, NGOs etc.)

Provide better advice on safer sex in conjunction with HIV testing.

- **Norwegian Board of Health** (all health-care workers, clinics for sexual health / prevention of sexually transmitted disease (STDs), NGOs)

Make HIV testing easily available.

- **Norwegian Board of Health** (municipalities, all health-care workers, polyclinics etc.)

Ensure that the HIV test is offered as a matter of routine to people seeking diagnosis and treatment of sexually transmitted diseases (STDs).

- **Norwegian Board of Health** (doctors, polyclinics etc.)

Assess (on a continuous basis) whether there is a need to offer the test to pregnant women as a matter of routine.

- **SHD, Norwegian Board of Health, National Institute of Public Health** (doctors)

Ensure that doctors are given better training in the recognition of symptoms and signs of acute and chronic HIV infection.

- **Norwegian Board of Health, National Institute of Public Health** (doctors)

Offer the HIV test to all asylum seekers and refugees when they arrive in Norway and ensure the quality of this service.

- **SHD, Norwegian Board of Health** (municipalities, reception centres for asylum seekers and refugees)

### Specific objective 1.7

Use of condoms must increase as compared with the period 1990-95.

#### Intended result:

Increased use of condoms among people in groups that are more vulnerable to the risk of HIV and sexually transmitted diseases.

#### Action:

Consider how the availability of condoms (both freely distributed and for sale) can be improved.

- **Norwegian Board of Health, National Institute of Public Health** (municipalities, points of sale)

Ensure that condoms are more easily available at «meeting places» for both homosexuals and heterosexuals.

- **Norwegian Board of Health, National Institute of Public Health** (municipalities, NGOs)

Improved availability of condoms in prisons.

- **Norwegian Board of Health** (Ministry of Justice (JD), prison health services)

Improved availability of condoms in drug rehabilitation centres.

- **SHD, Norwegian Board of Health** (county municipalities and municipalities)

Improved availability of condoms at reception centres for asylum seekers and refugees.

- **Norwegian Board of Health** (municipalities, reception centres for asylum seekers and refugees)

Improved availability of condoms for people with HIV.

- **Norwegian Board of Health, National Institute of Public Health** (health-care workers, Pluss [the support group for people with HIV])

### Specific objective 1.8

The prevalence of sexually transmitted diseases must be reduced.

#### Intended result:

Reduce the number of new cases of genital chlamydia infection during the period 1996-2000 to 70 per cent of the number of cases for the period 1990-95.

#### Action:

Ensure that the diagnosis and treatment of sexually transmitted diseases (genital chlamydia, gonorrhoea, syphilis) is free of charge (see Communicable Diseases Control Act (Smittevernloven) § 6.2 and circular I-18/96 (SHD))

- **SHD**, (National Insurance Administration (RTV), all health-care workers)

Make the diagnosis and treatment of sexually transmitted diseases more easily available for people generally and for injecting drug users.

- **Norwegian Board of Health, National Institute of Public Health** (clinics for sexual health/prevention of STD etc.)

Improved contact tracing after STD diagnosis.

- **Norwegian Board of Health, National Institute of Public Health** (doctors, clinics etc.)

### Specific objective 1.9

The general population's understanding of HIV/AIDS must be maintained.

#### Intended result:

No person associated with one of the target groups for the HIV preventive programme should become infected as the result of a fundamental lack of understanding of the ways in which HIV is transmitted, and of the ways in which individual people can protect themselves against infection.

#### Action:

Ensure that the health authorities make an effort to spread information about HIV/AIDS preventive measures, and also that they use the media to encourage non-discriminatory attitudes.

- **SHD, Norwegian Board of Health, National Institute of Public Health** (the media, schools, educational institutions)

Establish a scheme in which the central administration cooperates with the school authorities to develop an action plan for integrated sex education in schools.

- **SHD** (KUF, teacher training institutions, teachers' associations)

Provide systematised instruction about HIV/AIDS and sexual behaviour in primary and lower secondary schools as well as in upper secondary schools. The school health services could be an important resource both for pupils and as a source of information for teachers.

- **SHD** (KUF, schools)

Spread the message about HIV/AIDS and STD to young people in cooperation with the young people themselves.

- **Norwegian Board of Health** (NGOs, student organisations, municipalities, sexual health clinics etc.)

Implement special information schemes aimed at non-native speakers in Norway so as to ensure that these groups have the same level of information as the rest of the population.

- **SHD, Norwegian Board of Health** (JD, KAD/UDI, KUF, KIM, municipalities, the Olafia Clinic, and immigrant organisations)

Provide more information and implement more measures aimed at people who travel to areas of the world with high HIV prevalence. Check the effectiveness of these actions so that they can be improved if necessary.

- **Norwegian Board of Health, National Institute of Public Health** (Norwegian Ministry of Foreign Affairs (UD), the defence authorities, NORAD, the tourist industry, organisations/companies with foreign operations, immigrant organisations etc.)

Provide further instruction for professional groups that come into contact with the HIV/AIDS issue, focusing especially on questions of ethics and attitude.

- **SHD, Norwegian Board of Health, National Institute of Public Health** (health and social services personnel, workers at reception centres for asylum seekers and refugees, immigration authorities, prison officers, police etc.)

### Specific objective 1.10

Provide better information about which HIV and AIDS preventive measures are most effective.

#### **Intended result:**

An increased level of activity in the fields of research and assessment.

#### **Action:**

Increase and maintain skills in various professional fields in Norway.

- **SHD, Norwegian Board of Health, National Institute of Public Health**

Assess the measures which have been implemented as the result of grants for HIV/AIDS work from the Storting [Norwegian Parliament]. This will form part of the State's grant management.

- **SHD, Norwegian Board of Health, National Institute of Public Health**

Establish a separate research programme under the aegis of the Norges forskningsråd (NFR) [Norwegian Research Council].

- **SHD, NFR**

### Specific objective 2.1

During the course of this period there must be an improvement in the financial and social circumstances of people with HIV and AIDS.

#### **Intended result:**

Ensure that all people with HIV and AIDS have access to the social security benefits to which they are entitled. People with HIV and AIDS must not encounter discriminatory attitudes.

#### **Action:**

Ensure that more information about their entitlements and rights is given to people with HIV and AIDS.

- **Norwegian Board of Health** (Pluss, Aksept [The contact centre for people with HIV and AIDS run by the Church City Mission], health-care workers)

Ensure that personnel in the health, social and social security services are provided with better information about the rights of people with HIV and AIDS.

- **SHD, Norwegian Board of Health, National Institute of Public Health** (national and municipal authorities, educational institutions)

Implement initiatives that will influence the attitudes of personnel in the health, social and social security services who come into contact with people with HIV and AIDS.

- **SHD, Norwegian Board of Health, National Institute of Public Health** (national and municipal authorities, educational institutions, professional bodies)

Strengthen the social network of people with HIV and AIDS. One way of achieving this is to provide financial support to organisations for people who are HIV positive.

- **Norwegian Board of Health** (Pluss and other organisations currently working in this area)

### Specific objective 2.2

The medical treatment of people with HIV and AIDS must be improved.

#### **Intended result:**

Reduce the complications and increase the life expectancy of people with HIV in relation to the period 1990-95.

#### **Action:**

Develop better treatment procedures for immunodeficient patients.

- **SHD, Norwegian Board of Health** (clinics, health institutions and research establishments)

Use new methods of treatment which have a documented effectiveness.

- **SHD, Norwegian Board of Health** (county municipalities, municipalities, health institutions)

Encourage research which could increase our understanding of the factors which influence the course of HIV infection.

- **SHD, Norwegian Board of Health, National Institute of Public Health** (research establishments)

Ensure that the special health and living issues that concern women with HIV and AIDS form an important part of research into women's health.

- **SHD, Norwegian Board of Health, National Institute of Public Health** (Pluss, research and treatment centres and other groups that are cooperating in this work)

Maintain and develop skills among those who treat and look after people with HIV and AIDS.

- **SHD, Norwegian Board of Health, National Institute of Public Health** (municipalities, county municipalities, health institutions)

Combat discriminating and ostracising attitudes towards people with HIV and AIDS among personnel who treat and look after those with HIV and AIDS.

- **SHD, Norwegian Board of Health, National Institute of Public Health** (municipalities, county municipalities, educational institutions, professional bodies)





## Chapter 2

### *What is known about the HIV epidemic today*

#### 2.1 Our understanding of the HIV transmission pattern

The disease known as AIDS (Acquired Immune Deficiency Syndrome) is caused by the Human Immunodeficiency Virus (HIV). AIDS is just the last stage in the protracted weakening of the immune system caused by HIV.

It can be said that HIV only affects humans and it may be present in blood, semen, vaginal fluid and breast milk. The virus can also be present in other body fluids like sweat, saliva and tears, but these have no practical significance as far as transmission of infection is concerned.

HIV can be passed on to people by:

- sexual contact
- sharing syringes and needles contaminated with blood
- transfusing infected blood and using infected human material
- pregnancy, birth and breastfeeding (mother to baby infection)
- direct contact between infected blood or body fluids and sores or mucous membrane

Absolutely anyone can be infected by HIV. Usually, antibodies against HIV appear in the course of three to five weeks after infection, but it can take longer. Diagnosing HIV infection is usually done by finding HIV antibodies in the blood (HIV testing).

#### 2.2 Factors which affect the spread of HIV

For so long as there is no effective vaccine and treatment, the spread of infection will depend on the presence of the virus combined with biological conditions and behaviour that encourages transmission

(both sexual behaviour and behaviour relating to the sharing of needles).

##### *Biological conditions*

**The risk of infection varies a great deal** and in many respects we do not understand the reasons for this. The risk of infection is increased if one of the partners has a sexually transmitted disease (STD). This applies particularly to STDs that produce sores on the sexual organs. Women appear to be more susceptible than men to infection transmitted by sexual contact.

**The length of the infectious period** has a bearing on the spread of HIV. The average life expectancy of homosexual men after HIV infection is considered to be 11 - 13 years. It is probable that a person with HIV is infectious during the whole of this period. Infectiousness is usually at its highest during the first months after the transmission of infection and after the development of serious immunodeficiency.

##### *Sexual behaviour*

The transmission of HIV through sexual contacts depends on the rate at which partners are changed, the frequency of sex, sexual practice and use of condoms in the population. For HIV to spread, there must be a sufficient number of people who have on average two partners, one to be infected by and one to pass the infection on to. An estimate based on studies of sexual habits in 1987 and 1992 shows that only 0.4 per cent

of the population **change their partners frequently enough** to sustain an epidemic. It is likely that frequent changing of partners among groups of homosexual men has been an important factor in the start and continuation of the epidemic in this part of the population. **Frequency of sex** also has an effect on the spread of infection.

**Sexual practice** has an effect on the risk of infection. There is, for example, thought to be a greater risk of HIV transmission with anal sex than with vaginal sex, while oral sex is thought probably to involve little risk of transmission. **Use of condoms** prevents transmission of HIV. **Because the use of condoms is one of the most important measures for reducing the spread of HIV, the Plan of Action places considerable emphasis on making condoms easily available.**

#### *Sharing syringes and needles*

The extent of an HIV epidemic among drug users is dependent on how many inject their drugs and on how many of these people share dirty (used) syringes and needles. An increase in the number of injecting drug users or a reduced availability of clean (unused) syringes and needles can increase the spread of HIV. **Satisfactory availability of clean syringes and needles is therefore an important measure.**

#### *High risk sexual contact, syringe and needle sharing with groups with a high HIV prevalence*

For people in vulnerable groups, the risk of infection is affected by the prevalence of HIV in the sector of the population from which a sexual partner is chosen, or the sector of the population to which other drug users belong with whom needles are shared. The prevalence of HIV is higher and its spread is faster in most other countries of the world than in Norway.

#### *Which factors can one have an influence on?*

The most important measure taken by the health authorities in HIV preventive work is to influence people's behaviour so as to reduce the number of infectious incidents. **This applies primarily to sexual behaviour and to syringe and needle sharing.**

## 2.3 The international epidemiological situation

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### *Global prevalence of HIV and AIDS*

There are few countries that can state with any certainty what proportion of the population has **HIV**. The World Health Organisation (WHO) assumed that approximately 22.6 million people were infected at the beginning of 1997 (see figure 1 below). A large proportion of these, around 14 million, live in sub-Saharan Africa. There is however considerable variation in

HIV prevalence among different African countries. It is thought that around 510,000 people are infected in Western Europe, 2.3 million on the American continent (750,000 in North America and 1.3 million in Latin America) and 270,000 in the Caribbean. At least 5.2 million are infected with HIV in South and South-East Asia. 90 per cent of all people with HIV have been infected by heterosexual contact. In the world as a whole there are just as many women as men with HIV. It has been calculated that by the year 2000, 43 per cent of the world's HIV cases will be in Asia and around 35 per cent in Africa. All in all, it is thought that there will be getting on for 40 million people in the world with HIV in 5-6 years' time.

Between 1981-1982 and the end of 1996 there were just over 1.5 million **AIDS** cases notified to WHO. USA alone has notified 565,000 cases. 27 per cent (553,000) of all notified cases were from Africa, chiefly sub-Saharan Africa. 3.5 per cent of all the notified cases (53,000 people) were from Asia. Of these, 44,500 were from Thailand and 3,000 from India. It is thought that there are very many more cases of AIDS than are actually notified. 180,000 cases in Europe were notified, 120,000 of these in Italy, France and Spain. WHO calculates that there must have been around 8.4 million cases of AIDS in total, 75 per cent in Africa and 4 per cent in Europe.

The AIDS epidemic has the effect of increasing sickness and fatality from other infections, and this also applies to people who are not HIV positive. The greatest impact of this is on poor countries and poor people in rich countries.

When presenting these figures and estimates it is important to bear in mind that the facilities for testing, diagnosing, notifying and producing statistics regarding HIV and AIDS differ considerably in different countries and in different parts of the world.

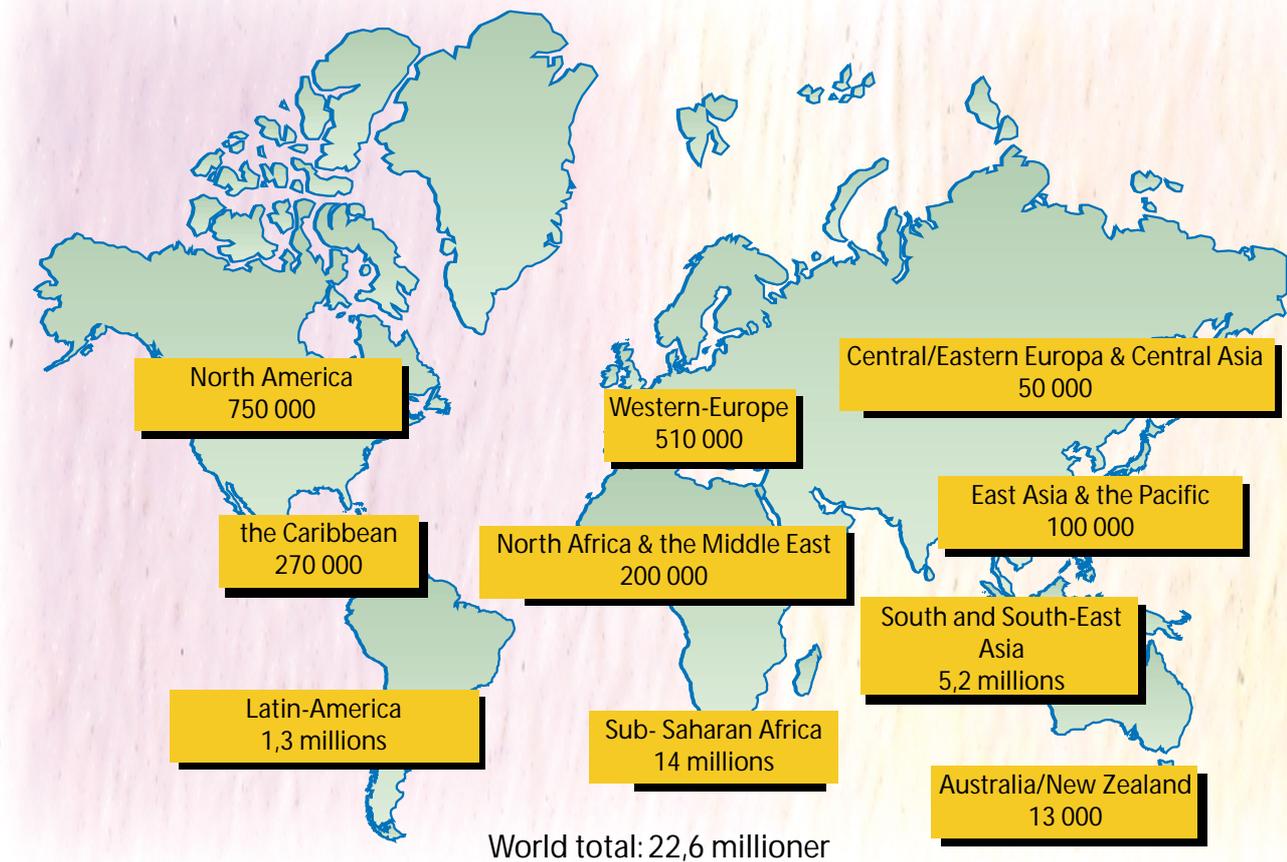
## 2.4 The epidemiological situation in Norway

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### *Introduction*

Even though a few individual cases of HIV infection were reported in Norway before 1980, the epidemic first became evident among **homosexual men** in the beginning of the 1980s and among **injecting drug users** in the middle of the 1980s. **Heterosexual** transmission of HIV started later and chiefly took the form of secondary infection associated with people using drugs.

By 31.12.96 561 **AIDS** cases had been notified, 477 men and 84 women. 453 of these have died. 55 per cent of the cases have been notified from Oslo. The incidence of AIDS has been stable in the last five years, with an average of 63 cases per year, while the

*The Global Epidemic 1996/97 (UNAIDS)*

average number of deaths has been 55 per year. (See table 1 below.) It is thought that several factors will affect the incidence of AIDS and the mortality rate in the future. The fall in HIV incidence in the mid 1980s must be expected to cause a fall in the incidence of AIDS now, in the mid 1990s. New medicines for treat-

ing HIV are having an impact on AIDS diagnosis. There is considerable optimism about the new combination therapy which was introduced in 1996. If these expectations are fulfilled, AIDS incidence and the AIDS mortality rate will be reduced, especially in the next two years.

**Table 1**  
AIDS in Norway by risk factor and year of diagnosis - reported as of 31.12.96 (MSIS, Folkehelsa)

Risikofaktor	Antall tilfeller diagnostisert														Tot.	%
	83	84	85	86	87	88	89	90	91	92	93	94	95			
Homo-/biseksuell	2	4	9	13	27	19	32	25	36	23	37	34	34	295	57,7	
Sprøytemisbruk			1		2	1	3	10	15	6	12	16	6	72	14,1	
Kombinasjon 1 + 2							1	2		2	1	2	1	9	1,8	
Hemofili/koagul. feil			1	2		1	1	2				2		9	1,8	
Fått blod/-blodprodukt				1	2	5	3		3	2	2		1	19	3,7	
Heteroseksuell praksis				1	3	3	2	11	5	11	8	9	17	70	13,7	
Høyendemisk fødeland					1		1	1	2	4	2	6	5	22	4,3	
Barn av HIV-positiv mor							1			1		1		3	0,6	
Annet/ukjent						1	1	2	1	3		3	1	12	2,3	
<b>Total</b>	<b>2</b>	<b>4</b>	<b>11</b>	<b>17</b>	<b>35</b>	<b>30</b>	<b>45</b>	<b>53</b>	<b>62</b>	<b>52</b>	<b>62</b>	<b>73</b>	<b>65</b>	<b>511</b>	<b>100</b>	

By 31.12.96 a total of 1,656 people had been diagnosed as **HIV positive** in Norway, 1,246 men and 410 women. The number of people with HIV who are living in Norway today can be calculated from the number of deaths (from AIDS and other causes), the number of people with HIV who have left Norway and the estimated number of people with HIV who have not been diagnosed. The health authorities estimate the figure to be around 1,200. In 1996 more people were diagnosed as HIV positive resulting from heterose-

xual transmission than has been the average for the last five years. The HIV epidemic in Norway is affected to a considerable degree by the international situation. See table 2 below, which shows HIV cases classified according to risk factor and year of diagnosis. The term «high prevalence native country» is still used for sub-Saharan Africa and Haiti. Where it is probable that people from high prevalence native countries have been infected after coming to Norway, they are classified under the appropriate risk factor.

**Table 2** HIV infections in Norway by risk factor and year of diagnosis - diagnosed as of 31.12.96 (MSIS, Folkehelsa).

Risikofaktor	Antall tilfeller diagnostisert												Tot.	%
	84	85	86	87	88	89	90	91	92	93	94	95		
Homo-/biseksuell	9	104	68	70	47	48	36	59	27	43	36	45	592	38,5
Sprøytemisbruk	1	71	99	68	32	23	18	13	12	11	10	9	367	23,9
Kombinasjon 1 + 2		5	8	2	2	5	3	2		1		2	30	2,0
Hemofili/koagul. feil		20	1										21	1,4
Fått blod/-blodprodukt		3		6	10	1		1	2	1	17		24	1,6
Heteroseksuell praksis		5	11	29	32	23	17	18	28	23	18	20	223	14,5
Høyendemisk fødeland		1	6	18	20	29	11	39	31	32		27	232	15,1
Barn av HIV-positiv mor			1		3	2	3						9	0,6
Annet/ukjent		1	1		5	2	3	5	6	2	12	2	39	2,5
<b>Total</b>	<b>10</b>	<b>10</b>	<b>195</b>	<b>193</b>	<b>148</b>	<b>134</b>	<b>90</b>	<b>140</b>	<b>106</b>	<b>113</b>	<b>93</b>	<b>105</b>	<b>1537</b>	<b>100</b>

The HIV/AIDS statistics are presented in «Meldingssystem for smittsomme sykdommer» (MSIS) issued by Folkehelsa.

#### *Men who have sex with men*

By 31.12.96, 629 cases were notified of HIV infection among men who have sex with men. Men who have sex with men represents the largest group of people with HIV in Norway, both in terms of the total incidence and the number of newly diagnosed cases. The proportion of young people among new notifications has not increased.

HIV testing has been carried out for 11 years. In this connection it has been important to chart the time of transmission. By knowing both the time of transmission for those who have been diagnosed as HIV positive and how widely HIV testing is being used, diagrams can be prepared which indicate the number of new infections for each year. Information about how much any particular group is using the HIV test also helps in estimating the number of undiagnosed cases. Investigations show that 50-80 per cent of men with homosexual behaviour have asked to be tested one or more times, and that tests are more in demand as the risk level increases. The results indicate that testing has decreased somewhat in recent times.

It seems that a significant change in behaviour occurred in the group 'men who have sex with men' as soon as the threat of HIV became apparent to the group and preventive measures started to be used. But there has been no reduction in incidence in this group since 1986. Men who have sex with men are still a vulnerable group with a relatively high HIV incidence.

#### *Injecting drug users*

By 31.12.96, 374 drug users were notified as HIV positive, 222 men and 152 women. The AIDS epidemic started later among drug users than among men who have sex with men. There was no positive identification before 1983 and the epidemic began in 1983-84. This epidemic did however reach its peak very quickly once knowledge of its existence spread through the drug culture, and preventive measures were initiated after 1985-86. The number of diagnosed drug users has remained around 10 cases per year during recent years. Investigations show that since 1985 there has been a high rate of HIV testing among drug users. It is likely that the HIV incidence among injecting drug users will for the time being stabilise at 10-15 transmissions per year. The total number of drug users with HIV who have not been notified is probably small. Heterosexual transmission is probably as common a transmission route as the sharing of needles.

Nevertheless the conditions within the group should be regarded as unstable and they may be affected by many different factors. The health authorities

have found that the fastest potential transmission routes are among injecting drug users.

#### *Heterosexual infection*

By 31.12.96, 258 cases of people probably infected by heterosexual contact had been notified, 143 men and 115 women. (People who were born and infected in high prevalence areas are classified as a separate group in the statistics and are considered in the section below.) The total number of diagnosed cases of heterosexual transmission has been stable since 1987 with an average of 23 cases per year up until 1996. The number of diagnosed cases of heterosexual transmission in 1996 was higher than the average for the previous five years.

There is an increasing proportion of people born abroad among those who have been infected by heterosexual contact, especially people from Asia but also people from Europe and South-America.

Epidemiological data indicate that the epidemic has developed slowly among heterosexuals at a relatively constant rate which is low or only slightly increasing.

#### *HIV prevalence among different heterosexual groups*

All pregnant women have been offered an HIV test since September 1987. By the end of 1996, a total of 719,200 HIV tests were carried out on pregnant women and 32 new cases of HIV infection were discovered. 96 per cent agreed to the test. National service recruits are also offered an HIV test. Around 25,000 are tested each year. Three people have been diagnosed as HIV positive since the time the tests were first offered. 100,000 blood donors have been tested each year since 1985, and six people have been found to be HIV positive.

There is less monitoring of the epidemic among heterosexual men than among women. Information from clinical establishments indicates that men are being tested on a considerable scale. Many men are offered an HIV test when having medical examinations, travelling abroad, being admitted to hospital or when there is the possibility of a sexually transmitted disease. In Oslo alone several hundred clients of prostitutes request a test each year. It is thought that any change in the HIV incidence among heterosexual men will be detected by the widespread HIV testing, but it is in regard to this group that there is the greatest uncertainty about how the epidemic could develop.

The number of people per year estimated to be infected by a heterosexual transmission route is roughly 20 to 30. The total number of undiagnosed cases of infection is probably between 100 and 200. There is little to indicate a widespread heterosexual HIV epidemic in Norway.

### *People infected in high prevalence native countries*

By 31.12.96, 264 cases were notified of people being infected in their high prevalence native country, 143 men and 121 women. Most of these people are thought to have been infected by a heterosexual transmission route.

The term «high prevalence area» was internationally applied from early in the epidemic to indicate areas in the world where HIV infection was especially prevalent. The term is now used primarily for sub-Saharan Africa and Haiti.

The number of people coming to Norway from Africa became sizeable in the mid 1980s and reached a peak in 1988 with 1,400 arrivals. As early as 1986 this group was offered an HIV test in conjunction with the obligatory medical examination for asylum seekers and refugees. Nearly 100 per cent agreed to the test up until 1993 when the central health authorities decentralised HIV testing to secondary reception centres. This is likely to have reduced the number of people having the test in recent years.

A large proportion of people from high prevalence areas registered as having HIV are no longer living in Norway. The number of estimated and undiagnosed people in this group is small, hardly more than 50. This unknown quantity will however be dependent on how much HIV testing is offered and on how closely people from high prevalence countries are monitored.

### *Infection from blood transfusion*

The first known case in Norway of infection via a blood transfusion was in 1980 and the last was in December 1985. HIV testing of blood and other human donor material was introduced in the autumn of 1985 and was implemented throughout the country in 1986.

It is known that 10 donors who are HIV positive and who have given blood in Norway were definitely or probably infectious before the testing of blood donors was introduced. In all, it is thought that 60 infected batches of blood resulted from this. At that time most blood banks did not have the facilities for tracing all the affected recipients of blood. There have also been several cases of infection which have not been diagnosed. Most transfusions are given to older patients, or to people who are seriously injured or suffering from an illness with a high mortality rate. Most of those who were infected are likely to have died with their HIV infection but not because of it. Now, ten years after this transmission route was effectively eliminated, it must be presumed that there are very few, if any, undiagnosed people in this group who are still alive. Given the current preventive measures there are thought to be no new incidents of infection from blood transfusion, or extremely few.

### *Children infected by mothers with HIV*

By 31.12.96, 12 children were notified as being HIV positive with HIV positive mothers. Nine of these children were born in Norway. After the offer of an HIV test to all pregnant women was introduced in 1987, it is reasonable to suppose that most parturient women are aware of their HIV status. Most mothers with HIV have been infected as the result of injecting drugs.

In Africa and among minority groups in the USA the risk of infection from mother to baby is towards 50 per cent while research shows it is down towards 8 per cent in Europe. In Norway 47 children with HIV positive mothers were monitored for more than one year after birth and 6 children have been found to be infected. This low rate of infection in Norway may be due to awareness of the pregnant women's HIV status, giving the opportunity for treatment with antiretroviral drugs (AZT) in sufficient time before the birth, and for precautionary measures against infection during birth and the period after birth (for example, no breastfeeding).

Children with HIV usually develop symptoms of illness very soon, so the number of unknown children in this group is likely to be none. It is likely that mother-to-baby HIV transmission will be responsible for only a small increase in the number of people with HIV in the years to come.

### *Other or unknown transmission routes*

It has not been possible to identify the transmission route for 42 out of the 1,656 people notified as being HIV positive. A few people have died in the acute stage before the exposure to risk was traced. In most cases the doctors have had a clear suspicion that one of the common transmission routes was responsible without the person concerned being willing to admit to his or her behaviour which has incurred the risk. Experienced «HIV doctors» have been unable to discover a probable transmission route in only a couple of cases. There are no documented cases in Norway of work-related HIV infection.

### *Monitoring general HIV testing*

The widespread activities relating to general clinical HIV testing form a part of the epidemiological jigsaw puzzle. Every month the medical microbiology laboratories send in data about the number of clinical HIV tests that have been performed. A total of 997,500 tests were carried out between 1985 and 1996. The HIV testing of pregnant women, military recruits and blood donors is in addition to this figure. The number of new HIV positive cases per 1,000 tests has gone down from 10.8 in 1986 to 2.4 in 1987, and since then has stabilised at between 1.5 and 1.0. There are no data for the total number of people who are tested or about their degree of exposure to risk. Assuming that there is a high rate of testing among

those in vulnerable groups, the growth in the number of HIV positive tests will provide a rough indication of the spread of HIV.

#### *Conclusions and forecasts up to the year 2000*

The incidence of HIV in Norway has been stable since 1986 and is estimated at 80 to 100 cases per year. It is thought that the number of undiagnosed people lies between 250 and 500 and that this group consists almost entirely of men who have been infected as the result of homosexual or heterosexual contact. Unless there are changes in the factors that affect the spread of HIV, there will be no great changes in the HIV situation in Norway. Nevertheless there is good reason for monitoring the development of certain conditions with particular attention:

- It is likely that the epidemic would gather momentum if it was less closely monitored. This particularly applies to the homosexual men group. The USA is witnessing now in the 1990s a wave of newly infected younger homosexual men. This group needs to be watched with extra attentiveness in the future in Norway as well.
- HIV prevalence is increasing in many parts of the world. Norwegians who have had sexual contact with people from high HIV prevalence countries will, to an increasing degree, be exposed to infecti-

on and become potential further transmitters of infection if they do not protect themselves.

## 2.5 The course of HIV infection

Most people infected with HIV experience a gradual weakening of the immune system. The degree of immune deficiency can be determined by means of sickness indicators and/or defined symptoms or illnesses. Different parts of the world have different systems for classifying the course of HIV infection. Norway uses a European modification of the American system from Centers for Disease Controls. The diagnosis of AIDS involves the presence of one or more specific infections, certain forms of cancer, dementia or emaciation. The average time for progression from HIV infection to AIDS among homosexual men in the USA is estimated to be 10 - 12 years, but this can vary a great deal. Some people develop AIDS 1-3 years after being infected while some others first develop AIDS after 15 - 20 years or more. The proportion of people with HIV who develop AIDS is not known. Some people with HIV die from other causes before they develop immune deficiency. Overdosing has been a more common cause of death among injecting drug users in Norway than AIDS.



## Chapter 3

### *Prioritised areas*

#### 3.1 Introduction - general measures

Chapter 3 first of all discusses the general preconditions and measures in the HIV/AIDS preventive programme. Then it considers especially prioritised issues both in the population generally and with regard to highly vulnerable groups and problem areas.

*Monitoring and plotting the HIV/AIDS epidemic so as to establish the priority areas for preventive measures*  
Monitoring and plotting contribute significantly to the understanding of the epidemic required for choosing effective preventive measures. Monitoring the epidemic is therefore a necessary precondition for assessing preventive measures and the best use of preventive and therapeutic resources. Wherever further analysis of routinely assembled data together with other data can improve our understanding of the epidemic, such analysis should be undertaken.

The HIV epidemic can be efficiently monitored by using information that is contained in the HIV/AIDS notification system and information about HIV testing in the population as a whole. In order to assess how thoroughly the HIV notification system records all those who have become infected, it is necessary to carry out repeated studies of HIV testing among vulnerable groups such as homosexual men and injecting drug users. This also applies to other groups who may be at risk such as foreign aid workers and people from countries with a higher HIV prevalence than Norway. In this respect the National Institute of Public Health has a particular responsibility for ensuring the quality of its data. Monitoring and plotting STDs can provide an understanding of behaviour that carries a high risk and should therefore be continued.

#### *HIV testing in the preventive programme*

There are three aspects in particular that distinguish the tests for HIV antibodies from other diagnostic investigations:

- There is at present no cure for people with HIV.

- HIV infection is unusual in that a large proportion of those who have been infected can live for many years «in physical and psychological health», which means that a test result showing the presence of HIV antibodies may in itself cause a poorer quality of life.
- Those with HIV are liable to be discriminated against. In certain vulnerable groups, particularly among men who have sex with men, there is a strong connection between being diagnosed as HIV antibody positive and being revealed as a homosexual.
- Last year new therapies were developed which inhibit the course of the disease among those who are HIV positive. This makes it vital to be aware of one's HIV status so that the right treatment can be started at the right time.

#### *Why test for HIV?*

HIV infection must first be diagnosed before medical follow-up and HIV treatment can be given. Prophylactic therapy for HIV-related diseases will only be given after HIV is confirmed. HIV status can also be an incitement to changing one's behaviour both among those with HIV and among those who are not infected. It is therefore important that health-care workers use this opportunity to provide information and personal counselling about protection from infection. This personal counselling should include an assessment of how much the person's behaviour is exposing him or her to risk of infection, and how protection for both the individual and others can be improved.

HIV testing is a precondition for epidemiological monitoring. HIV testing of blood and other human

material for medical use is an effective preventive measure.

#### *How should the HIV test be carried out?*

The result of an HIV test, especially if it is positive, is an extremely sensitive piece of information. Confidentiality must be observed, and information about HIV status must be kept in a secure manner. The patient must be allowed to take the HIV test anonymously. HIV testing of people with other cultural backgrounds and language difficulties can present particular difficulties. It may be difficult for the doctor to provide information in a language that the patient understands, and it will be difficult to maintain confidentiality if the patient needs an interpreter. Good communication models between patient and doctor must be developed so as to enable *informed consent, personal counselling about protection from infection and tracing the transmission route.*

#### **Informed consent**

A person should not feel obliged to take an HIV test if he or she does not wish to have one. The offer of a test, and information about it, should be communicated in a language and manner which ensure that the individual understands the consequences of a possible HIV positive result. The Communicable Diseases Control Act requires the doctor to provide information about the infection that the test might identify, and this should include details about the nature of the infection such as the way it is transmitted, degree of infectiousness, course of the disease, available treatment and prognosis.

#### **Counselling about protection from infection**

When testing for dangerous infectious diseases, the Communicable Diseases Control Act requires the doctor to provide personal counselling about protection from infection. This counselling must include an assessment of the probabilities of the patient having been infected by the disease. The doctor must discuss the issues, based on this assessment, and give advice to the patient on how he or she can avoid infection, or avoid passing it on to others.

#### **Tracing the transmission route**

When a person has been diagnosed as HIV positive, the doctor must trace the contacts in the transmission route. Informing other people with HIV, and people who have been exposed to risk of infection, about the way HIV is passed on and giving them counselling about safer sex is an important preventive measure.

#### **Who should be offered an HIV test on a routine basis?**

Since 1987, pregnant women have been routinely offered a voluntary HIV test. People who are diagnosed and treated for STDs, together with refugees and asylum seekers arriving in Norway, should also be offered a voluntary HIV test as a matter of routine. The offer of an HIV test should be a high priority for people who may have been exposed to HIV infection.

#### *Ensuring the safety of blood, blood products and other human material for medical use*

Protecting blood and blood products against HIV and other infections must depend on a high degree of national self-sufficiency together with four other factors:

1. *Careful selection of blood donors and donors of other human material.* A person may be infectious at an early stage of infection and still produce negative tests at the transfusion centre. It is therefore important to exclude all blood donors who may have risked exposure to any infective agent before they donate blood. The criteria for accepting a blood donor must be continuously revised in relation to epidemiological developments.
2. *Serological testing for HIV and any other infective agents each time blood is donated.* Current HIV testing indicates antibodies to the virus as early as 14 days after the time of infection. It is thought that most infected people will react positively to the test within three months of the time of infection. There is therefore still a certain risk that the tests will not identify a newly infected person. This risk is greatest in countries where the HIV epidemic is spreading quickly through the population. The probability of an infected donor not being detected at either level one or two is therefore minimal in Norway, where new infections are occurring in very limited numbers.
3. *Virus inactivation of plasma products.* Inactivation is achieved by chemical treatment or by heat treatment. These are considered to be safe methods for inactivating HIV. Whole blood cannot be inactivated so this must still be given untreated. The aim therefore is to avoid using whole blood.
4. *Strict indications for the use of blood and blood products.* Strict medical indications for the use of blood and blood products will continue to be an important element in protecting against infection.

#### *Ensuring the safety of blood, blood products and other human material:*

##### *conclusion*

The risk of HIV infection from the use of blood and blood products in Norway is now thought to be extremely small. It is important to maintain a high level of screening and protection against infection where blood and blood products are concerned, and this presupposes considerable skill among all health-care workers.

##### *Increasing the use of condoms*

The use of condoms has been shown to be an effective HIV preventive measure. Condom use will to a considerable degree be dependent on availability and the will to use them. Condoms should be available at many different locations and «meeting places» for heterosexuals and homosexuals, as well as in prisons,

treatment centres for drug users, STD clinics and reception centres for refugees and asylum seekers. Condoms should also be easily available for people with HIV through their support groups and their doctor if necessary. Now that there is more understanding of effective preventive measures, it is desirable to increase the use of condoms among the most vulnerable groups.

#### *Treatment of people with sexually transmitted diseases*

The presence of other STDs increases the risk of HIV transmission, especially with STDs that create sores on the sexual organs. People who are examined and treated for STDs should be offered an HIV test as a matter of routine.

### **3.2 Measures involving the whole population**

The key way of preventing the spread of HIV here in Norway is to influence people's behaviour so that they do not expose themselves or others to the risk of infection. If we are to achieve this, we must inform people of the different ways HIV is spread, although it is not certain that providing people with information will necessarily change their behaviour. If we are to develop effective ways of influencing people's behaviour, we must therefore systematically assess the success of national and international initiatives aimed at changing behaviour.

In this section, both the population as a whole and individual groups are examined. An introductory section will evaluate the risk of infection and related problems for each group, and further measures will identify the key priorities of the action plan for each group, covering the period 1996-2000. Measures for preventing HIV will be continuously assessed and developed.

#### *The general population*

On the whole, the risk of HIV infection is low in Norway and people are generally well informed of HIV and its transmission routes. However, in many parts of the world the number of HIV cases has increased significantly and this could pose a threat to Norwegians who travel quite extensively.

On a global scale, the number of infected women is on the increase. In sub-Saharan African countries, more women than men are infected. This is not the case in Norway even though one quarter of all those diagnosed as HIV positive are women. It is therefore important to highlight the fact that women are especially susceptible to infection and that there is a need for more awareness and information concerning this. The perspective of women in this issue is also important because of the many roles they have in society (such as mothers, spouses / partners / lovers, information workers, carers and health-care workers).

#### *Further measures*

Reduced coverage in the media may give an impression

that HIV/AIDS is no longer a threat to the average Norwegian. The Ministry will therefore invest in maintaining people's awareness and understanding of HIV/AIDS. The Ministry believes that this can be achieved by working together with the media to convey factual information. Additional effort must be given to directing specific information to the most important targets among the general population, including young people and people who travel abroad.

Further information campaigns dealing with sexuality, STDs and HIV/AIDS must also be focused on women (and young women in particular) to prevent infection, unwanted pregnancies and transmission of infection from mother to baby.

#### *Young people*

A key challenge lies in the estimated 50,000 young people who will have their first sexual experience during any given year. They need to be provided with information about the ways HIV is transmitted as part of their general education in sexual and relationship issues.

There is now sufficient knowledge to suggest that openness about sexuality in schools may delay the first sexual experience or increase the use of various forms of contraception. Research has been done into how sex education influences the attitudes and behaviour of young people. The results from such research and the evaluation of various teaching methods should therefore be correlated and assessed.

#### *Further measures*

Measures to prevent HIV among young people must therefore form part of an overall strategy, which must include input from those who influence young people's attitudes towards their bodies and identity. This strategy must be based on the philosophy that sexuality is a positive and healthy part of people's lives. There is a definite need to increase awareness of the differences in the roles and dominances within relationships which can, for example, have an affect on the use of condoms. The strategy must also highlight the fact that the need to be protected against HIV is not the only challenge young people face when they have their first sexual experience. Indeed, pregnancy and sexual identity are more important to most young people. HIV preventive work should therefore be linked to sex education as well as guidance about prevention, and be adapted to the lives of young people.

Being open about sexuality can help young people to feel more secure within themselves and provide them with a greater sense of responsibility with regard to sexual issues. This sexual openness would also include different forms of sexuality, ensuring that young people have the opportunity to develop both heterosexual and homosexual identities with equal confidence.

*Skoleverket (Forsøksrådet for skoleverket) [National Council for Innovation in Education]*

SHD will work together with the school authorities to coordinate sex education in schools. The measures which will be taken will be based on and run alongside what has been done and what is being done in schools to prevent unwanted pregnancies. Teachers should also receive further training in the communication of such knowledge. Schools play an important role in informing young people about homosexuality and influencing their attitudes on this issue. Schools will therefore aim to ensure that young people who are lesbian, homosexual and bisexual are met with understanding and acceptance within the school environment and that young people can identify positively with their growing awareness of sexual orientation.

An increase in injecting drug use could increase the spread of HIV. It is therefore important that drug abuse prevention measures in schools are continued.

*Other sectors*

Alongside cooperation with schools, the health authorities also intend to target other measures towards young people. The work of the Kommunehelsetjenesten [Primary Health Care Department] with guidance on prevention, diagnosis, treatment and tracing the transmission routes of other STDs should continue.

Media aimed specifically at young people contribute to moulding the sexuality of young people. Health authorities will continue to provide information to young people in the form of advertisements and will provide funds for the production of articles, films, etc., in cooperation with young people and the media in question. The high cost of such measures would mean that they would have to be linked to other campaigns aimed at young people, for example the work to prevent unwanted pregnancies.

*People who travel abroad*

Large areas of the world have a higher HIV prevalence than Norway (see Chapter 2). The increase in the rate of infection is also probably greater in most other areas. Norwegians travel more to other places in the world than they ever have before, both because of holidays or leisure activities and in connection with their work. Norwegians who work abroad are especially at risk through prostitution and other sexual contact. With an increase in HIV prevalence around the world, Norwegians will be more susceptible to infection if they expose themselves to the risk. Many non-native speaking people living in Norway also travel extensively and may expose themselves to these risks in the same way as Norwegians travelling abroad.

*Further measures*

People who travel abroad must remain an important target group for HIV preventive measures. With regard to spreading information about HIV and about

other measures which could prove to be effective, there must be better cooperation with the hotel and tourist industry, with NORAD, The Defence Authorities, companies and other organisations which have employees in parts of the world with high HIV prevalence. In this area, it will be important and appropriate to cooperate with organisations for immigrants and other bodies which have knowledge about specific countries and their culture.

### 3.3 Specific measures targeted at special groups and problem areas

*Men who have sex with men (homosexual and bisexual men)*

At an early stage in the epidemic, it became clear in Norway, as in other Western countries, that men who have sex with men were most at risk of being infected. There is much to indicate that this is still the case. At the beginning, little was known about how many men in Norway were practising homosexuals and could be at risk of infection. Nowadays, there is more information to hand.

Homosexual and bisexual men do not form a distinct group. The group ranges from men who are openly gay to men who usually have sex with women, but who, in the course of their lives, have sex with another man or men on one or several occasions. The group also includes men who always have unprotected sex in risky situations and people who never or seldom have sex at all.

*Non-native speaking males who are active homosexuals or bisexuals*

In many cultures there is little openness around homosexuality and bisexuality, and in many societies homosexuality is punishable. The concept of homosexuality may be absent from the language and the existence of the phenomenon denied. However, this does not mean that sex between people of the same sex does not occur among non-native speakers here in Norway as well.

*Non Governmental Organisations (NGO)*

*Helseutvalget for homofile*

Most of the HIV preventive work directed towards men who have sex with men has been carried out by voluntary organisations. The Helseutvalget for homofile (HU) is the most important of these. HU's activities are mainly state-financed. HU is connected to Landsforeningen for lesbisk og homofil frigjøring (LLH) [Norwegian Association for Gay Liberation] and has representatives throughout the country.

Different methods have been used in preventive work to reach the different groups of men who have sex with men. The 'Stopp AIDS' project in Oslo, carried out by HU in 1988-89, is an example of work to

strengthen man-to-man sharing of information among declared, closeted, organised and unorganised homosexual and bisexual men. These information campaigns continue now as a central part of HU's day-to-day work in many places in Norway.

A specific project for men from Spanish and Arabic-speaking cultures was carried out by HU in 1990-91. From 1992, preventive work among men from other cultures has been integrated into HU's normal activities.

#### *Homosexual organisations*

LLH with its established affiliated groups is a central organisation in the work to prevent HIV and in the work to create an identity. LLHs commitment should also have great potential in spreading information among young people, both within and outside the educational system. The monthly newspaper 'Blikk' and the magazine 'Løvetann' are important forums for information and discussion about HIV and AIDS issues.

#### *The use of condoms among homosexual men*

Using condoms reduces the risk of infection. In the studies into sexual habits, people are questioned about condom use in their most recent sexual encounter. In 1987, 9 per cent of homosexual men said that they had used a condom. In 1992, the figure was 27 per cent. Oslo HIV-kohortstudien [Study of HIV among special groups] is a follow-up study of HIV positive people, most of whom were diagnosed in 1985-87. In this study, 70 homosexual men were asked about their sexual habits before and after being diagnosed. 28 per cent replied that they had used a condom half or more of the times that they had had anal intercourse before they were diagnosed as being HIV positive. After they knew their HIV status, the figure rose to 72 per cent. There is not enough information about whether the change in behaviour at the end of the 1980s continues to apply today.

#### *Number of partners among homosexual men*

Having several sexual partners increases the risk of HIV infection if a person has unprotected sex. Practising homosexual men in the three years prior to the study of sexual habits in 1987 had on average 1.0 new partners each year. In 1992, the figure stood at 0.3. There is therefore a strong indication that there has been a considerable reduction in the number of partners among men who have sex with men. In Oslo HIV-kohortstudien, the average number of partners per year before HIV diagnosis was 4.3. After diagnosis, the figure stood at 1.6.

#### *Further measures*

The assessment report into the HIV/AIDS preventive programme work in Norway (1995) recommends that measures aimed at high-risk groups be consolidated. The Ministry believes that measures targeted at the group 'men who have sex with men' must be

strengthened in the coming years. This covers measures directed generally at men who have sex with men and to specific groups such as young men with a different cultural background, men who are closet homosexuals, and bisexuals.

#### *Who is most at risk?*

In the assessment report, it was noted that preventive work at places where homosexuals meet, such as saunas, should be given high priority. It was also noted that the 'coming out' phase for homosexual men is a vulnerable period also with respect to HIV infection and that preventive measures should be directed to reach young people.

Most of the information points towards the fact that safer sex is, as a rule, practised with a non-regular partner. With regular partners, however, many do not wish to use condoms. Being in a fixed homosexual relationship has therefore been highlighted as an important potential area for HIV infection both in Norway and in other countries.

#### *Treatment of sexually transmitted diseases*

Homosexual men traditionally have a higher occurrence of STDs than the population in general. As has been mentioned previously, the presence of STDs can increase the risk of HIV infection. It is therefore important that men who have sex with men have easy access to examination and treatment with regard to STDs.

#### *Information regarding HIV testing*

It is still important to provide the best conditions possible for a high level of testing among homosexual men. There is strong evidence to suggest that the HIV test can be an important way of changing behaviour and of ensuring good clinical follow-up for those who have been diagnosed as HIV positive. However, this requires that HIV positive people are not discriminated against either in their own environment or in society in general. Counselling about the HIV test is therefore of great importance. Clinics that perform HIV testing and provide counselling in connection with HIV/AIDS and other STDs must therefore continue this work in the years to come.

What is required is good information about sexuality in general and especially about homosexuality and bisexuality in order to be able to counsel men who have sex with men. Work must be continued to ensure that the health service can be in a better position to treat homosexuals in a professional and non-discriminatory way. It is still a central part of the preventive strategy to ensure the availability of condoms at sites both indoors and outdoors where homosexual and bisexual men meet.

Preventive work in the future must also be carried out as a cooperation between the health authorities,

Helseutvalget for homofile and support groups for lesbians, homosexual men and bisexuals.

#### *Injecting drug users*

An increase in the number of injecting drug users will increase the transmission potential of HIV. There are however no clear estimates of the size of the injecting drug user group, or of the number who share syringes and needles. Since the incidence of HIV is greater among injecting drug users than in the population generally, and since drug users often choose sexual partners who also take drugs, this group is exposed to an increased risk of sexual HIV transmission. HIV infection has spread more slowly among drug users than was expected at the beginning of the epidemic, but the situation could easily become unstable. In the coming years intensive and persistent efforts will still have to be made to prevent further spreading of the infection.

#### *Further measures*

It is not enough just to concentrate on prevention and treatment of drug abuse. It must be ensured that HIV preventive work is directly targeted at the group in addition to continuing with the general programme for limiting the abuse of drugs.

#### *Preventing and treating drug abuse*

SHD, in collaboration with the county municipalities, will continue to assess the need for any new initiatives. It is necessary to continue with HIV prevention as part of the day-to-day programme at drug rehabilitation centres, and it is also necessary that the need for any specific HIV preventive measures be assessed. Outreach activities make it easier to establish contact with drug users in their own environment.

#### *Living conditions and health*

The HIV epidemic remains a challenge for the health services when it comes to working with drug users and HIV/AIDS. As well as direct HIV preventive work, special attention must be given to the prevention of other STDs and hepatitis. Health service facilities aimed at improving the general health of drug users must be easily accessible in all localities. It should also be assessed whether the facilities for vaccinating drug users against hepatitis B could be improved on the local level. Drug users have been offered the HIV test and counselling on the AIDS information bus for several years. It is important that HIV testing continues to be easily available for drug users throughout the country.

#### *Availability of syringes and needles*

The central health authorities regard it as crucial to the way the epidemic develops that the availability of syringes and needles continues to be guaranteed, and that the measures relating to this are made as permanent as possible.

#### *Sexual transmission*

Many drug users have partners who do not take

drugs themselves. This applies for instance to youths and men who have young women as partners. Outreach workers and personnel at relevant institutions have tried various approaches to try to make these young women take responsibility for their own sexuality, set boundaries and demand condoms for intercourse. The programme to strengthen the cultural awareness of young women must be continued while at the same time increasing the measures aimed at male drug users with regard to taking responsibility for safer sex and use of condoms.

Where one partner is HIV positive and both partners are drug users, the problem is particularly difficult. Various rehabilitation centres have worked with this issue, and they must continue with it so that procedures and ways of approaching the issue can be developed. Condoms are not easily available in all rehabilitation centres. The central health authorities will take the initiative for further improving availability of condoms.

#### *Non-native speaking drug users*

Non-native speaking drug users have had little contact with the health and social services that are involved with drug use in Norway. It is important that the health authorities obtain an overview of the extent of drug use and at the same time initiate measures aimed at drug users from other cultures. The AIDS information bus in Oslo and outreach workers in various parts of the country will be able to collaborate in this initiative.

At present there are virtually no injecting drug users from other cultures to be found in the drug rehabilitation centres. The need for rehabilitation for non-native speakers would represent a new challenge to the rehabilitation system in Norway. It is necessary to develop good methods of communication, particularly when dealing with first generation immigrants. The best and most appropriate cooperative partners in this work would be societies and organisations devoted to foreign cultures and also individuals who are respected in their own particular cultural environment.

#### *Drug users in prison*

Prison sentences should be used to provide information and education to prisoners about HIV and AIDS, sexually transmitted diseases and sexuality. Measures involving prisoners should be encouraged. Despite security control, there is some use of syringes in the prisons, and there is not much access to clean needles in Norwegian prisons. The Prison Board (Fengselsstyret) directed the prison governors in November 1994 to make chlorine available to prisoners.

#### *Buying and selling sexual services*

The buying and selling of sexual services is a potential source of spreading HIV in Norway, but has so far not had much impact here. Paying for sex with

prostitutes abroad probably represents a greater risk of HIV infection than in this country.

#### *Paying for sexual services*

The 1992 study of sexual habits reported that 13 per cent of men have on one or more occasions paid for sex. An insignificant number of women were reported to have done the same. Around half of these Norwegian men paid for sex abroad, some in countries with high HIV prevalence. However, the study shows that Norwegian men are now paying for sex less frequently and that the use of condoms has increased since 1985.

#### *Further measures*

Measures to prevent HIV transmission through prostitution have two main objectives: to try to get men to stop paying for sex and to get men who do pay for sex to practise safer sex. It should also be assessed whether special attention should be paid to Norwegian military forces stationed abroad.

#### *Selling of sexual services*

In the 1992 study of sexual habits, it was reported that around 1 per cent of men and 1 per cent of women had sold sexual services at one time, but the figures are not conclusive. Both women and men reported to have sold sexual services on only one or two occasions. Both with respect to the sex workers themselves and to their customers, it is important that those who sell sex are protected against infection.

#### *Further measures*

Rehabilitation measures for prostitutes, such as the center for prostitutes (Pro-senteret) in Oslo, are important in HIV preventive work. The need for suitable facilities in other towns and cities in the country must be assessed. People who sell sex must, regardless of their mother tongue or knowledge of Norwegian, be ensured the necessary information about how they should protect themselves, their lovers and customers against HIV infection and other STDs.

It has been seen as an important task to ensure good health-care facilities for women and men who sell sex. In 1994, the municipality of Oslo introduced a collaborative scheme with the Olafia Clinic and the Pro-center to improve the health-care facilities for women and men who sell sex.

The extent of prostitution among boys and men must be analysed and HIV preventive measures must be assessed, since experience shows that HIV has a higher incidence in the group 'men who have sex with men'. The Pro-center will continue with this work.

Outreach workers, personnel in institutions for young people and others must be alert to men and women from other cultures who are selling sexual services. The intention will be to help them abandon prostitution, and at least give them instruction in safer sex.

#### *Non-native speakers*

Non-native speakers in Norway could be an important target group for HIV preventive work and they are discussed separately for the following reasons:

- information work can be difficult because of cultural and language differences
- non-native speakers often have a stronger contact with countries where HIV is more common than in Norway
- non-native speakers may have other diseases which increase susceptibility to HIV infection, and which can be treated
- non-native speakers may be particularly exposed to discrimination

There is little understanding of how increased is the risk of HIV infection for non-native speakers who are living in Norway. Neither is there sufficient understanding of whether people with a non-native speaking background represent a potential for the transmission of infection. There is a great deal of variation in the infection risk level and need for information among the different immigrant groups. This must be taken into account when preparing information strategies. It is taken for granted that information schemes and other measures are planned, developed and carried out together with the relevant cultural bodies, organisations or groups, and that the health authorities listen to and assess the advice they receive from these areas before the measures are implemented.

Equal access to health services and information, irrespective of ethnic origin, is an important principle. When applied to HIV/AIDS and other STDs this means that the section of the population that is unfamiliar with Norwegian language and culture has a right to information which can be understood and accepted by every individual.

The number of first and second generation immigrants in Norway on 1 January 1996 totalled just under 224,000. Just under half of these (46 per cent) come from the Nordic and other European countries. The remainder come from different parts of the world.

Non-native speakers in Norway are exposed to HIV infection in just the same way as the rest of the population, be it through heterosexual or homosexual behaviour, transmission from mothers during pregnancy or injecting drug use.

#### *Further measures*

More measures must be targeted at non-native speakers. It is central to the HIV preventive work among members of this group that information and initiatives are communicated and formulated in cooperation with the group itself.

Voluntary HIV tests must be offered to all refugees and asylum seekers as a matter of routine when they seek residence in Norway. Medical examinations should also be undertaken for hepatitis and STDs. Guidance about preventing the transmission of infection must be given to all those diagnosed as HIV positive in a way that is fully understood. People with HIV must be offered clinical follow-ups of their condition, and this must be irrespective of where they move to and reside in the country. If the changes introduced in 1993 to HIV testing procedures are shown not to be working in practice, the central health authorities will assess once again where the first offer of an HIV test should be given.

HIV and tuberculosis are becoming an increasing problem throughout the world. It can be quite common for the same people to be suffering from active tuberculosis and HIV. Treating tuberculosis in people with HIV at an early stage usually produces good results. It is therefore important to check for tuberculosis in people with HIV who come from parts of the world where tuberculosis is more common than in Norway. Similarly it is important to check those suffering from tuberculosis for possible HIV infection.

Many refugees and asylum seekers come from parts of the world with poorer public health care than Norway. This is one of the reasons for such a high HIV prevalence. Both those who are HIV positive and those who are HIV negative must be offered diagnosis and treatment for STDs. Many non-native speakers in Norway are vulnerable to HIV/AIDS-related discrimination. This is due in part to the fact that the media can be very blunt in their presentation of the HIV/AIDS situation in various parts of the world. A consequence of this is that an association is made between skin colour, nationality and HIV infection. It is important to be aware of this when planning information schemes and other measures for this target group.

It must be ensured that non-native speakers in Norway have an adequate knowledge and understanding of HIV/AIDS and other STDs. It will help to combine this instruction with the provision of information about, and treatment of, other infectious diseases together with HIV testing and checking for tuberculosis. But there must still be the possibility for introducing special measures to ensure that the facilities are equally comprehensive for each individual irrespective of background. Non-native speakers must be asked for their advice about the decision making processes which concern preventive programmes targeted at them. The health authorities must therefore actively involve members of the relevant culture in this work and increase the number of partners within and outside these cultures.

#### *The role of those who are HIV positive in the preventive programme*

People who are already infected by HIV present a particular challenge in the work to prevent infection. HIV prevention in Norway is based on the principle of mutual responsibility for stopping the transmission routes. This means that there is a fundamental assumption that no one actually wants to infect another person, and that both partners in a sexual relationship share the responsibility for protection. People with HIV represent a vital resource in HIV preventive work.

#### *Further measures*

Identifying those who are HIV positive is important for following up and treating the individuals concerned and also for the HIV preventive work overall. This presupposes a continued collaboration between the central health authorities and Pluss (the support group for people with HIV). Two years ago In-pluss was formed, a support group for non-native speaking people with HIV based on Pluss and Aksept (the contact centre for people with HIV and AIDS run by the Church City Mission). Africans with HIV belong to this group. It is important to ensure that people with HIV are involved in the decision making processes concerning HIV preventive work.

#### *Counselling in connection with HIV testing*

It is a preventive measure in itself to ensure that the greatest possible number of people who are HIV positive are aware of their HIV status. This prevents people exposing others to the risk of infection because of ignorance of their condition, and also ensures that those concerned will have good medical care. Counselling in connection with HIV testing is therefore important to ensure that the preventive potential is better utilised, be the test result negative or positive. Health-care workers are responsible for thorough medical and psycho-social follow-up and for providing information about the ways each individual can prevent the spread of infection after being diagnosed as HIV positive.

HIV testing of pregnant women can play an important part in preventing the transmission of infection to the foetus, as any pregnant woman who is found to be HIV positive will be helped to prevent this happening. Treatment with antiretroviral drugs has been shown to reduce mother-to-baby-transmission.

#### *Tracing the transmission route*

It is especially important to identify groups that are particularly vulnerable to HIV infection by tracing the transmission contacts. Those who have sexual contact with people who are HIV positive represent such a group.

### *The HIV negative partner of a person who is HIV positive*

It is not uncommon that a person who is HIV negative starts a relationship with someone who is openly HIV positive. Studies of such couples that have been made in other countries indicate that the correct use of condoms each time the couple have intercourse provides effective protection against HIV transmission. A number of courses have been given on safer sex for HIV-positive/HIV-negative couples, both heterosexual and homosexual. Since the practical results of these initiatives have been very encouraging, such initiatives should be reinforced and further developed in the coming years.

### *HIV positive non-native speakers*

The number of non-native speakers with HIV may possibly increase in the future. Some will already be infected when they arrive in Norway and others will become infected here. Non-native speakers are especially vulnerable to the discrimination and prejudice that is associated with HIV. In many cases it proves to be even harder for such people to «come forward» than it is for Norwegians. One consequence of this is that HIV/AIDS remains rather hidden in these social areas, which means that the potential for using people with HIV as an important element in the preventive programme cannot be realised. Also there are fewer opportunities for forming mutually supportive links with others in the same situation. Health-care workers have a particular responsibility for ensuring that people with HIV from other cultural backgrounds receive information about safer sex in a manner which they can understand and accept.

### *Personnel and public services*

Many professional groups, such as health-care and social services personnel, the police, prison officers and teachers come into contact with HIV/AIDS issues in the course of their work. These people must be taught how best to protect themselves from infection. Experience shows that even well-educated and trained personnel may be over-anxious about infection and take unnecessary steps to protect themselves when they meet someone with HIV, or someone they think has HIV, for the first time.

### *Further measures*

The task for the future is to ensure that training and information schemes concerning HIV/AIDS are continued with an increased focus on questions of attitude. This is especially important with regard to health-care and social service personnel, but also for other groups who supervise or look after other people, such as teachers, the police, prison personnel and others.

It is essential that all those who, in the course of their work, come into contact with people who may be especially exposed to the risk of infection have the necessary basic understanding about protection from infection, and develop the correct attitudes towards people with HIV and AIDS, not least towards those who have little understanding of Norwegian society and the health service. The authorities will give more priority to several areas such as training in schemes connected with protection from infection, attitude development, communication with people from different groups, cultures and countries etc.

## 3.4 Research and assessment

A sound strategy for dealing with the HIV epidemic must be based on an understanding of how the spread of HIV, and the development of disease among those who are infected, can be best prevented. Therefore there is a need for systematically collected data concerning the development of the epidemic and the factors which affect it, HIV and its effect on those are infected, the distribution of behaviour which affects the transmission pattern, and how behaviour can be influenced.

The measures which have been implemented have to be assessed to see if they have had the desired effect. Since the start of the epidemic a great deal of effort has been put into research in the field of HIV/AIDS throughout the world. Research establishments in Norway have contributed to this, and this should continue since Norway has an international obligation as a rich country, and also because international research findings cannot be simply transferred to the Norwegian context. In addition to this, the Norwegian authorities are dependent on the skills which are acquired by taking part in research.

Norway has an advantage over many other countries with regard to epidemiological and behavioural research. This country is small and easy to study, without large cultural or other differences (religious, for example) which make this kind of research and/or the interpretation of results more difficult.

The central health authorities will give more priority during the period of the Plan of Action to the assessment of current measures, and to ensuring that assessment is incorporated as an element in current projects. This will provide the basis for assessing which measures should be strengthened and which should be reduced or phased out.



## Chapter 4

### *HIV, attitudes, follow-up and treatment*

This chapter first considers problems and experiences concerning attitudes towards HIV/AIDS. There is then a section on medical follow-up and treatment of people with HIV and AIDS. Next there is a section about special groups of people with HIV and the challenges these represent. After a survey of the possibilities for medical treatment in the coming years, the chapter ends with a discussion of challenges and measures during the period of the Action Plan.

#### 4.1 HIV and attitudes

HIV infection is the first global epidemic disease in the media age. Speculation and announcements in the media created anxiety about the infection which contributed to the ostracisation, stigmatising and prejudice suffered by those who were infected. Despite the fact that there is now more understanding of HIV, and of how the infection is and is not transmitted, there is still a great deal of needless anxiety about infection felt by the general population.

HIV infection confronts us with two common taboo areas: death (often of young people) and sexuality. Many of those who are infected belong to groups that used to be marginalised, and the tendency to stigmatise and discriminate against people with HIV is strongest with regard to these groups. The attitude of the public towards cancer patients, for example, is much more equitable. Discrimination can be connected with the disease itself or with the social group to which most people with HIV belong (and belonged to before they became infected). There are clear indications that some people distinguish between the ways in which a person has become infected, and that some ways are considered «guilty» while others are «innocent».

In Norway, there are relatively few reports of stigmatising and discrimination against people with HIV, and by far the most of these refer to professional people and the health service. But there have also been reports about discriminatory treatment which has been ascribed to HIV status when people who are HIV positive have applied for accommodation or training, visited the Social Welfare or Social Security Offices [sosial- or trygdekontoret] or a department of the health service, or come into contact with the police or the prison service, etc. Despite the fact that the number of cases of evident discrimination has been limited in Norway, there are not many people with HIV who have decided to be entirely open about their HIV status. Studies in other countries show that fear of rejection is greatest in connection with family and friends. Experience in Norway, however, suggests that things have worked out very well for most people who have been completely open to those they are closest to. Many people with HIV are anxious about the way in which their employers or colleagues will react. This stems from their uncertainty about keeping their jobs, or about being given other duties etc.

#### *Further measures*

The central health authorities will continue their beneficial cooperation with Pluss and support further

measures which help this type of organisation to contact as many people with HIV as possible. People with HIV must be involved in all decision making processes concerning current and future HIV preventive measures.

It is a challenge for the central health authorities to create a climate in which it is easier for people who are HIV positive to declare their status openly, if they wish to. Indeed, one of the most important initiatives against discrimination and stigmatisation in Norway will be to encourage sympathy for HIV sufferers by humanising the whole issue.

The report which assesses the HIV/AIDS preventive programme in Norway points out that more attention should be given to providing information to health-care workers. This particularly concerns the information and understanding around which attitudes are formed. The behaviour and attitude of health-care workers have an influence on the self-image of people with HIV, and also on their response as patients and their ability to «get on». They can also serve as a good example to the rest of the population.

## 4.2 Medical follow-up and treatment of people with HIV and AIDS

### *General measures*

The measures implemented by the health service for people with HIV and AIDS involve the normal health and social service infrastructure on municipal, county-municipal and regional levels. All health-care and social service workers must be prepared to come into contact with people who have HIV and AIDS, and they will have no opportunity for declining to participate in treating them. Health-care and social service workers must have a reasonable familiarity with HIV/AIDS issues so that they can provide the necessary advice and guidance to individual patients, or be able to refer them to the appropriate person or organisation. Whenever an HIV test is being offered, the offer must be accompanied by the provision of information and personal counselling, both before the test is carried out and - not least - when the result is given.

All doctors who request an HIV antibody test must know what to do if the result proves positive. People who are told that they are HIV antibody positive will react in much the same way as anyone who learns that he or she has a fatal disease. But in addition there is the awareness that one may be stigmatised for having this disease, and also that being a carrier of the disease will influence one's future way of life. It is important that the doctor makes sure that the person in question has some kind of network (family, friends, support groups, the public authorities) which is immediately accessible, and it is also

important that the doctor arranges another appointment with the patient in the near future. It has been shown that people with HIV are most in need of support and care immediately after they have learnt that they have been infected, and also when symptoms of the disease start to develop. The Pluss organisation offers excellent help to people who have recently been diagnosed as HIV positive, and the patient should therefore be told about Pluss early on.

Many people say that forming close human relationships during all the years that usually come between the time of infection and the start of symptoms often creates bigger problems than the virus itself. For many people self-image and self-esteem are associated with social circumstances, education and work. Learning that you are infected with HIV is enormously stressful, and is characterised by fear, uncertainty and a change in living circumstances. It can mean financial difficulty and different working conditions. The medical after-care must concentrate on what can be done to improve the quality of life and living conditions. The challenge to the clinician is to think holistically: preventing and treating the psychological disturbance and physical illness represents only a part of the follow-up.

People with HIV should be offered frequent consultations during the symptomless period before immune deficiency develops, and should also be offered consultations with a specialist in infectious diseases at least once a year. When immune deficiency does develop, the follow-up and treatment must be managed by a specialist in infectious diseases in joint consultation with the specialist department in the regional hospital. The health service today has excellent opportunities for improving quality of life and prolonging life expectancy by means of prophylaxis and treatment. HIV is still a relatively new disease which presents enormous challenges and about which there is a constantly growing expertise.

One aspect of the follow-up of people with HIV is to prevent further spread of infection. Information must be given (and possibly frequently repeated) about the different ways in which the disease is transmitted, and about how the individual can protect others against infection. It is necessary to take time to establish trust and collaboration between patient and therapist, since all the measures for preventing HIV infection are essentially concerned with blocking the transmission routes. Sexuality is an important subject in many stages of the follow-up, for example when the doctor takes down the patient's history of infections, traces the transmission route, discusses the patient's relationship with his or her partner etc. Most people with HIV have been infected by sexual contact. There is no reason to believe that people with HIV give up having sex (and this is not an aim either). Various studies have shown that

the correct and consistent use of condoms provides effective protection against HIV infection, so long as both partners are aware that one of them is infected. People with HIV have both an ethical and a legal duty to inform people who might be exposed to HIV infection. The objective is to prevent the further spread of HIV while at the same time allowing the individual to enjoy a normal sexual life.

*HIV positive women, pregnancy, birth and breastfeeding*

Only a small proportion of all the research into HIV and AIDS is concerned with specifically female issues. Studies suggest that women with HIV can show other clinical presentations than men when they develop immune deficiency. More research is needed into gynaecological diseases, for example cervical cancer. HIV positive women were originally advised against becoming pregnant. If they did become pregnant, they were advised to consider termination of pregnancy. But if a pregnant woman is treated with antiretroviral drugs and her delivery is by Caesarean section, studies indicate that the risk of her baby becoming infected may be less than 10 per cent. It is important that health service personnel provide clear information and discuss pregnancy with women in a realistic and non-judgmental way. Whatever decision the woman makes, it must of course be respected and supported. Women with HIV must be closely monitored by specialists throughout the pregnancy and treatment must be given in joint consultation with the regional hospital. Women with HIV who decide to go ahead with their pregnancy must be made aware that Caesarean section should be considered at full term in order to reduce the risk of infecting the baby. For the same reasons they should not breastfeed their babies.

*Injecting drug users who are HIV positive*

There is a particular problem when following up injecting drug users. This will often concern drug users with a long and persistent history of drug use. The treatment for people with a long established HIV infection requires that they have a more ordered and regular way of life than is the case for most drug users, and this often makes it extremely difficult for them to obtain the full benefit of their medical treatment. Experience gained from the «HIV-met» [HIV-«methadone»] project in the municipality of Oslo indicates that switching to oral methadone maintenance therapy as part of a broad treatment plan can make drug users with immune deficiency better able to receive medical treatment and follow-up. In an assessment report on «HIV-met» it was documented that those patients who were involved in the project had less sickness and a significantly longer life expectancy than patients who did not participate in this programme. In addition an improved quality of life was recorded according to the report. At present there are controls on the prescription of methadone. The treatment must be started in a hospital or the patient

must be taking part in a project approved by SHD. People with HIV have the same rights as people suffering from any other dangerous infectious disease, namely the right to medical assessment and diagnosis, treatment, care and any other help that is needed to prevent further infection. In this context such help could for example take the form of treatment in a drug rehabilitation centre or being helped with accommodation.

*Non-native speakers who are HIV positive*

It is possible that the number of non-native speakers with HIV might increase in the coming years. It is important to ensure the overall quality of HIV testing, so that non-native speakers with HIV are followed up just as thoroughly as their Norwegian counterparts. A support group (called In-Pluss) for HIV positive non-native speakers was established in 1994 as part of Pluss. It is important to support this work in the future, with regard both to the individuals concerned and to the prevention of further infection. This type of measure requires cooperation with non-Norwegian cultural areas and groups (see chapter 3).

Health-care workers must take into account the fact that people from other countries, cultures and religions who are receiving treatment in a hospital or clinic may experience the predicament of having HIV or AIDS in a different way from Norwegian patients. In such cases it is important that the patient and health-care worker reach a mutual understanding of the therapy and after-care so that the treatment and stay in hospital are of maximum benefit.

*Prisoners who are HIV positive*

Prisoners with HIV have the same rights as others to medical after-care. Usually they will need special support from the prison medical departments which are independent municipal health-care facilities. The prison authorities have no right to know the prisoners' HIV status. It is very important that the prison medical departments are careful to maintain confidentiality regarding HIV status, and do not reveal it to the prison authorities. Inmates with long established HIV or AIDS should not normally be in prison. The Prison Board (Fengselsstyret), has indicated that the need for early release on parole, or transfers to a hospital or treatment centre should be assessed.

*Medical treatment of people with HIV and AIDS in the coming years*

Since the start of the AIDS epidemic there has been a considerable increase in our understanding of the clinical progression of HIV infection and the broad spectrum of medical presentations and complications in the patient. The central health authorities believe that the Norwegian health service has on the whole managed to keep up with these rapid developments.

The treatment facilities which have been and are available in Norway have never lagged behind those available in other Western countries.

The clinical pictures of HIV infection may to some degree be caused by the virus itself, but is most of all associated with the development of serious immune deficiency. The complications resulting from immune deficiency are chiefly a broad spectrum of infections and certain types of malignant tumour, especially Kaposi's sarcoma and certain lymphomas. A great deal of progress has been made with regard to diagnosis and therapy for a number of the most serious infections. In recent years prophylactic treatments have been established for several of these infections, and these can have a considerable preventive effect if they are administered at the right moment during the development of immune deficiency. At the same time new types of drug treatment have been developed which act directly against HIV and its viral replication. The first of these drugs was zidovudine (AZT), and later other related drugs also became available. Altogether these advances have already increased life expectancy and improved the quality of life for many HIV patients in Western countries. These therapies are not widely available in the Third World because of lack of public funds and expertise.

The development of new diagnostic methods, treatment and prevention of HIV infection and its complications, is now an important field of research. New and more effective therapies are discovered and implemented and in all probability the treatment will improve even further during the next five years. The new therapies may be expected to fall into one of four categories.

#### *New forms of therapy and prophylaxis for serious infections*

With the rehabilitation programme which we have at present, we can expect an excellent response rate to the treatment of opportunistic infections, in other words infections which affect patients with immune deficiency but which do not normally cause disease in healthy individuals, and also to the treatment of «ordinary» infections like tuberculosis, which can have an especially dangerous progression to its active form in patients with HIV. There is hope that new drug therapies will become available for infections that cannot be treated at present.

#### *New forms of antiretroviral therapy*

The development of immune deficiency and disease is clearly associated with viral replication. An effective treatment of HIV therefore must involve the successful inhibition of viral replication, and today this can be achieved in several different ways. In addition to established antiretroviral drugs in the same group as zidovudine, protease inhibitors are now being prescribed. A combination of these drugs can significantly

inhibit the ability of the virus to replicate. Research is also being conducted into HIV drugs which use other means to attack the virus's ability to replicate. A combination of several drugs increases their effectiveness and reduces side effects and the development of resistance.

#### *Immune-modulating drug therapy*

Increased understanding of the way in which HIV causes the development of immune deficiency has opened up new possibilities for treatment. This has to do with stimulating parts of the immune system which have a role in combating the virus, and also regulating the immune reactions which can be damaging for the patient. Several types of immune-modulating therapy are under development, including immune therapy using different kinds of HIV vaccines. Immune-modulating therapy will probably have a role in combination with other types of treatment as described above.

#### *New types of therapy for HIV-related types of cancer*

Current therapies for Kaposi's sarcoma and other HIV-associated lymphomas have a very limited effect in most cases. New types of therapy are being tested and are likely to be used in the near future.

#### *Further measures*

There is reason to believe that the new types of treatment will increase patients' life expectancy and improve the quality of their lives. But ever more complex and resource-demanding treatments will require a considerable amount of expertise at the relevant clinics. A highly specialised laboratory service is essential both for diagnosis and for monitoring the progress of a therapy. Current forms of treatment will probably be introduced much earlier in the course of an HIV infection than is the case at present. These factors suggest that regional hospitals will come to play a central role in the coming years in the treatment of people who are HIV positive. The regional hospitals must therefore be given the necessary resources for providing the best possible treatment of HIV patients.

In the course of a few years the treatment of HIV infection will be considerably more complex and more responsive to individual needs, and will start sooner after the initial infection. Not only must the person with HIV receive the best possible treatment, but he or she must also be able to live as normal a life as possible. It is important to avoid unnecessary sickness during drug therapy and to reduce the risk of making the patients isolated and passive. The central health authorities will monitor the treatment resources available for HIV/AIDS patients and increase them if necessary.

It is with good reason that Norway has an excellent international reputation with regard to HIV/AIDS prevention. In order to maintain and develop this standing, there must be support, care and sympathy for all who are affected by the epidemic, both the people who are infected and those who are close to them.





## Chapter 5

# *Allocation of duties and responsibilities Administrative and financial implications*

### Introduction

This chapter outlines the allocation of the main duties and responsibilities, against the background of the priority areas described in chapters 3 and 4.

It concludes with a short discussion of the administrative and financial implications of the HIV/AIDS preventive programme during the period of the Plan of Action.

An important starting point for this survey is the implementation of the so-called two-tier model for the central health administration on 1 January 1994. This has an influence on the allocation of duties and responsibilities concerning the work on the HIV/AIDS epidemic during the period of the Plan of Action.

Another important starting point was the new Communicable Diseases Control Act which came into force on 1 January 1995. This Act contains a summary of responsibilities and duties in the field of infection prevention both for the municipal and for the state sector. The act is based on the concept of a consistent preventive programme aimed at all the infectious diseases in Norway. This means that the HIV/AIDS work during this period must be gradually «normalised» so that this epidemic, and the work to limit it, becomes a natural part of ordinary work in the field of communicable diseases. It is very important in this context that the authority of the communicable diseases Act guarantees the full constitutional rights of those people who are targeted by the measures of the Plan of Action.

#### *The two-tier model for the central health administration*

Up until 1 January 1994, the National Institute of Public Health was linked with the Helsedirektoratet [Directorate of Health] as a subordinate department. After that date, the National Institute of Public Health was directly linked with SHD in line with the National Board of Health. This means that SHD must

coordinate work on HIV/AIDS, and the ministry must show a stronger involvement in this area. In other words the ministry must be responsible for formulating the overall premises and policies for this field, while the monitoring must be delegated to the Norwegian Board of Health and the National Institute of Public Health.

#### *Departmental management and its relationship with the voluntary organisations*

In this context departmental management must be conducted as normal with regard to cooperation between the ministry and subordinate departments, that is to say with management by objective and result as the underlying principle.

It is also appropriate in this connection to point out that cooperation with the NGOs is founded on the same principle. The principle of management by objective and result is in line with the practice that the Norwegian Board of Health has followed for many years. At the same time it must be clear that one is talking about voluntary work, and that the work which must be managed by the public authorities includes only the part or parts of the programme that are financed with public funds. If the work is financed by the organisations' own funds (from collections etc.), this should not of course be managed by the public authorities.

It will therefore be natural for the Norwegian Board of Health to collaborate with the NGOs much

as it does at present. The forms of collaboration must be decided by the Norwegian Board of Health, based on the objectives which the institution has been instructed to fulfil in respect of HIV/AIDS work. It is also desirable that the National Institute of Public Health cooperates with the voluntary organisations more extensively than before, and that appropriate methods for cooperation with the Norwegian Board of Health and the NGOs are formulated.

#### *Cooperation with other ministries*

Now that the ministry will be taking on more responsibility than it did before it was reorganised in line with the two-tier model, it will be easier to arrange cooperation with other ministries on common schemes.

Chapter 1 presented a number of such schemes or actions, and the most important of these will be the collaboration with the Ministry of Education, Research and Church Affairs in a scheme aimed at reaching young people. Another example would be working together with the Ministry of Justice on problems for prisoners, and working with the Ministry of Local Government and Labour/UDI on measures targeted at immigrants etc.

#### *Coordination with the rest of the preventive programme*

The new Communicable Diseases Control Act pinpoints the responsibility for carrying out a consistent programme for preventing all infectious diseases as an integrated element in the operations of all administrative levels.

The analysis in chapters 2 and 3 indicates that the HIV/AIDS epidemic here in Norway appears to have stabilised, not least because of the important work done by the NGOs.

It is therefore appropriate that during the period of the Plan of Action the central authorities should gradually phase out their allocation commitments to specific schemes which, according to current legislation, are the responsibility of the municipal and county municipal authorities. This will mean that after the conclusion of the period of the Plan of Action this work will have to be financed, from the very start, out of the ordinary budgets, in keeping with the way finance is provided for work with other infectious diseases. If the situation should alter, it would naturally be appropriate to increase the earmarked input. For the sake of completeness, the ministry points out that the Communicable Diseases Control Act guarantees the rights of people with HIV, and this means that they cannot be refused assistance on the grounds of insufficient funds.

Consequently when organising cooperative projects with the voluntary organisations it must be remembered that after the year 2000 most of the financing will have to come out of the ordinary budgets, and in response to

whatever measures are required at any particular time. It is also probable that work by the voluntary organisations will have to be supported by grants from central government after the conclusion of the plan of Action period. This will be assessed in the course of the period.

Otherwise there will have to be plans to ensure that the Norwegian Board of Health and the National Institute of Public Health have adequate funds from their current budgets after the end of the period of the Plan of Action to enable them to implement whatever measures the HIV/AIDS work might require at the time, as well as the wide range of measures needed for the rest of the infection prevention programme.

#### *More about the allocation of duties at ministerial level*

It is appropriate that the allocation of duties between the Norwegian Board of Health and the National Institute of Public Health should be continued in much the same way as at present.

The successful cooperation that the Norwegian Board of Health enjoys with the NGOs should carry on as before.

It makes sense for the AIDS Information and Awareness Unit at the National Institute of Public Health to cover the whole range of STDs.

#### *Regional level - the county medical officers*

During the last years of the current period the activities of the county medical officers in connection with HIV/AIDS work have been scaled down. In the years to come it will be incumbent on the county medical officers to restructure operations so that HIV/AIDS work becomes part of the ordinary programme for the prevention of infectious diseases.

#### *The municipalities*

It is natural that in many municipalities the work has been scaled down in response to actual developments and different needs. The Communicable Diseases Control Act and Act relating to Municipal Health Services (kommunehelsetjenesteloven) oblige the municipalities in Norway to operate a preventive programme in respect of infectious diseases. When state funds earmarked for this purpose are gradually reduced, the municipalities will have to maintain their HIV/AIDS preventive work at an efficient level out of their own budgets. City municipalities will have to make allocations which will maintain the preventive work for the foreseeable future at the same level as today. Oslo is a special case because most people in Norway who are HIV positive either live or are staying in Oslo. Consequently the most appropriate way to combat the further spreading of HIV in Norway will be to maintain, and reinforce if necessary, the preventive programme in Oslo.

In addition to the preventive work carried out by the voluntary organisations and health service facilities such as the Olafia Clinic, most of those admitted to hospital with HIV are treated in two hospitals, the Ullevål Hospital and the State Hospital. These two hospitals together with the Olafia Clinic now have considerable expertise and experience in the prevention of HIV infection and in the treatment of people with HIV and AIDS. In the preventive work targeted at HIV/AIDS and other STDs, it might therefore be prudent to base further developments on the advantages that the Olafia Clinic can offer in terms of experience and organisation. This applies particularly to the preventive work among non-native speakers that the Clinic has been involved in for many years.

#### *Administration*

The ministry will have to become more fully engaged in HIV/AIDS preventive work because of the implementation of the two-tier model in the central health administration, but apart from this there will be no need for administrative changes to the organisation of this work during the period of the Plan of Action.

#### *Financial implications*

Annual reports and financial reviews from the Norwegian Board of Health for the period 1990 - 1994 provide the following summary of funds that have been allocated to HIV/AIDS preventive work:

- From and including 1990 up to and including 1994 the total consumption of resources has fallen slightly, from almost NOK 35 million in 1990 to NOK 28.4 million in 1994.
- During the period 1990 to 1994 the voluntary organisations have received approximately 23 per cent of these funds, at roughly the same level each year - in other words circa NOK 7-8 million per year.
- The central information scheme has cost an average of around 29 per cent of the budget throughout the period. In 1994 costs dropped to just under NOK 7 million, compared with circa NOK 10 million in 1992 and 1993.
- Local initiatives have received around 27 per cent during the period. There has been a steady fall in this allocation from circa NOK 10 million in 1990 to circa NOK 7.5 million in 1994.
- The county medical officers have received around 8 per cent of the funds, the highest single allocation being circa NOK 5 million in 1990. From and including 1991, this allocation was reduced. When the new Communicable Diseases Control Act was introduced in 1995 extra funds were made available to reinforce the work of the county medical officers.

#### *Use of resources during the period of the Plan of Action 1996 - 2000*

The work undertaken so far has been assessed in Chapter 3 (Prioritised Areas). The allocation of resources during the period of the Plan of Action will be primarily based on this assessment.

In this connection the following points are important:

- Work which targets both the traditional and any new vulnerable groups must be ensured for the future. This means that the excellent cooperation with the voluntary organisations must be continued in the form of fund allocations, but with certain adjustments which are necessary because of increased emphasis on management by objective and result. After the conclusion of the period of the Plan of Action it is also probable that work by the voluntary organisations and other especially important groups will have to be supported by central budget allocations.
- The central information programme could be scaled down, but at the same time we must ensure that a better quality of information is provided in the future, particularly for non-native speakers and young people.
- The trimming of state support for local infection preventive measures must be continued, but this will not excuse local authorities from fulfilling their responsibilities according to the Communicable Diseases Control Act. During the Plan of Action period it might still happen that state support is provided for cities and any other places where the prevalence of HIV is high on the national scale. Another possibility is that the state will share in the financing of a professional centre with nationwide functions relating to particular priority areas. During the Plan of Action period consideration will have to be given as to how this kind of important measure should be financed after the end of the period.
- In line with the Norwegian Board of Health and the National Institute of Public Health, the offices of the county medical officers must aim gradually to integrate their work with the HIV/AIDS epidemic as part of their general programme to prevent the spread of infectious diseases.

# Appendix 1

## *Addresses*

Aksept Kontaktsenter  
(Contact Centre for HIV-positives and relatives)  
Postboks 2658 St. Hanshaugen  
N-0131 OSLO  
Tel 22 71 55 22  
Fax 22 71 76 34

Helseutvalget for homofile  
Øvre Slottsgate 29  
N-0157 OSLO  
Tel 22 33 70 15  
Fax 22 33 62 72

Info-phone on AIDS (Oslo)  
St. Olavs pl. 5  
N-0165 Oslo  
Tel 800 34 000  
Hverdager:  
kl. 0900 - 1500 og  
kl. 1800 - 2200

Klinikk for seksuell opplysning  
Hammerfestgt. 1  
Postboks 6699 Rodeløkka  
N-0502 OSLO  
Tel 22 37 51 44  
Fax 22 37 59 13

Landsforeningen mot AIDS  
Universitetsgt. 20 III  
N-0162 OSLO  
Tel 22 42 37 90  
Fax 22 42 38 55

Medisinernes Seksualopplysning (MSO)  
Student Pavillion  
Ullevål Hospital  
N-0407 OSLO  
Tel 22 46 92 80 (onsd. 18- 20)

MIRA Senteret  
(Migrant and Refugee Women's Centre)  
Tel 22 11 69 20

Olafiaklinikken (Oslo kommune)  
(Polyclinic for sexually transmitted diseases)  
Olafiagangen 7  
N-0188 OSLO  
Tel 22 08 29 50  
Fax 22 08 29 90

Info-phone for sex and health:  
Tel 810 02244

PION  
(Prostitutes' support group in Norway)  
St. Olavsplass 2  
N-0165 OSLO  
Tel 22 20 74 34  
Fax 22 20 68 83

Pluss (og Kvinner Pluss og In+)  
(Support group for HIV-positive)  
Postboks 835 Sentrum  
N-0104 OSLO  
Tel 22 33 01 60  
Fax 22 33 01 25

PRO-senteret  
(Welfare assistance scheme for male and female prostitutes)  
Tollbugt. 24  
N-0157 OSLO  
Tel 22 41 13 28  
Fax 22 41 05 44

Senteret for Ungdom, Samliv og Seksualitet (SUSS)  
(Provide teaching materials, information, counselling and advice)  
Sannergaten 11  
N-0557 OSLO  
Tel 22 71 77 41  
Fax 22 71 81 56

Sosial- og helsedepartementet  
Forebyggings- og utviklingsavdelingen  
Postboks 8011 Dep  
N-0030 OSLO  
Tel 22 24 87 01  
Fax 22 24 86 56

Statens helsetilsyn  
Avdeling for samfunnsmedisin  
Postboks 8128 Dep  
N-0032 OSLO  
Tel 22 24 88 11  
Fax 22 24 88 68

Statens institutt for folkehelse  
Seksjon for informasjon og dokumentasjon (SAID)  
Geitmyrsveien 75  
Postboks 4404 Torshov  
N-0403 OSLO  
Tel 22 04 23 89  
Fax 22 04 23 84

**Enquiries about local HIV/AIDS bodies should be directed to the county medical officer.**

### **Other important organisations**

African Forum in Norway  
Torggt. 26  
N-0183 Oslo

African Health Team  
c/o Olafiaklinikken  
Olafiagangen 7  
N-0188 Oslo  
Tel 22 08 29 50

Afrikan Youth in Norway  
Korsgt. 31  
N-0551 Oslo  
Tel 22 35 46 35

Antirasistisk senter  
Tel 22 11 60 00  
Fax 22 11 61 00

Innvandrerne Landsorganisasjon (INLO)  
Postboks 555  
N-4001 Stavanger  
Tel 51 56 29 60  
Fax 51 56 29 66

Islamsk Råd Norge  
Trondheimsveien 24  
N-0560 Oslo  
Tel 22 35 76 13

Kontaktutvalget mellom innvandrere og norske myndigheter  
Youngstorget 6  
N-0181 Oslo  
Tel 22 24 71 67

Norsk Organisasjon for Asylsøkere (NOAS)  
Torggt. 26  
Postboks 8893 Youngstorget  
N-0028 Oslo  
Tel 22 20 84 40  
Fax 22 20 84 44

Organisasjonen mot offentlig diskriminering (OMOD)  
Torggt. 35  
Postboks 2832 Tøyen  
N-0608 Oslo  
Tel 22 20 87 37/22 20 62 17

Oslo Røde Kors Internasjonale Senter (ORKIS)  
Torggt. 26-28  
N-0183 Oslo  
Tel 22 11 69 30/31/35  
Fax 22 11 69 33

Pakistan Advisory Council  
Storgt. 39  
N-0182 Oslo  
Tel 22 20 70 03

Rainbow Foundation  
Storgt. 38  
N-0182 Oslo  
Tel 22 08 85 59  
Fax 22 20 85 62

Sekretariatet for flyktninger og innvandrere  
Thv. Meyersgt. 67  
N-0552 Oslo  
Tel 22 04 37 00