

Overview of the HIV epidemic in Norway 2003-2005

Since 1985, surveillance of the HIV/AIDS epidemic in Norway has been based on a universal notification system where cases are reported anonymously to the Norwegian Institute of Public Health using a non-unique identifier linking reports from clinicians and laboratories. While prevalence studies have been regularly carried out in pregnant women, drug users, military recruits and blood donors, no prevalence studies among the general population has been undertaken.

During the three year period 2003-2005, an increase in newly diagnosed cases of HIV has been observed in Norway. This increase has been caused by two factors; more HIV-positive asylum seekers and refugees arrived from countries outside Europe with generalised HIV epidemics and a considerable increase of newly infected cases among men having sex with men (MSM). Asylum seekers and other immigrants constituted 48% of the total number of reported cases in this period, 26% of the cases occurred in MSM. The remaining cases occurred in intravenous drug users and heterosexuals living in Norway with the majority of cases occurring among males acquiring their infection while travelling abroad.

By the end of 2005, the cumulative total of diagnosed HIV positive individuals in Norway was 3261 (table 1), 2219 males and 1042 females. According to the statistics there are approximately 2500 persons at present living with HIV/AIDS in Norway.

Table 1. HIV infection notifications in Norway 1984-2005 by risk category and year of diagnosis

Risk category	< 00	00	01	02	03	04	05	Total
Heterosexual	733	131	106	151	152	164	130	1568
- residence Norway	319	38	27	28	34	43	33	519
- immigrants	376	93	79	123	118	121	97	1049
Homosexual (MSM)	733	32	39	30	58	70	55	1017
Injecting drug use	442	7	8	16	13	15	19	520
Received blood products	46							46
Mother -to-child *	22	3	2	2	5	1	5	40
Others / unknown	41	2	3	6	10	2	6	70
Total	2017	175	158	205	239	252	215	3261

* The majority infected abroad before immigrating to Norway

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

National response to the AIDS epidemic

Responsibility and Consideration. A strategy for the prevention of HIV and sexually transmitted diseases (2001-) is Norway's fourth action plan on HIV/AIDS prevention since 1986. The Strategic plan has two general objectives and nineteen specific objectives. The specific objectives are important elements in the achievement of the main goals.

The main goals of the Strategic plan are:

- Reduce the number of new cases of HIV and STD
- Secure that everyone who is infected with HIV and/or other sexually transmitted diseases is given the proper follow-up regardless of their age, sex, sexual orientation, place of residence, ethnic background and financial situation.

The most important preventive strategies are based upon:

- Easy access to knowledge and information about HIV/AIDS, counselling and education that emphasise ownership, self-confidence and pride of own body, sexuality and the use of condoms
- Easy access to voluntary counselling and testing
- Easy access to condoms
- Secure rights, living conditions and quality of life for people living with HIV/AIDS.

In the last three year period the integration of strategies on prevention of unwanted pregnancies and abortion, STDs and HIV directed towards the general population, and specifically targeting the age groups 15-19 and 20-25 years, has been strengthened.

In Norway, much emphasis have been put on the triad of offering free HIV testing and screening of pregnant women, offering adequate treatment free of charge for the patient, and active case-finding around each diagnosed case. Generally, it is important to raise the level of awareness and knowledge of the disease in the general population, and to target varied information to high-risk groups. Condom availability is an essential preventive measure. Harm reduction is obtained by ensuring clean needles and syringes. Asylum-seekers and other immigrants from areas with high HIV prevalence are voluntarily tested for HIV. Few immigrants refrain from HIV testing.

For the period 2003-2005 the HIV preventive work has thus tried to balance targeted measures focusing on the population at large, including young people, and measures focusing on high-risk groups and securing of rights, living conditions and quality of life for people living with HIV/AIDS¹. High-risk groups are defined as men who have sex with men, sex workers, injecting drug users and immigrants from high prevalence countries

Strategies and preventive efforts have to a great extent been developed and carried out in close cooperation between health authorities at national, regional and local level and NGOs. The NGOs have been the prime actor in carrying out activities. The activities have been based upon the above mentioned strategies, and taken the target group's sex/gender, age and culture into account.

Gender perspective

The Strategic plan focuses strongly on the gender perspective. The plan lists a number of objectives and policy instruments aimed at ensuring that "gender-related issues are taken into consideration in plans, priorities and measures":

- Organisations receiving public grants must take the gender perspective into account in their applications and project descriptions.
- Awareness of the gender perspective must be increased through information and advice from the central health authorities.
- Networks for women with HIV should be established.
- Networks for gay men should be established.
- Measures to increase the awareness of the role played by men should be implemented.

The gender issue has been included in strategic plans since the beginning of the 80-ties, focusing mainly on men having sex with men. The past years the focus on women has been strengthened as heterosexual practice now causes more new HIV cases than in the early phases of the epidemic. Women have not been given sufficient attention in HIV prevention

¹ It is important to note that the Strategic plan does not comprise efforts directed towards medical treatment and the follow up of HIV positive patients by the health services. Medical treatment and the follow up of HIV positive patients are an integrated part of the ordinary specialist and primary health services and free of charge for the patient.

work, and increased efforts to reach women especially have been requested. Organisations receiving public grants are required to take the gender perspective into account in their applications and project descriptions, and such applications from NGOs have been prioritised in the last few years. Networks for HIV positive women have been established by NGOs. This is a difficult task, especially among immigrant women. Improvements can be seen, but more work needs to be done. Measures to increase the awareness of the role played by men have not however been given sufficient attention.

Communicable diseases control

The purpose of the Communicable Diseases Control Act is to protect the population from communicable diseases by preventing their occurrence and hindering them from spreading among the population, and by preventing such diseases from being brought into Norway or carried out from Norway to other countries. The provisions of the Communicable Diseases Control Act relating to services and measures apply to every person residing in Norway, including undocumented migrants.

Everybody is entitled to necessary assistance with communicable diseases control (vaccination, information or other necessary preventive assistance, medical evaluation and diagnosis, treatment and care). Such assistance is regarded as part of the right to medical assistance of the Act relating to Municipal Health Services, the Hospital Act and the Act concerning the Patient's right.

The prevention of HIV and STDs is an important part of communicable disease control at municipal level. The municipality shall ensure that necessary preventive measures, opportunities to be examined, treatment and care in or outside a health institution are available to everyone domiciled or temporarily residing in the municipality. A survey completed in May/June 2003 shows that 93% of the Municipalities have a municipal medical officer, 78% have communicable disease control plans, 50% of these revise the plans every fourth year, while 39% lack revision plans². In 2005 the number of municipalities having a contingency plan was close to a 100%. However, the central health authorities lack knowledge on the inclusion of HIV/AIDS in the communicable disease control plans and to what extent municipal authorities have the sufficient knowledge in the field of infectious disease control³.

HIV testing and treatment are free on charge. The number of HIV-tests in Norway has been fairly constant the last 15 years – 60 000 tests on pregnant women, 100 000 tests on blood-donors and 100 000 clinical test are taken every year. National data on the number of HIV tests on high risk groups are not available.

Young people

Sexual education in school is compulsory in Norway and starts in the fifth grade. Norwegian studies show that teenagers prefer contraception education given by healthcare personnel. Counselling, education and information about HIV, STDs (Chlamydia being emphasised) and contraception is carried out by the local youth healthcare services. Condoms are given out free of charge (2 million yearly). Health clinics for children, mothers-to-be and young people and the school health service run by the municipalities therefore play an important part in the prevention of HIV and STDs among young people. The number of school health services has

² Norwegian Board of Health (2003). Kartlegging av kommunenes beredskap på smittevernområdet pr. juni 2003 (Survey of the municipalities' preparedness in the area of communicable diseases – June 2003)

³ Norwegian Board of Health (2005) reports from their Countrywide Supervision in 2004 of Municipal Health Services for Newly-arrived Asylum Seekers, Refugees and People Reunited with their Family, that there is no mention of asylum seekers or refugees in the municipal plans for control of communicable diseases, and there are no set routines for offering examination for communicable diseases to people who are reunited with their families.

been constant in the period 2003-2005 with one in every municipality (431 in total), while the number of special youth clinics has increased slightly from 320 to 330. Education and counselling are also carried out by NGOs.

Pilot projects improving health services for students (age group 20-24 years) at a number of different universities and university colleges in Norway have been launched in 2005. The aim of the projects is to ease the access to contraception, testing and counselling.

As boys use other information channels, and seem to profit from other kinds of information and training than girls, the health authorities have the recent years tried new ways to reach them. In the past years we have launched different interactive information and training programs - on the Internet, SMS and computer games. A main strategy that seems to be profitable to most young girls is practically oriented basic training in self-assertiveness. This kind of training programme has during the past years been carried out all over the country. Young people are encouraged to be directly involved in the preventive work, and local peer educational groups has been established many places. Training is given by the national volunteer organisation of young medical students specialised in sexual education.

Sex workers

It is estimated that there are about 2555 women and men working as sex workers in Norway⁴. The majority of sex workers are women. We have limited data and knowledge about the scope of male prostitution. In 2005 the number of street sex workers was 1055, 70% of these being foreign, mainly from Eastern Europe and countries outside Europe with generalized HIV epidemics. 1500 sex workers are registered working on the indoor market – estimated number being 50% foreign. There has been an increase of foreign sex workers working especially in street prostitution from 2003 to 2005. In Oslo the number of foreign sex worker registered at the Pro centre was 644 in 2003 and 1064 in 2005⁵. The number of Norwegian sex workers has decreased from 692 in 2003 to 463 in 2005.

The number of blood tests⁶ taken at the main health clinic for sex workers in Oslo, the Pro centre, has increased from 266 in 2004 to 464 in 2005. Based on the HIV findings in these samples, it is estimated that the HIV-prevalence among sex workers in Norway is about 2%.

There are a number of different organizations and public institutions working on prevention of HIV and STDs among sex workers in the major cities in Norway. Free condoms and lube, information, education and voluntary counselling and testing are key components in their work. Reaching-out casework and cultural intermediaries are methods being used. These methods have proven to be very successful in getting in contact and dialog with the sex workers working both on the indoor market and on the streets. Based on their dialogue with the sex workers, they report that most sex workers have good knowledge about HIV and STDs and all claim the use of condoms with their clients.⁷ The amount of condoms being distributed every year to sex workers indicates an extensive use of condoms.

Men having sex with men

There has been a significant increase in newly HIV infected cases among men having sex with men (MSM) from 30 in 2002, 57 in 2003, 70 in 2004 to 55 in 2005. A majority of the men were infected in Oslo.

⁴ Unpublished data from Pro Senteret (the Pro Centre) - Norwegian national resource centre on all matters related to prostitution and a social service centre for women and men in prostitution. Data are collected in three of the main cities in Norway (Stavanger, Bergen and Oslo).

⁵ Pro centre, annual reports - 2003, 2004 and 2005.

⁶ Most of these samples are tested for HIV.

⁷ Norway has not completed special surveys on level of knowledge about HIV-prevention or the use of condoms among sex workers.

Two anonymous surveys have been carried out in Oslo in 2003 and in Bergen in 2005 among MSM⁸. The surveys were conducted in various saunas, bars, discos and a SM-club for MSM. Due to the relative low number of respondents and the sampling method used, the results must be interpreted with care. It might however give some indications on sexual habits and HIV testing among MSM.

Of the 572 respondents in Oslo, 87% state that they have taken a HIV test once throughout their life, while 67% state that they have taken a test the last 22 months. 30% have had unprotected sex with an occasional partner the last 12 months, while 52% have had unprotected sex with their steady partner the last 12 months. Of the ones reporting unprotected sex with a steady partner, 60 % of these reported unprotected sex with an occasional partner. There is an insignificant difference between test activity and unprotected sex. The survey conducted in Bergen in 2005 shows similar trends. The number of respondents was however so low that we cannot draw any conclusions based on the results.

The HIV epidemic among MSM in Oslo in 2003 and 2004 has led to increased funding and preventive efforts directed towards primarily HIV positive MSM, young MSM and MSM with immigrant background. Measures have included information, counselling and testing and the establishment of a health service for MSM one night a week in a health clinic in Oslo. Central actors in the preventive work have been NGOs (Gay & Lesbian Health Norway being the most central organization), local governmental institutions and gay magazines and Internet sites.

With 5 year intervals Norway completes surveys on the population's sexual habits. The last survey, completed in 2002⁹, shows that 10,7 percent of the male and female respondents have had sexual experience with another male. In the age group 18-24 years, the number is 14, 1 percent. 3,8 percent reported to have had sex with another male the last year.

Norway has not completed surveys on expose/use of key prevention services among MSM. It is therefore difficult to assess to what extent the target group is reached with prevention programmes. Information from two health clinics in Oslo used by MSM (Olafiaklinikken and Brynsenglegene) shows however that there has been an increase in the number of MSM visiting the clinics for counselling and testing. Gay & Lesbian Health Norway has been very active distributing condoms, lube and information (on safer sex/HIV) in various bars, saunas and sex on premises venues (SOPV) for MSM. A distribution service for free condoms and lube over the internet has also been established. The organization further reports an increase of other activities directed towards MSM and support for these

Intravenous drug users¹⁰

Based on statistics for overdose deaths, intravenous drug use in Norway was estimated in 2002 to involve between 11 000 and 15 000 persons. Work is being done with the intention of changing the basis for calculating the so-called fatality indicator, but this has yet to be completed. There is therefore no such new estimate available for the reporting period.

The number of HIV-cases among intravenous drug users (IDU) remains relatively low and few new infections are detected among this group. In 2003 the number of reported HIV infections among IDU was 13 (total number of new infections in 2003 being 238), in 2004 15 (total infections: 252) and 19 in 2005 (total infections: 215). The proportion that has

⁸ National Institute of Public Health, Aidsinfo 1:2004, 4:2005.

⁹ Three random samples were selected, age 18-49 years. The forms were returned anonymously. The respondent rate was 36%, thus the data has to be interpreted with care. Træen B, et al. (2002) Rapport fra seksualvaneundersøkelsene i 1987, 1992, 1997 og 2002 (Report on the sexual habits surveys conducted in 1987, 1992, 1997 og 2002)

¹⁰ Sources for this are; Sirius (2003, 2004, 2005) The drug situation in Norway

developed AIDS remains low and stable. There has, however, been a slight increase of the numbers from 2002 onwards.

The reason for the stable, low incidence of HIV among intravenous users is not entirely clear, but a high level of testing, great openness regarding HIV status within the user milieu combined with a strong fear of being infected and self-imposed rules, are assumed to be important factors. In Oslo, the first methadone project, which was started in 1991, was aimed solely at HIV-positive IDUs with immunodeficiency. In addition, many of the sources of infection in the drug-using milieu have disappeared due to overdose deaths or been rehabilitated through substitution therapy or other forms of rehabilitation. However, the extensive outbreaks of hepatitis A and B in recent years, and the high incidence of hepatitis C, show that there is still extensive needle sharing. The future situation as regards to HIV is therefore deemed to be very unpredictable.

Municipalities having low-threshold health services, where drug users are offered medical checkups, free needle exchange¹¹, follow-up of overdose cases and referral to specialist treatment has increased from 27 in 2003 to 38 in 2005. The municipalities report that these services are beneficial. The services are at street level and accessible, they reach hardcore problem users, contribute to improving the health of this group and probably contribute to reducing the number of overdose fatalities. The municipalities report an increase in the number of queries and consultations, and extensive health problems are also detected among many problem users through these services.

An injection room in Oslo was opened on the 1st of February 2005 as a three-year trial scheme. The service is run by health personnel and is open from 9.30AM to 3.30PM every day. Interest in the room has been great, and the upper limit on the number of users has already been reached (300 are registered as users and 5145 injections have been made in 2005). The project will be evaluated by Norwegian Institute for Alcohol and Drug Research (SIRUS).

Medically-assisted rehabilitation for drug abusers (LAR) was established as a nationwide service in 1998. As it is organised in Norway, this form of treatment presupposes close cooperation between the specialist health service and the municipal health and social services. The number of applications for such treatment has been much greater than originally calculated, and capacity has been under considerable pressure both in the municipalities and in the specialist health service (LAR centres). Methadone and buprenorphine are currently approved for this treatment. The number of clients receiving medical-assisted treatment was 2431 in 2003 (550 on waiting lists), 3003 in 2004 (437 on waiting lists) and 3434 as of August 2005 (372 on waiting lists).

Bleach has been allowed in prisons in Norway, while drug injection equipment has not been allowed in any prison. HIV testing has been offered regularly to IDUs in prisons.

Immigrants

336 HIV infections were reported among asylum seekers and refugees in the period 2003-2005, a majority of these being women. Asylum seekers and other immigrants thus constituted 48% of the total number of reported cases in the period. Most of them were infected before they came to Norway and many were unaware of their HIV status before they took the test.

Municipalities shall according to the Municipal Health Service Act § 1-1 provide essential health services for everyone domiciled or temporarily residing in the municipality. Municipalities therefore have the responsibility to ensure that refugees and asylum seekers

¹¹ Access to sterile equipment is legal in Norway. Needle exchange services were established in 1988.

are provided essential health services. The provision of information about health services and essential health care in connection with communicable diseases is an essential part of the municipality's responsibility. In relation to HIV, the information shall emphasise that refugees and asylum seekers has access to voluntary HIV testing, counselling and treatment and the person's possible knowledge of HIV status before arrival in Norway has no bearing on the application process. The information must be adapted in such a way that it is understood by the recipients. Professional interpreter services shall be provided as needed.

In 2004, the Norwegian Board of Health carried out countrywide supervision of health services for newly-arrived asylum seekers, refugees and people reunited with their families. Supervision was carried out in 55 municipalities¹². The results of the supervision have shown that one-quarter of the municipalities did not ensure that everyone received information about health services. Another finding was that some municipalities were not aware that they had a duty to provide information, or that it was not clear who in the health services had responsibility for this. As a rule, interpreter services were used when people were given information.

In 10 of the 55 municipalities that were investigated, the Norwegian Board of Health in the counties found deficiencies in preventive measures and examination for communicable diseases. In some municipalities, no special attention is given to people who come from countries where the prevalence of communicable diseases is high. There is no mention of asylum seekers or refugees in the municipal plans for control of communicable diseases, and there are no set routines for offering examination for communicable diseases to people who are reunited with their families.

In the view of the Norwegian Board of Health, it is a very serious situation that many municipalities have not organized things to ensure that newly-arrived asylum seekers, refugees and persons reunited with their families receive information about health services a short time after they have become resident in the municipality. It is thus not possible for them to ask for the health services they have a statutory right to receive. Norwegian society is unfamiliar to most of these people. They have no knowledge of how health services are organized, what types of services are available, or how health services can be contacted. Deficiencies can have serious consequences for individuals. In the opinion of the Norwegian Board of Health, it is unacceptable that many municipalities do not meet their responsibility to provide information in a satisfactory way.

The Norwegian Board of Health is concerned that many municipalities do not pay adequate attention to communicable diseases other than tuberculosis, and that they do not follow up newly-arrived persons. Control of communicable diseases is considered to be a right to essential help care, and in the opinion of the Norwegian Board of Health, deficiencies in this area are unacceptable.

As a result of these findings, the Directorate for Health and Social Affairs and the Norwegian Institute of Public Health, arranged communicable disease prevention conferences targeting health personnel working with asylum seekers and refugees in 2005. The Directorate also funded a conference arranged by The Norwegian Nurses Association for nurses working in health services for asylum seekers and refugees. HIVNorway (NGO) has also in the period completed information campaigns targeting health personnel working with asylum seekers

12 The most important areas for supervision were: whether municipalities meet the regulations on control of tuberculosis; whether information is provided about health services and essential health care in connection with communicable diseases, pregnancy and mental disorders; whether municipalities meet their responsibilities for supervision of environmental health in reception centres for asylum seekers.

and refugees. Leaflets containing information about HIV and hepatitis A, B and C have been published in fourteen languages and are available from central health authorities as well as at reception centres for asylum seekers and from municipal health services. A new guideline for health services to asylum seekers and refugees was published by the Directorate for Health and Social Affairs in 2003¹³.

Persons with immigrant background are often object to discrimination, prejudice and racism in different areas and contexts. HIV infected immigrants find themselves the object of double or even triple discrimination - being a woman, being an immigrant and being HIV positive. HIVNorway and Aksept are reporting an increase of immigrants seeking their help and support. HIVNorway have established three different network groups for HIV positive immigrants. The purpose of the groups is to provide a forum where HIV positive persons with a minority background can meet and exchange experiences. Esperanza has approximately 40 members, and is open to men and women. AMAN targets HIV positive African men, while Freedom is a network for HIV positive women. The groups are run by volunteers. Queer world – a network for queer immigrants was established in 2005.

Activities and networks working on the prevention of HIV among immigrants and the support of especially HIV positive immigrant women are given priority in the follow-up of the Strategic plan.

People living with HIV/AIDS

3261 people have been diagnosed with HIV since 1983. 890 cases of AIDS have been reported, out of these 594 have died. It is estimated that around 2500 people are living with HIV in Norway.

According to the Communicable Disease Control Act, HIV is defined as a serious communicable disease that is hazardous to public health. HIV testing, counselling and treatment is therefore free of charge. The act comprises all people who live or stay in Norway. All people living with HIV/AIDS (PLHIV) thus have access by law to anti retroviral treatment when needed.

In terms of social security the Government presented a plan of action to combat poverty, Report No. 6 (2002- 2003) to the Storting¹⁴. This plan contains targeted measures to prevent persons from ending up in, and help them escape from, a situation of persistent low income and difficult living conditions. The goal is to ensure that as many people of working age as possible manage to make a living through their own efforts and that those who have no income receive welfare benefits to cover their living costs. Priority is given to measures designed to help more people become self-supporting. Specific projects and programmes are being carried out during the period covered by the plan, 2002-2005 for the following priority groups: immigrants and refugees, long-term social welfare recipients, persons receiving disability benefits, single supporters and other disadvantaged families with children, children and young people, substance abusers, persons with mental problems and the homeless.

The agreement of intent concerning an inclusive working life is a joint endeavour between the authorities and the social partners and aims at reducing sickness absence, employing persons with disabilities and rising the retirement age. The agreement was evaluated in autumn 2002. The evaluation showed that the trend for all three objectives is still negative. Efforts to promote an inclusive working life have become widespread in Norwegian business

¹³ Directorate for Health and Social Affairs (2003): Helsetilbud til asylsøkere og flyktninger (Health care for asylum seekers and refugees).

¹⁴ Source for this is; Ministry of Foreign Affairs (2003) Human Rights 2003. Annual report on Norway's Efforts to Promote Human Rights

and industry, and this may bring results over time. The social partners have agreed to continue the agreement with stronger focus on the joint effort that must be made at each workplace in cooperation between employer and employees, for instance by setting more stringent requirements as regards the monitoring of employees on sick leave and resumption of activity.

PLHIV and working life has a number of times been discussed publicly the past years. There have been some trials where PLHIV have had to fight against illegal grounds for termination and the right to employment¹⁵. In FAFO's (2002) report on living conditions and quality of life among people living with HIV in Norway in 2001/2002¹⁶, 23 percent of the respondents say they chose not to be open about their HIV status in fear of losing their job, while 43 percent claim that their health problems has led to reduction or termination of their participation in labour force. The lack of openness combined with the respondents health problems, may make it difficult for many PLHIV to participate fully in the working life.

The income level for PLHIV is on average the same as for the general population. PLHIV do however more often have financial problems than the average population. The HIV positive immigrants and drug users are the worst off. According to the findings in the FAFO report it seems that social status is more important for the level of income than HIV status. The financial problems can be seen as a result off a combination of growing expenditures, loss of overview of the economy due to the fact that life crisis make you loose control and individuals can experience a short-term reduction income.

In spite of the fact that information about HIV/AIDS has been distributed widely the past year, PLHIV are meet with prejudice and negative attitudes and discriminated. The two most recent studies of attitudes towards PLHIV (Barometer, 2003¹⁷) and living conditions and quality of life among people living with HIV in Norway in 2001/2002 (FAFO 2002) support this.

The telephone survey (Barometer) from 2003 shows that 73 % would be against having a HIV positive partner, about 50 % would be opposed having a HIV positive baby-sitting, 66 % would not drink from the same glass as an HIV positive, while 7 % would oppose having a HIV positive colleague. The FAFO report shows that many chooses to be silent about their status. 33 percent claim that their future opportunities would be reduced if they were open about their status, while 18 percent believe people would be frightened if they revealed their diagnosis. 34 percent fear social exclusion and 15 percent fear rejection due to their HIV diagnosis.

There are a number of NGOs working to improve rights and living conditions and offering support for PLHIV in Norway¹⁸. The findings in the surveys coincide with the experience

¹⁵ In connection with employment rights, in 1987 a Supreme Court decision stated that a person's HIV status is not legal grounds for termination

¹⁶ The study was commissioned by the Royal Norwegian Ministry of Health and Social Affairs and Pluss – The Norwegian Association Against AIDS (now HIVNorway) and carried out by FAFO. (research centre). The study covers issues like income and economy among people living with HIV, employment, housing, openness about HIV status, isolation or belonging, sexuality and partnerships, mental and somatic health, and experience with the health services and other public services. 311 HIV positive were interviewed.

¹⁷ Telephone survey carried out by Barometer in 2003. 250 respondents in the age 15 – 40 years were asked a number of questions related to their attitudes towards HIV and HIV positive.

¹⁸ HIVNorway and Aksept (the Church City Mission) being the most central ones. HivNorway (HivNorge) is a national organisation that protects the rights and concerns of HIV positive people within the community as well as working to prevent the spread of HIV and AIDS. Aksept offers psychosocial support and care. HIVNorway and partly Aksept are founded over the Strategic plan.

these organizations have working with and for PLHIV. HIVNorway further reports that many PLHIV experience lack of understanding of how it is to live with HIV both in the general population and in their meeting with health care workers and other personnel working in public institutions.

4.0 Major challenges faced and actions needed to achieve the goals/targets

The main goals of the Strategic plan are:

- Reduce the number of new cases of HIV and STD
- Secure that everyone who is infected with HIV and/or other sexually transmitted diseases is given the proper follow-up regardless of their age, sex, sexual orientation, place of residence, ethnic background and financial situation.

Major challenges faced to achieve these goals:

Immigrants:

- A majority of the newly infected HIV positive persons in Norway are infected in other countries than Norway. Immigrants constitute the majority of these people. However, an increasing number of Norwegian men have tested HIV positive after contracting the infection abroad. An increasing number of immigrants in Norway also run the risk of being infected during return visits to their native countries.

Actions needed:

- Provide adequate health services and information for asylum seekers and refugees.
- Ensure that persons who are infected are diagnosed early and given the proper follow-up in a manner suited to the individual's ability to communicate, cultural background and life situation.
- Build a stronger cooperation with interest groups in the immigrant communities.
- Strengthen outreach programmes in immigrant communities, person-to-person talks and group discussions and peer education run by NGOs.
- Offer special help to high risk immigrant women.
- Launch activities targeting people going visits to their native country;
 - Health authorities must contribute to a strong media focus and individual guidance in relation to vaccination on the risk of communicable diseases when travelling abroad.

Men having sex with men (MSM):

- Norway has witnessed an increase of newly infected MSM the past years. The development can be characterised as an epidemic with an epicentre in Oslo. More measures needs to be taken in order to stagnate and reverse this development.

Actions needed:

- Ensure easy access to voluntary testing and counselling for MSM
- Ensure easy access to information and knowledge about HIV and other STDs and sexual health in general.
- Strengthen preventive measures that lead to safer sexual behaviour through a holistic approach.
- Strengthen preventive measures that lead to safer sexual behaviour among MSM with high risk behaviour.
- Strengthen outreach programmes in homosexual communities, person-to-person talks and group discussions and peer education run by NGOs.
- Strengthen health care workers ability to meet MSM in a professional satisfactory and unprejudiced way.

People living with HIV/AIDS

- People living with HIV/AIDS (PLHIV) are subject to discrimination and stigmatization in the Norwegian society. Securing the rights, living conditions and quality of life among PLHIV has to be achieved.

Actions needed:

- Combat stigmatization and discrimination of people with HIV and AIDS.
- Ensure that PLHIV are offered the proper follow-up.
- Ensure that PLHIV and their partners are given proper individual infection control guidelines.
- Build up knowledge about the living conditions of persons with HIV and AIDS.
- Offer particularly vulnerable persons with HIV and AIDS suitable follow-up.
- Ensure that the workplaces have the proper preparedness as regards occupational exposure to HIV and ensure knowledge about how HIV infection is not transmitted.
- Reduce mother to child transmission.
- Strengthen dentists, health care and social workers ability to meet PLHIV in a professional satisfactory and unprejudiced way.
- Secure good living conditions and quality of life among PLHIV.

Injecting drug users (IDU)

- The HIV situation seems to be stable and the rate of infection is relatively low. There has, however, been a slight increase in the incidence the last few years and the situation has to be followed very closely.

Actions needed:

- Health authorities must strengthen the cooperation with other relevant authorities which aim to reduce the recruitment of new substance abusers and rehabilitate existing substance abusers before they are infected with a communicable disease that is hazardous to public health.
- Ensure easy access to HIV testing, counselling, follow-up and treatment, as well as clean needles, syringes, bleach and condoms for IDUs and prison inmates.
- Ensure high level of information about relevant viruses, ways to become infected, the importance of good syringe hygiene, the use of condoms and ongoing information about local outbreaks.
- Increase rehabilitation and treatment facilities for injecting drug users.
- Strengthening “damage-control” measures in order to direct abuse away from injecting abuse.

Sex workers

- The HIV situation among sex workers in Norway is changing due to the increase of foreign sex workers from high prevalence countries. A number of Norwegian men acquire HIV infection while travelling abroad.

Actions needed:

- Ensure easy access to voluntary testing and counselling for sex workers
- Ensure easy access to information and knowledge about HIV and other STDs and sexual health in general.
- Launch activities targeting people going on holidays to high prevalence countries;
 - Health authorities must contribute to a strong media focus and individual guidance in relation to vaccination on the risk of communicable diseases when travelling abroad.
- Launch attitude changing campaigns directed towards persons who purchase sexual services in Norway and abroad in an effort to combat the factors that promote the development of prostitution.

National spending assessments

In Norway, there are no exact methods to measure costs for patients or specific patients groups for somatic care in specialist health care. However, the Activity Based Funding scheme based on DRG-logic gives an indication of the average cost for specific diagnose groups/ patients. There are two DRGs for HIV, measuring the number of incidences and reimbursement level gives an indication of the cost in Norwegian hospitals related to HIV. HIV-spending for 2005, with 60% DRG reimbursement, was 7 284 329 NOK (1 121 000 USD¹⁹) for DRG 489 based on 157 incidences and 1 646 301 NOK (253 000 USD) for DRG 490 based on 87 incidences. Theoretically, with 100% DRG-reimbursement, the total figure would be around 15 millions (2,3 million USD) NOK for 2005.

In addition to this, expenditure related to primary health care services and pharmaceutical spending for HIV patients (approximately 100 000 NOK per year (15 400 USD)) has to be added. We have no exact data on the expenditure related to these areas.

Earmarked grant to the follow-up of the Strategic Plan was in:

- 2003: 16 600 000 NOK - 2 554 000 USD
- 2004: 19 400 000 NOK - 2 985 000 USD
- 2005: 18 600 000 NOK - 2 862 000 USD

¹⁹ Note: The calculation is based on flat USD rate 6,5 NOK

Global commitment and action

1. Amount of bilateral and multilateral financial flows (commitments and disbursements) for the benefit of low and middle- income countries.

Table 1 HIV/AIDS funding (NOK 1000) (including DAC 130.40, UNAIDS and GFATM)

	2001		2002		2003		2004		2005	
	No.	%	No.	%	No.	%	No.	%	No.	%
HIV/AIDS (DAC)	160,687	2,0	180,294	2,1	166,340	1,7	184,422	1,9	*	
+ UNAIDS	69,891		84,998		90,206		106,247		125,000	
+ GFATM			130 000		118 300		125 000		151 541	
+ Multi-bilateral ODA (UNICEF, UNFPA etc)							84, 179		*	
Total	230,578		395 292		374 846		499848			

Note: UNIDS and GFTM calculated based on flat USD rate 6,5

Note also: The GFATM numbers include funding for malaria and TB as well as HIV/AIDS. Within the first 4 rounds, 56 % of the funds have been utilised for HIV/AIDS activities.

*No available statistics yet

Table 2: HIV/AIDS – DAC code 130.40 according to channels (NOK 1000)

	2001		2002		2003		2004		2005	
	No.	%	No.	%	No.	%	No.	%	No.	%
Public sector (not NGO)	94,551	58,8	90,769	50,3	79,087	47,5	105,339	57,1	*	
Norwegian NGO	49,412	30,8	69,893	38,8	70,679	42,5	57,449	31,2	*	
Local NGO	11,788	7,3	11,387	6,3	12,810	7,7	16,085	8,7	*	
Regional	121	0,1	3,484	1,9	200	0,1	2,00	1,1	*	
Internat. NGO	4,814	3,0	4,760	2,5	5,564	2,1	3,00	1,9	*	
Total	160,687	100	180,294	100	166,340	100	184,422	100	*	

*No available statistics yet

2. Amount of public funds for Research and Development of preventive HIV vaccine and microbicides 2001 - 2005.

Table 3: Public funds for Research and Development of preventive HIV vaccine and microbicides 2001 - 2005. (NOK 1000)

	2001	2002	2003	2004	2005
International AIDS Vaccine Initiative (IAVI)	10 000	10 000	12 500	15 000	25 000
International Partnership for Microbicides (IPM)		5 000	5 000	10 000	20 000
The Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM)*		130 000	118 300	125 000	151 541
Total	10 000	145 000	135 800	150 000	196 541

* The GFATM numbers include funding for malaria and TB as well as HIV/AIDS. Within the first 4 rounds, 56 % of the funds have been utilised for HIV/AIDS activities.

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