

UNGASS COUNTRY PROGRESS REPORT NORWAY

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Abstract

In June 2001, Heads of State and Representatives of Governments met at the United Nations General Assembly Special Session on HIV/AIDS and issued the Declaration of Commitment on HIV/AIDS. The declaration recognizes that with sufficient will and resources, communities and countries could reverse the devastating HIV/AIDS epidemic.

The biennial reporting system developed by UNAIDS in relation to the follow-up of the UNGASS declaration, highlights the importance of building strong monitoring and evaluation tools and systems at national level to measure achievements made in HIV prevention, treatment and care.

The Norwegian Directorate of Health, in collaboration with the Norwegian Institute of Public Health and Norwegian Agency for Development Cooperation (NORAD), has been responsible for the 2008-2009 reporting from Norway. Relevant stakeholders and NGOs have been involved both in relation to data collection and drafting of the report.

Since 2002, the Norwegian national HIV strategies comprise the relevant commitments made in the UNGASS declaration. The main achievement in the period 2008-2009 is the launch of an intersectoral national HIV strategy (2009-2014) involving six different ministries (Ministry of Labour and Social Inclusion, Ministry of Children and Equality, Ministry of Health and Care Services, Ministry of Justice and the Police, Ministry of Education and Ministry of the Environment and International Development). The strategy defines a number of specific targets and strategic moves which need to be addressed and implemented in order to halt the growing epidemic among vulnerable groups in Norway and prevent the epidemic from reaching the general population.

However, even though progress can be seen, the 2008-2009 UNGASS reporting shows that the country is still facing challenges related to increasing incidence of HIV among MSM and immigrants despite considerable efforts invested in HIV prevention the past years. In addition, PLWHA are still facing a high level of stigma and discrimination in the Norwegian society and the level of knowledge and attitudes towards PLWHA in the general population and especially among youth and adolescents, needs to be improved.

The main challenges identified in the reporting period include lack of collaboration between the primary and specialist health care services, lack of knowledge on HIV in the public sector, inadequate sexuality education in schools, lack of rights to health for paperless irregular immigrants and lack of financial predictability for civil society working on HIV.

The findings from the UNGASS reporting will be used in the continuous work on improving HIV preventive efforts in Norway. In addition, it will be an important contribution to the development of an improved evaluation and monitoring system for HIV prevention, treatment and care in Norway.

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List of abbreviations:

- LGBT – Lesbian, gay, bisexual and transpersons
- MSM – Men having sex with men
- IDU – Injecting drug users
- GP – General practitioner
- STI – Sexually transmitted infections
- PLWHA – People living with HIV/AIDS
- NGO – Non governmental organization
- DRG-system – Diagnosis Related Group System
- MAT – Medically assisted treatment
- MFA – Ministry of Foreign Affairs
- NORAD – Norwegian Agency for Development Cooperation
- TAMPEP – European Network for HIV/STI prevention and Health Promotion among Migrant Sex Workers
- VCT – Voluntary counselling and treatment

1 Status at a glance

1.1 The inclusiveness of stakeholders in the report writing process

The Norwegian Directorate of Health, in collaboration with the Norwegian Institute of Public Health and Norwegian Agency for Development Cooperation (NORAD), has been responsible for the 2008-2009 reporting from Norway.

The reporting process has involved the coordinating group for the follow-up of the National HIV strategy at directorate level. In addition, relevant stakeholders have been consulted in relation to data collection and drafting of the report. A number of different NGOs have contributed to the process (see Appendix 3 for an overview of contributing partners).

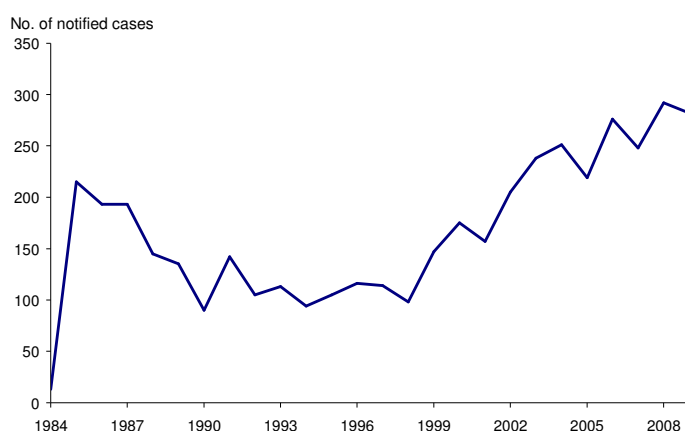
The Norwegian Institute for Public Health has been responsible for the main work on collection and analysis of data on prevalence and incidence of HIV and other STIs. The Norwegian Directorate of Health assumed the main responsibility for the drafting of the narrative report and data collection and reporting on the National Composite Policy Index, part A. The Norwegian government has underlined the important role of NGOs in the 2008-2009 reporting. A consultant was engaged to coordinate the NGO responses to the National Composite Policy Index, part B.

A draft report was submitted to Aidsnett¹ and a number of other NGOs. The NGOs were asked to either comment directly in the narrative report or invited to write their own contributions to a shadow report. A total of four NGOs commented on the report. Their remarks have been incorporated in the report either in the text or in separate text boxes with headings.

1.2 Status of the epidemic

In 2008 and 2009, 299 and 282 newly diagnosed cases of HIV were reported in Norway. 4368 people have been diagnosed with HIV since testing became available in 1985.

Figure 1. Notified cases of HIV infection Norway 1993-2009 by year of diagnosis



Source: Norwegian Institute of Public Health

¹ Aidsnett is an informal network of Norwegians involved in HIV related work internationally and nationally. The draft report was sent to Aidsnett's core group (20 members).

1.3 The policy and programmatic response

Norway got its first program to combat HIV/AIDS in 1985. The strategies and action plans from the mid 1980ties until today's action plan have mainly been rooted in the health sector. From 2002-2009, the national HIV effort has mainly been followed up within the framework of "Responsibility and Consideration - Strategic plan for preventing the spread of HIV and sexually transmitted diseases. The strategic plan was based on four guiding principles: The measures should encroach as little as possible on personal freedom; efforts should be targeted at groups with a high risk and prevalence of HIV and at the general public; the authorities should cooperate with civil society; and society should show solidarity with PLWHA. The strategic plan had two general objectives and 19 specific objectives with relevant measures that were aimed at the population, target groups and individuals.

In 2009, Acceptance and coping – National HIV strategy (2009-2014) was launched. The strategy is multisectoral and involves six different ministries; Ministry of Labour and Social Inclusion, Ministry of Children and Equality, Ministry of Health and Care Services, Ministry of Justice and the Police, Ministry of Education and Ministry of the Environment and International Development. The National HIV strategy is the most important policy document related to HIV prevention, care and support. However, the Strategic plan does not comprise efforts directed towards medical treatment. Medical treatment and the follow up of HIV positive patients in the specialist and primary health care are integrated parts of the ordinary health services and free of charge for the patient. The coverage of medical treatment is believed to be close to 100 %.

The work on the strategy has been rooted in an interministerial steering group at the state secretary and senior official level, chaired by the Ministry of Health and Care Services, with representatives from the six different ministries. The strategy development process has involved civil society, relevant research institutes as well as public authorities. A draft of the strategy has also been submitted to the National AIDS Council (see description below).

The interministerial working group established in relation to the work on the current strategy, is continuing its work as a steering group in the follow-up of the strategy at a senior official level. A coordinating group is established at the directorate level. The tasks of the coordinating group is to develop early annual operational plans, secure intersectoral collaboration, and scale up systems for monitoring and evaluation.

In addition to the intersectoral working groups, Norwegian National HIV and AIDS Council was established in December 2006. The Council's work supports the strengthening of the relationship between the Norwegian and international efforts to prevent the spread of HIV and AIDS in consultation with affected and involved parties. Another important concern is to make people more aware that HIV is a political challenge that the government is investing in through political involvement and leadership. The Council was established with an advisory but not a decision-making mandate. It is the political administration's use of the Council that gives it its justification and professional standing. The meetings are alternately arranged and chaired at the political level of the Ministry of Health and Care Services and the Ministry of Foreign Affairs. The Council is broadly composed of a number of private and public sector organizations.

1.3 b Comments to the policy and programmatic response from civil society

HIVNorway

HivNorway finds the National HIV strategy full of good intentions, with ambitious and sensible goals. We do however; see some challenges regarding the implementation of the strategy. A good plan is not enough. It has to be political will to actually implement the plan.

HivNorway would also stress the importance of proper funding. There has been no increase in the funding in the HIV and AIDS field since 1998. An ambitious new strategy requires proper funding if the ambitious goals are to be met.

1.3.1 Political framework for HIV prevention, treatment and care

National action plan for better life quality for lesbian, homosexuals, bisexuals and transpersons (2009-2012), Ministry of Children, Equality and Integration

www.regjeringen.no/nb/dep/bld/tema/homofile-og-lesbiske/ny-utgave-av-regjeringens-handlingsplan-.html?id=537226

National action plan against human trafficking (2006-2009), Ministry of Justice and the Police

www.regjeringen.no/nb/dep/jd/dok/rapporter_planer/planer/2006/regjeringens-handlingsplan-mot-menneskeh.html?id=457852

National action plan for preventing unwanted pregnancies and abortion (2004-2009), Ministry of Health and Care Services

www.regjeringen.no/upload/kilde/hd/pla/2004/0001/ddd/pdfv/201350-handlingsplan.pdf

National action plan for preventing unwanted pregnancies and abortion (2010-2015) – strategies for better sexual health – Norwegian Directorate of Health

www.helsedirektoratet.no

Migration and health - challenges and trends, Norwegian Directorate of Health

http://www.helsedirektoratet.no/vp/multimedia/archive/00133/Migration_and_health_133289a.PDF

Responsibility and Consideration - Strategic plan for preventing the spread of HIV and sexually transmitted diseases (2002-2009), Ministry of Health and Care Services

www.regjeringen.no/upload/kilde/shd/rap/2001/0014/ddd/pdfv/161821-strategic_plan_hiv_aids.pdf

Acceptance and Coping – National HIV strategy, Norwegian Ministries (2009-2014)

www.regjeringen.no/se/dep/hod/tema/folkehelse/acceptance-and-coping---national-hiv-str.html?id=576820

Guideline for health services to asylum seekers and refugees – Norwegian Directorate of Health

http://www.helsedirektoratet.no/publikasjoner/veiledere/veileder_helsetjenestetilbud_til_flyktninger_og_asylykere_2757

Norway's HIV and AIDS policy: position paper in development cooperation – Norwegian Ministry of Foreign Affairs

<http://www.norad.no/en/Tools+and+publications/Publications/Publication+Page?key=109607>

1.3.2 Main objectives

The main aim of the National HIV Strategy (2009-2014) is that by the end of the strategy period, Norway will be a society that accepts and copes with HIV in a way that both limits new infection and gives persons living with HIV good conditions for social inclusion in all phases of their lives.

The aim is twofold with one focus on prevention of new infections and another on living conditions for PLWHA. Although no effort must be spared to ensure that as few people as possible are infected with HIV, we must recognise that tens of millions of people in the world are living with HIV. To ensure that more of PLWHA in Norway experience that they have good living conditions is in itself a crucial preventive strategy for avoiding the spread of HIV.

In addition to a main objective, the strategy has two operative general objectives and eight specific objectives. Under each of the specific objectives, a number of strategic moves are listed. Taken together, this amounts to a framework that gives direction

General objective

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

Specific objectives

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

A shadow document to "Acceptance and Coping" (operational plan) will be developed in 2010, which will include indicators for each individual strategic move. The aim is to build-up a sustainable monitoring system to measure the degree to which the general and specific

objectives are achieved. A comprehensive monitoring and evaluation system is also important in order to fulfil the reporting obligations associated with the international declarations.

1.3.3 Roles and responsibility

Objectives and strategies in “Acceptance and Coping” involve stakeholders at all administrative levels and many sectors of society. Six ministries and their underlying agencies, including the regional and local levels, play a role in the follow-up of the strategy. The Ministry of Health and Care Services has the overall responsibility for coordinating the interministerial work, while the Directorate of Health heads the coordinating group at Directorate level.

Civil society and NGOs are also key implementing agents. Involvement of persons living with HIV in the implementation of the plan is a crucial success factor.

1.3.4 Overview of public authorities involved in the development and implementation of the strategic plan

The Ministry of Labour and Social Inclusion (MLSI) is responsible for labour market policy, working environment and safety policy, integration and diversity policy, immigration and asylum policy, Sami and minority policy, pension policy and welfare and social policy. In the working environment area, one of the main objectives is to help promote safe and inclusive employment for all, where importance is attached to preventing injuries, illness, accidents and social exclusion. The authorities' main policy instruments in this work are to develop regulations, provide supervision and carry out the development of knowledge and methods.

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

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

The Ministry of Justice and the Police (MJP) works to reduce criminality, promote security, safety, openness, democracy and the Criminal Justice Systems solution of problems and service to the public. One of its main objectives is to ensure the security of the

society and the individual. Among other things, the Ministry of Justice and the Police should help ensure quality in the legislation.

The Ministry of Education and Research (MER) is responsible for developing the comprehensive policy for day nurseries, education, lifelong learning and research.

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

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

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

The Norwegian Institute of Public Health is the Norwegian Government's institute for the prevention of communicable diseases pursuant to Section 7-9 of the Communicable Disease Control Act. Important tasks include monitoring infectious diseases, conducting research in the area of prevention of communicable diseases, ensuring an adequate stock of vaccine and/or preparedness and providing guidance to institutions and the population on measures for the prevention of communicable diseases. In accordance with regulations concerning the prevention of communicable diseases in the health service, the Norwegian Institute of Public Health shall maintain an overview of the prevalence of infection in institutions, prepare statistics and offer assistance in the clarification of outbreaks. Furthermore, the Institute shall conduct education activities, hold courses and update information about the prevention of communicable diseases.

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

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

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

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

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

The Directorate of Integration and Diversity (IMDi) is the Ministry of Labour and Social Inclusion's executive body for the Government's integration and social inclusion policy and is an important contributor to the development of policy in this field. IMDi's most important tasks are to:

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

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

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

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

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

The regional health authorities (RHF) shall ensure that persons with a permanent domicile

or residence in that health region are offered specialist health service in and outside of institutions. Among other things, RHF shall help ensure that the services offered are adapted to the patients' needs and are accessible to the patients.

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

1.3.5 Relevant regulations

There is an extensive body of regulations that governs actors' and services' obligations and rights related to the HIV strategy. The most relevant are:

Communicable Disease Control Act

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

The Municipal Health Services Act

This Act shall ensure that the nation's municipalities shall provide necessary health service to everyone who lives or has temporary residence in the respective municipality. The municipality's health service includes public organised health service that does not come under the authority of the central government or county administration and private health enterprises that are run in accordance with an agreement with the municipality. Through its health service, each municipality shall promote public health and well-being and good social and environmental conditions and seek to prevent and treat illness, injuries or bodily defects. It shall spread information about and increase interest in the things that the individual him/herself and the general public can do to promote their own well-being and health and public health.

The Specialist Health Services Act

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

The Patients' Rights Act

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

The Health Personnel Act

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

The Working Environment Act

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

The National Insurance Act

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

The Day Care Institutions Act

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

The Education Act

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

The Anti-discrimination and Accessibility Act

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

The Social Services Act

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

General Civil Penal Code (the Penal Code)

Article 155 of the Penal Code has the purpose of protecting the society against the spread of communicable diseases that are hazardous to public health. This provision imposes penalties on those who have reason to believe that they are infected with a communicable disease that is hazardous to public health and who wilfully or negligently transmit that infection or expose someone else to the risk of becoming infected. The maximum penalty is up to 6 years imprisonment for a wilful violation and 3 years for a negligent violation. The Communicable Disease Control Act's definition of a "communicable disease that is hazardous to public health" is also applicable for the Penal Code. The content of the concept

may alter with time, depending, for example, on the treatment possibilities for various diseases and the possibilities of preventing the transmission of infection.

Article 202 of the Penal code prohibits all kind of activity related to prostitution like advertising and renting out premises. Article 202 A criminalizes the purchase of sexual activity or a sexual act. The provision states that any person who;

- a) engages in or aids and abets another person to engage in sexual activity or commit a sexual act on making or agreeing payment,
- b) engages in sexual activity or a sexual act on such payment being agreed or made by another person, or
- c) in the manner described in (a) or (b) causes someone to carry out with herself or himself acts corresponding to sexual activity,

shall be liable to fines or to imprisonment for a term not exceeding six months or to both. If the sexual activity or sexual act is carried out in a particularly offensive manner and no penalty may be imposed pursuant to other provisions, the penalty shall be imprisonment for a term not exceeding one year. A separate section applies when the relevant acts are committed against a person under 18 years of age.

1.3.5 b Comments to the Anti-discrimination and Accessibility Act from civil society

HIVNorway

A new law against discrimination has been proposed. This proposed law aids at providing a common basis against all forms of discrimination a person or a group can be exposed to. If this law is passed it will reduce the protection against discrimination PLWHA are enjoying under the present law.

1.3.6 National funding estimates for HIV prevention, treatment and support

HIV prevention, care and support are integrated parts of the health and social services and educational system at state, regional and municipal level. There are no specific budget lines related to HIV prevention, treatment and support since the different sectors' responses to HIV is an integrated part of their ordinary services. Thus estimates of the total costs of HIV prevention, treatment, care and support is unavailable.

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 Diagnosis Related Group (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. Estimates for HIV-spending for 2008 and 2009 is unavailable, however, in 2005 the HIV spending, with 60% DRG reimbursement, was 7 284 329 NOK (1 121 000 USD²) 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.

² Note: The calculation is based on flat USD rate 6,5 NOK (2005 rate).

In addition to this, expenditure related to primary health care services and pharmaceutical spending for HIV patients (approximately 100 000 NOK per person per year (15 400 USD) – 2005 figures) has to be added. We have no exact data on the expenditure related to these areas.

Every year since 1985, the Parliament has adopted an earmarked budget for the follow-up of the national action and strategy plans for combating HIV. The Ministry of Health and Care Services has delegated the disposition and follow-up of the funds to the Norwegian Directorate of Health. The allocation of funds to NGOs and public actors is done on a yearly basis and based on applications. The budget for the 2008 was 16,5 million NOK (2,9 million USD) and for 2009, 18,3 million NOK (3,2 million USD).

1.4 UNGASS indicator data

Indicator	Description	Value /Comments
Expenditures		
1	Domestic and international AIDS spending by categories and financing sources	Not available
Policy development and Implementation Status		
2	National Composite Policy Index	See Appendix 4
National Programmes		
3	Percentage of donated blood units screened for HIV in a quality-assured manner	100 %
4	Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	It is reason to believe that all PLWHA in need of Antiretroviral Therapy has good access to medication in the public health system. According to the Communicable Disease Control Act all people residing in Norway has the right to free VCT and treatment for HIV and other communicable diseases that are hazardous to public health.
5	Percentage of HIV-infected pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	All pregnant women are screened for HIV (voluntary testing). All pregnant women with HIV are offered ART to reduce the risk of MTC. Norway has not registered any chases of MTC transmission in the country since 1999.
6	Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	According to the Norwegian surveillance regulations, all TB + HIV cases shall be reported as AIDS by the medical officer in charge of the patient to the Norwegian Public Health Institute. However, these cases are only reported sporadically.

		We have no reason to believe that any TB+HIV cases are not receiving adequate treatment for TB/HIV.
7	Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their result	Given the low prevalence of HIV in the general population, the indicator is not seen as relevant.
8	Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their result (MSM, sex workers, IDUs)	<p>Sex workers: Several of the low-threshold health services for sex workers collect data on HIV testing among sex workers. However, no systematic behavioural surveillance/surveys have been conducted.</p> <p>MSM: 56 %</p> <p>IDUs: Limited prevalence studies (200-300 participants) among IDUs have been carried out in the city of Oslo the past years in relation to the municipality's needle exchange program. In addition to offering health checks, vaccination and clean needles, the program is screening for syphilis, tetanus, Hepatitis A, B and C, HIV and Human T-lymphotropic virus. The surveys the past years have showed only one case of undiagnosed HIV. These results indicate that the harm reduction strategies have a positive effect on incidence of HIV and that there are few hidden sources of error related to HIV diagnostics among IDUs.</p>
9	Percentage of most-at-risk populations reached with HIV prevention programmes (MSM, sex workers, IDUs)	<p>Sex workers: No data available</p> <p>MSM: 56 %</p> <p>IDUs: No data available</p>
10	Percentage of orphaned and vulnerable children aged 0-7 whose households received free basic external support in caring for the child	Subject matter not relevant
11	Percentage of schools that provided life-skills based HIV education in the last academic year	No data available
Knowledge and Behaviour		
12	Current school among orphans and non-orphans aged 10-14	Subject matter not relevant
13	Percentage of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of	65 %

	HIV and who reject major misconceptions about HIV transmission	
14	Percentage of most-at-risk populations (IDUs, sex workers, MSM) who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Data not available
15	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	9.3 %
16	Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	Representative sexual behavioural studies have been conducted in Norway on 5 year interval from 1987 onwards. However, the response rate for the 2008 survey was too low (20%) for the data to be used in the reporting.
17	Percentage of women and men aged 15-49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse	No data available (ref indicator 16).
18	Percentage of female and male sex workers reporting the use of a condom with their most recent client	No data available
19	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	53 %
20	Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	No data available
21	Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	No data available
Impact		
22	Percentage of young people aged 15-24 who are HIV infected	< 0.01 %
23	Percentage of most-at-risk populations who are HIV infected	No data available
24	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	No data available
25	Percentage of infants born to HIV-infected mothers who are infected	< 0,01%

2 Overview of the HIV/AIDS epidemic

2.1 HIV infection

HIV testing became available in Norway in 1985, and anonymised reporting of HIV infection was introduced in 1986 with retroactive effect. Since then, 4,369 HIV-positive persons have been confirmed in Norway 2,931 men and 1,437 women.

Table 1 HIV infection notifications in Norway 1984-2009 by risk category and year of diagnosis

Risk category	< 06	06	07	08	09	Tot
Heterosexual	1570	164	141	185	170	2230
- residence Norway	519	42	41	46	44	692
- immigrants	1051	122	100	139	126	1538
Homosexual (MSM)	1019	90	77	92	87	1365
Injecting drug use	521	7	13	12	11	564
Received blood products	46				1	47
Mother-to-child*	40	6	9	4	4	63
Others / unknown	67	9	8	6	9	99
Total	3263	276	248	299	282	4368

* The majority infected abroad before immigrating to Norway

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

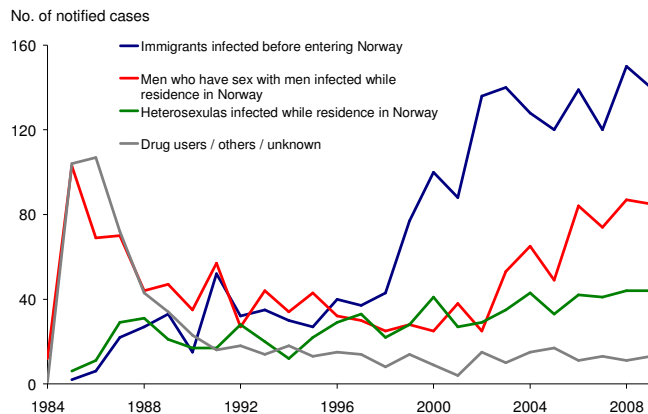
In practice, only sexual transmission and transmission through the use of unclean injection equipment among substance abusers have any significant effect on the HIV situation in Norway. Only one case of infection through blood transfusion has been confirmed in Norway after 1986, and HIV infection of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

Since the HIV monitoring is based on anonymity, there is not any data showing how many PLWHA are living in Norway at present. Of the 4,368 reported HIV-positive cases, 618 have been reported to have died from AIDS, some have died of other causes, and others have travelled out of the country. The Norwegian Institute of Public Health assumes that around 3 500 persons PLWHA in Norway, 300-500 of which do not know that they have HIV (hidden sources of error).

The nature of the HIV epidemic in Norway has changed very little in the last 25 years with regard to infection patterns and the groups that are most affected. More than 90 per cent of HIV-positive persons in Norway are still from the original at-risk groups of MSM, immigrants from high-endemic areas, Norwegian men who have sexual contacts in high-endemic areas and IDUs. The virus has gained very little access to the rest of the population. This is mainly

due to the fact that HIV has relatively low contagiousness through sexual contact and hence mainly has the potential to spread in groups that have a great deal of casual and unsafe sex and/or sexual contacts in communities that have a high prevalence of HIV or sexual practices that have a higher risk of infection (anal sex).

Figure 2 Notified cases of HIV infection 1993-2009 by year of diagnosis and risk groups



Source: Norwegian Institute of Public Health

2.2 Homosexually infected persons

Among MSM, there has been a rapid increase in the number of HIV cases since 2003, and the number of yearly confirmed HIV cases in the group has more than doubled since the 1990s. A similar trend has been observed in both the USA and a number of other western countries. 60 per cent of the HIV cases reported since 2003 were infected in Oslo, 10 per cent in the rest of Norway, and 24 per cent abroad, while for 6 per cent of the cases, the place of infection was unknown. In the period 2007-2009 there has been a clear increase in homosexual HIV infection outside of Oslo.

The situation with infection among MSM is still distinguished by the fact that many are infected by casual or anonymous sex in Norway or on holiday trips abroad. In the period 2003-2008, 66 per cent of the newly diagnosed patients reported that they were infected by a casual partner and 16 per cent by a steady partner, while in 18 per cent of the cases the relationship to the person who had infected them was unknown. The median age at the time of diagnosis has remained around 36 years, and there are no definite signs that more young MSM are now being infected.

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

2.3 Heterosexually infected persons

The majority of heterosexually infected persons that are now confirmed to be HIV-positive in Norway are persons of foreign origin who were infected before their arrival in Norway. In order to get a better picture of the HIV epidemic among heterosexuals, the heterosexually infected persons are divided into two groups according to whether they had permanent residence in Norway when they were diagnosed or whether they were diagnosed before their arrival in Norway.

2.3.1 *Infected while domiciled in Norway*

Since 1985, a total of 692 HIV cases have been confirmed in this group: 418 men and 274 women. The number of HIV-positive persons has undergone a slight increase in the last ten years from about 30 cases per year around 2000 to 44 cases in 2009. Until recently, most of the cases in this group (85 per cent) have been persons with a Norwegian background, but the percentage of immigrants infected while they were residing in Norway has increased in recent years, especially among women, and now constitutes about one third of the heterosexually infected cases. Among persons born in Norway, the number of confirmed infected persons and infection patterns have altered little in recent years. As a rule the women are infected in Norway, usually by their steady partner who is unaware of his HIV infection. The men are usually infected through casual sex abroad, and for many years Thailand has been reported as the most frequent source of infection by far.

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

2.3.2 *Infected before arrival in Norway*

This group consists of persons who were born abroad and who were infected with HIV before they arrived in Norway for the first time. Most of them came as refugees, asylum seekers and family reunification immigrants and the number of HIV-positive persons in this group has increased in recent years in step with the number of immigrants arriving in Norway. Since 1985, a total of 1,538 HIV cases have been confirmed in this group: 620 men and 918 women. The number of HIV-positive persons has increased in the last 10 years from about 80 cases a year around 2000 to 126 cases in 2009. The majority are from areas of conflict in East Africa, most frequently from Ethiopia, Somalia and Eritrea. Most of the HIV positive immigrants from Asia are Thai women who have come to Norway to marry a Norwegian husband. The median age for the cases reported in the last 10 years has been 34 for men and 30 for women.

2.4 *Injecting drug users*

The incidence of HIV among drug abusers in Norway has remained at a stable low level in the last ten years with about 10-15 cases diagnosed annually, of which 70 per cent were men (12 cases in 2008 and 11 cases in 2009). The median age has remained steady around 35 for both women and men. About 20 per cent of the cases have been immigrants infected before their arrival in Norway. Of the cases infected in Norway, 60 per cent state that they were infected in Oslo.

The reason for the low incidence of HIV 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 strong internal justice in the milieu, are assumed to be important factors. In addition, many of the sources of infection in the 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 HIV situation is therefore still unpredictable.

2.4.1 *Drug use in prisons*

A survey that covered all Norwegian prisons showed that two-thirds of the inmates (69%) had used drugs in the period prior to their imprisonment. Almost half of the inmates (45%) were what is described as «hardcore» drug users in the period prior to imprisonment. A

quarter of the inmates (26%) were regular and frequent IDUs in the period prior to their imprisonment. The number of inmates in Norwegian prisons amounts to about 3,400 persons at any given time. It is assumed that about 60 per cent of the inmates in Norwegian prisons have substance abuse problems, and about half of these inmates had injected drugs with hypodermic needles. According to the Public Health Institute no HIV transmission between inmates has been reported the past years.

2.5 Infection from mother to child

Since 1985, 63 perinatally infected children have been reported (4 cases in 2008 and 2009). The routine offer of HIV testing of pregnant women in Norway and the use of antiviral prophylaxis for mother and child in connection with birth have resulted in a greatly reduced risk of infection for the child. The last child with congenital HIV infection in Norway was born in 1999. Of children with HIV infection, most of the cases reported in the last 10 years have come to Norway together with asylum-seeking parents, usually from Africa.

2.6 AIDS

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

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

2.7 Surveillance of HIV/AIDS

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.

HIV screening has been offered on a routine basis in antenatal care since 1987. 96% of all pregnant women are screened for HIV. Prevalence studies on IDUs, military recruits and blood donors have been conducted regularly. However, no prevalence studies among the general population have been undertaken.

2.7.1 Notification system in Norway (MSIS)

The Norwegian surveillance system of infectious diseases (MSIS) is regulated by law, owned by the Ministry of Health and operated by The Norwegian Institute of Public Health (NIPH). The four notifiable sexually transmitted infections are:

- HIV infection
- Gonorrhoea
- Syphilis (infectious)
- Genital Chlamydia

HIV infection, gonorrhoea and syphilis are reported anonymously using a non-unique identifier

linking reports from clinicians and laboratories. Patient data reported includes gender, month and year of birth and place of residence. In addition a variety of epidemiological data is reported including country of birth, diagnostic methods, isolation site, drug resistance, indication for testing, place of infection, clinical picture, and information on gender and relationship to source partner. Genital Chlamydia surveillance is only laboratory based. Data on year of birth, gender and municipality is reported once a year on all laboratory confirmed cases.

However, these surveillance data are not sufficient to understand the epidemiology of STIs in specific risk groups because information on sexual risk behaviour, social and sexual networks are lacking. Thus, first generation epidemiological data needs to be supplemented by second generation epidemiological data and surveys on risk behaviour.

2.7.2 *Hidden sources of error*

The European Centre for Disease Prevention and Control (ECDC) estimates that between 20 and 30 per cent of all HIV-positive persons in Northern and Central Europe are not aware of their HIV status. In Denmark, it is estimated that the hidden sources of error amount to between 15 and 25 per cent. The Norwegian Institute of Public Health estimates that between 300 and 500 persons in Norway are HIV-positive without being aware of it. Some studies have shown that in a population of HIV-positive individuals, the 20 per cent who were not aware of their HIV status accounted for more than 50 per cent of new infection of others. Norwegian research shows that up to 20 % of MSM have never taken a HIV test.

3 National response to the AIDS epidemic

3.1 Prevention

The prevention of new HIV infections has been a main area of focus in the national HIV preventive work since the 1980ties. The main strategies have been;

- Easy access to knowledge and information about HIV/AIDS
- Easy access to counselling and education that emphasise skills to support 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 PLWHA.

Objective 1 in the National HIV strategy (2009-2014) states that; *New infection with HIV shall be reduced – especially in groups with high vulnerability to HIV.* HIV prevention, care and support are integrated part of the health and social services and educational system at state, regional and municipal level. The prevention of HIV and follow-up PLWHA in the primary health care is the responsibility of the municipalities. The regional health authorities on the other hand are responsible for offering specialist health care services for PLWHA.

An earmarked budget is allocated to the follow-up of preventive activities through the national HIV strategy. There has been a slight increase in the budget for HIV prevention in the period 2008-2009. There are no additional earmarked financial schemes covering HIV preventive activities specifically at a national level.

The Communicable Disease Control Act is an important act in relation to HIV preventive work. Its purpose is to protect the population from communicable diseases by preventing their occurrence and hindering them from spreading through the population. The Act highlights the responsibility of the health authorities and other authorities in implementing measures necessary to control communicable diseases. In addition, it underlines the legal rights of individuals related to receiving adequate information, counselling, testing and treatment for communicable diseases. Since the provisions of the Communicable Diseases Control Act apply to every person residing in Norway, it is an important act in relation to securing undocumented migrants the right to health services. All consultations, including testing, counselling and treatment for communicable diseases listed in the law (including HIV) are free of charge.

3.1.1 Gender perspective

Different strategic plans on HIV prevention and care have underlined that gender inequalities are a key driver of the HIV epidemic. The focus on gender inequalities and HIV has until recently mainly been on MSM and their vulnerability related to e.g. minority status, gender norms and adequate access to health services. However, during the past ten years there has been an increased focus on women as heterosexual practice now causes more new HIV cases than in the early phases of the epidemic and more women are living with HIV in Norway. In addition, there are more immigrants living in Norway, many of whom score low on a number of living condition variables and face greater barriers to health services which may indicate the likelihood of poor sexual health (education, economy, sexual autonomy). This is especially relevant for many women coming from areas that have a high prevalence of HIV.

Preventive strategies and follow-up measures must have a clear gender perspective that particularly takes into consideration that many women are highly at-risk of contracting HIV. Among other things, this may involve a lack of sexual autonomy, a lack of self-determination with regard to the use of contraceptives, biological factors and their personal economic situation. Thus organisations receiving public grants are required to take the gender perspective into account in their applications and project descriptions. Applications from NGOs focusing on women and MSM have been prioritised in 2008-2009.

3.1.2 General Civil Penal Code (the Penal Code)

Section 155 of the Penal Code has the purpose of protecting the society against the spread of communicable diseases that are hazardous to public health (ref The Communicable Disease Control Act³). This provision imposes penalties on those who have reason to believe that they are infected with a communicable disease that is hazardous to public health and who wilfully or negligently transmit that infection or expose someone else to the risk of becoming infected. The maximum penalty is up to 6 years imprisonment for a wilful violation and 3 years for a negligent violation.

The current penal regulations have been subject to considerable debate the past years. As of today, it is only cases of HIV transmission and exposure which has been prosecuted under this section of the Penal Code. Many argue that the penal code has potential adverse consequences on the impact on the uptake of HIV testing and access to HIV prevention, treatment and care services. This is in line with UNAIDS who argue that "...there is no evidence demonstrating that broad application of the criminal law to HIV transmission achieves either criminal justice or prevents further infections" (www.unaids.org).

The National HIV strategy underlines that there is a need for more research-based knowledge of a criminological and medical nature. Basic knowledge about unintended effects of current regulations, including the extent to which current regulations discriminate against HIV-positive persons and/or have a negative effect on the individual's behaviour, protective strategies and willingness to be tested, needs to be improved. In addition, current knowledge about the risk of transmission of infection from unprotected sex with an HIV positive person with a low viral load is limited. It is up to the court to assess how great the risk must be in order for the offence to come under the General Civil Penal Code. Criminal liability is not incurred if there is appropriate use of condoms. Thus, the degree of risk of transmission of infection through unprotected sex is not only a general health issue, but also a matter of importance for the assessment of whether the matter will lie within or outside of the lower limit of criminal liability for risk.

In 2010, The Ministry of Health and Care Services will in collaboration with the Ministry of Foreign Affairs and Ministry of Justice, appoint an expert group to;

- strengthen knowledge of unprecedented effects of today's court practice;
- and systemize existing and highlight any gaps in evidence based knowledge on risk for HIV transmission for persons under effective treatment.

The work will be seen in relation to UNAIDS' work on the issue.

³ Which diseases are defines as communicable, may alter over time, depending, for example, on the treatment possibilities for various diseases and the possibilities of preventing the transmission of infection.

3.2.1 b Comments to Section 155 of the Penal Code from civil society

HIV Manifesto Group Norway (Hiv Manifest Gruppen)

HIV Manifesto Group was established three years ago by a group of Norwegian HIV positive people who wishes to contribute to a better quality of life for people diagnosed with HIV in Norway and globally. Our first focus issue has been the criminalization of HIV. We believe this practice in a harmful manner strengthens the prejudices many people affected by this medical diagnosis experience, nationally and globally.

In this report we describe our thoughts and ideas on what Norway should do to create better and more worthy conditions for HIV positive people, and to strengthen efficient prevention efforts.

Criminalization of sexuality - a dangerous path

Prosecution of consensual sexual activity between adults takes place in Norway today. The Penal Code § 155 is used to prosecute HIV positive people who exposes another person to any kind of risk of infection. This paragraph also lays the ground for prosecuting other forms of consensual sexual activity between adults. This practice is strongly criticized by many leading figures in the fields of medicine, law and human rights.

In March 2004 the Netherlands evaluated its criminal practice in relation to HIV, after several cases of conviction of HIV positive people. They established a commission consisting of leading figures from various professional groups such as lawyers, judges, physicians, nurses, philosophers and social workers, and produced a very thorough evaluation report, "Detention or prevention" A report on the impact of the use of criminal law on public health and the position of people living with HIV. (1) The Commission concluded that this was a practice with heavier negative than positive consequences. A main argument to stop the practice was that this practice opened up for a general prosecution and criminalization of consensual sexuality between adults, a fact they highlighted as very dangerous for the society.

Also England have moved away from criminalization of HIV: In 2006, various British organizations, police and doctors came together, and called for an updated assessment of the legislation in this area from the CPS - the British Crown Prosecution Service. This was recently completed and published. CPS now places more stringent requirements for prosecution to take place. Among the highlights are the following: - Scientific evidence has reported that actual transmitted HIV infection, is a prerequisite for criminal prosecution. - The accused must have been aware of his or hers HIV status at the time of infection. - Consistent condom use is a defence against guilt. Terrence Higgins Trust and NAT (National Aids Trust) has made the following joint statement: "The new guidelines from the CPS goes a long way to remove ambiguities, confusion, and clarify where people with HIV and other sexually transmitted diseases stand in relation to the legislation. The level of evidence that will be required, suggest that there will be less focus on criminal prosecution in the future ". (2)

Equality before the law

In Norway, the Norwegian politician and member of Parliament, Olav Gunnar Ballo, from the Parliament's rostrum stated that he is surprised that nobody so far has been convicted in Norway in connection with other sexually transmitted diseases than HIV, such as clamydia and Hepatitis B. These are, like HIV, classified as general dangerous diseases, and may have serious health consequences such as infertility, liver damage and increased risk of cancer. At the same time HIV is classified by an increasing number of infectious medicals today as a chronic disorder, with virtually normal life expectancy (in countries with access to treatment).

We call for removal - not changing – of the law

The HIV Manifesto Group began its work two years ago, and has contributed to put the issue of criminalization and HIV on the agenda of the media, and to increase the focus on the matter on the political agenda. We think the paragraph represents the heaviest psychosocial burden for Norwegian HIV positive people today, and that it is important for this paragraph to be removed. We believe that sexuality among informed adults should be free of law-regulation, and that adults should be responsible for their own sexuality - and their own protection. We are not opposed to people with HIV, or other serious sexual disease, exercising an imprudent/reprehensible behaviour being corrected, from the health sector, with advice, information, therapy, etc. In particularly serious cases of deliberate infection, we also agree that the Penal Code addressing bodily harm can be used for prosecutions. As they have done in the Netherlands in recent years, after the report mentioned above led to a modified law-practice.

Strong opposition to Norway's law-practice

Among people that support our view is Norway nector in HIV, Professor Stig G. Frøland, the South African Supreme Court judge Edwin Cameron, former judge at The International Court of Justice in The Hague, Gro Hillestad Thune, and Member of Parliament Anette Trettebergstuen. In addition, our manifesto, where the removal of § 155 is the main focus, has been endorsed by a number of important Norwegian and international persons and organisations. (3).

During the past year also the Norwegian Infectious Medical Association and the Norwegian Church Council has asked the Norwegian Justice Committee to abolish this law.

Norway's export of stigma

Norwegian legislation in this area means that other countries in the Third World, may launch its laws and refer to the practice of "humanitarian giants" like Norway (and Sweden). The South African Supreme Court judge and HIV activist Edwin Cameron recently had a full-page article "Norway's exports of stigma" in print, in one of the leading Norwegian newspapers, Dagbladet. In this chronicle he strongly criticized the Norwegian government for this legislation, and practice, and tells about the devastating consequences this has on his home continent Africa. (4)

What we think is the best strategy for Norway on these matters in future:

A virus - not a crime

§ 155, and the suggested revision, must be abolished. Health service actors must be strengthened, to help create better psychosocial health for the minority of HIV positive people who need it. Health service must be given the resources to prepare updated and efficient guidelines for this work, and to implement it in practice.

Better information in the population

An evaluation report from the Norwegian research institute FAFO was recently published, where it was made clear that knowledge about HIV in the general Norwegian population is low. The knowledge in the population should be increased. This will result in a reduction of prejudice towards HIV-positive people. Less prejudice will again lead to increased transparency, lower threshold for testing, and fewer undiagnosed HIV positive people, who are estimated to account for a significant part of new infections. The general population should be better informed, by various measures, such as campaigns, articles in the media, programs on television etc. The information should inform about what it means to live with HIV today, and how it can be spread, and how it not can be spread (many still do not know this, a fact that creates unnecessary fear, quite a few people still believe a HIV positive person can transmit the virus through sharing a glass etc).

Better information for specific risk groups

In the risk group men who have sex with men, we believe the level of knowledge is good. Here the authorities have for years supported information work, and knowledge about HIV, and the need for protection against HIV and other STDs is good. But, after the practice of criminalizing was initiated a few years ago, the infection numbers of HIV have been increasing, and there are reports of widespread zero-sorting. This means that people are no longer so focused on protecting themselves, but rather chooses to evaluate a possible partner, to see whether he looks healthy or not. A dangerous development. The Dutch report mentioned above, warns strongly against weakening the individual's motivation and responsibility to protect themselves against HIV and other STDs.

Among immigrants, the other major risk-group in Norway, there should be more and better information. There should be people with ethnic backgrounds from the most vulnerable population groups to participate in the preparation of information material, so that it is adjusted to fit their cultural background.

Better information about sexuality for people living with HIV

In addition, we believe HIV positive people should receive thorough information about sexuality and their new situation, after one has been diagnosed with HIV. This works poorly today, and gets still worse with the threat of criminalization. Many now refrain from talking to health professionals about their sex life. It should be produced updated in-depth information material that addresses various aspects of HIV and sexuality. In addition, health professionals should be trained specifically in addressing these matters with HIV positive patients, without moral focus, but based on factual information and ethics. Thus, HIV-positive in need of it, may become strengthened in their sexual confidence, and experience a elevated ethical awareness.

Norway's humanitarian obligations

People living with HIV in Norway often report about discriminatory experiences, from employers, health professionals, dentists etc. This comes in addition to feelings of prejudice and ignorance in the general population towards people with this medical diagnosis. Much remains to protect the human rights of people living with HIV, and those most affected by the disease.

We wish that Norway in the future will live up to its ambitions to be a humanitarian superpower, and in its protection of human rights, also includes sexual rights (5). We expect that the ongoing evaluation in Norway and UNAIDS, on the consequences of criminalization of HIV, will result in that we will follow UN guidelines, and abolish the idea of punishment as a preventive agent towards STDs and HIV. The link between HIV + and criminal conduct is cementing the prejudices which far too long has been attach to this medical diagnosis, hampers the fight against stigma and damages prevention efforts, which rely on a a good relation to the health care system, and willingness to testing.

Norway's global humanitarian efforts

In addition, we believe Norway should participate stronger on the field, as a supplier of solutions of high ethical standards globally. Norway can not expect credibility in this area, at the same time that the United Nations and UNAIDS criticize our law practice and labels it harmful. On the international HIV and Aids conference in Mexico in 2008, criminalization was a main topic, and from several quarters it was commented upon that the Scandinavian countries, surprisingly, had some of the strictest (and most discriminatory) laws in the field.

Information in the media

We believe there should be information packets prepared and distributed to key people within the media. During the HIV epidemic's history, the media has predominantly angled cases of speculative and sensational purposes, from Oprah Winfrey who predicted that 1 in 3 Americans would die within a few years, to the Norwegian newspapers bulletins about "The dangerous HIV man" etc in war types. Media has a great responsibility for the stigma that has become attached to this diagnosis, and the suffering it causes for all people who are affected and their close ones. We believe that accurate information can put an effective stop to further speculative approaches.

Our goal

Many HIV positive people state that the social burden of their diagnosis is heavier than the medical burden. In addition, criminalization and prejudice are hindrances for openness and anti-stigma-efforts. Stigma and secrecy in turn hampers prevention efforts. Our goal is that HIV is considered purely as a medical diagnosis, which comes without social prejudice. Both in Norway and globally.

Notes

- (1) http://www.aidsactioneurope.org/uploads/tx_windpublications/574-0.pdf
- (2) <http://www.tht.org.uk/binarylibrary/cpsupdateiii.pdf>
- (3) <http://solutio.no/HivManifestoEng.html>
- (4) http://www.poz.com/articles/cameron_norway_hiv_criminalization_401_16670.shtml
- (5) <http://www.ippf.org/en/Resources/Statements/Sexual+rights+an+IPPF+declaration.htm>

HIVNorway

As the advocacy organisation of PLWHA in Norway HivNorway has lobbied for several years for a change of section 155 of the penal code. The purpose of this section is to protect the society against HIV and other diseases. For several years we have maintained that this section of the penal code is not working according to its intention.

HivNorway is also concerned because we can state that this section of the penal code is used more frequently today than ever before. Through the court rulings we have also learned that judges and lawyers are no different to the rest of our society, they have the same limited knowledge of HIV; how it is and how it is not transmitted and what it is like living with HIV in Norway today.

HivNorway is concerned because we see that the judges, in their rulings, interpret “risk of HIV transmission” in the strictest way possible. They consider HIV to be such a hazardous diagnosis that in fact their rulings say that almost any exposure of risk should be criminalized.

The latest conviction in Norway stated that also unprotected oral sex, including sex without the active part taking the sperm in his or her mouth, can be a criminal offence according to section 155.

HivNorway has already stated that there is a need for knowledge about how this section works. We have asked the government to build up an expert group consisting of lawyers, criminologist, doctors and sociologists. The expert group should be mandated to see whether this section fulfils its purpose.

3.1.2 Youth

Main strategic moves 2008-2009:

- Further develop age and gender-specific methods for improving sexual autonomy and for training in behavioural skills in sexual situations
- Initiate new, knowledge-based methods for spreading information about HIV and safer sex in various communication channels.
- Further develop and integrate (knowledge-based) information about sexual health that also includes HIV.
- Easy access to condoms and lubricants

Comprehensive scientifically based sexuality education in schools grounded in human rights and values of respect, is an important element in preparing young people for managing their sexual life and in preventing sexual violence and abuse. Sexuality education in school is compulsory in Norway and starts in the fourth grade. Nordic studies and summaries of knowledge show that knowledge, communication and skills training about sexuality are not comprehensive and targeted in dealing with the aspects of sexuality that are most difficult to deal with and those related to sexual enjoyment. Only the targeted, comprehensive programmes have proven to be effective. The studies particularly emphasise that the teaching and training in schools is not very skills-oriented and that important topics are

introduced too late, way past the developmental stage when children and youth need it. The studies also show that the instruction is still not sufficiently aimed at including gender and minority perspectives. Reaching minority groups may have the greatest effect in levelling out social health differences that could have important impact on sexual practices.

In 2006, a comprehensive curriculum reform (the Knowledge Promotion Reform) was introduced in primary, lower secondary and upper secondary education and training. The reform places increased focus on basic skills and knowledge promotion through outcome-based learning. Based on this reform and a survey conducted in 2008 in Trondheim among high school teachers⁴, the Ministry of Education and Research and the Directorate for education and training developed new resource material for teachers in 2009 to be used in sexuality education in primary and secondary school. The new material is a capacity building tool giving guidance on how sexuality can be taught in different classes and in relation to different topics and themes. The document is particularly focusing on ensuring the sexual minority perspective in all education related to sexuality.

In addition to securing youth a comprehensive fundament of theoretical knowledge, one main challenge is to give adolescents and young adults good training in putting this theoretical knowledge into practice. Experience shows that teenagers prefer that the medical part of sexuality education is given by healthcare personnel rather than the teacher. Thus the counselling, education and information services run by local youth healthcare services play an important role in addressing sexual health among youth.

The number of school health services has been constant in the period 2008-2009 with one in every municipality (430 in total ranging in size from 216 (Utsira) to 585 000 inhabitants (Oslo)). Number of full-time equivalent in the youth health care services rose slightly from 2007 (3421) to 2008 (3480) while the municipalities' expenditures for prevention and local youth health services increased by 190 million NOK from 2007-2008⁵. However, this increase can mainly be attributed to salary increase. Data from 2008, show that 3 out of 4 municipalities are offering low threshold youth health services (14-20 years) 2 hours a week. This number has been constant the past three years. It is primarily the smallest municipalities in Norway that do not offer this service.

Education, training and counselling are also run by a number of different NGOs. Many of their capacity building activities are carried out in school settings or on arenas for youth (youth clubs, festivals, sport activities etc.) Young people are encouraged to be directly involved in the preventive work, and local peer educational groups have been established by the local youth health services and NGOs in many places. In 2009, Aksept (City Church Mission) organized a young leadership program for young PLWHA in collaboration with Hope's Voice International. The work on young leadership will be continued by Aksept in 2010.

In 2005, the Norwegian Directorate for health and the Student Welfare Associations established health services for students (age group 20-24 years) at 7 different universities and university colleges in Norway. The services aim to ease the access to contraception, testing and counselling for students in the age group 20-24 years. This age group is particularly vulnerable because it is a very mobile population group who often has their designated general practitioners in the municipality of origin, while the access to health

⁴ The study was conducted among 4000 teachers (response rate 50%) in lower secondary school in Trondheim. The study showed that sexuality education is primarily given in relation to natural science. The majority of respondents estimate the volume of teaching to be approximately one day per year. The study showed that the teaching has many weaknesses, e.g. it is primarily hetero normative and pays little attention to gender aspects.

⁵ Total expenditure 2007: 1 764 440 000 NOK and 2008: 1 953 533 000

services where they study is limited. In 2008 and 2009 the number of student health services increased to 20. Estimates from 2007, showed that approximately 10 % of the students used the services. The users were mainly women. There is still limited access to student health services.

Surveys show that youth and adolescents in the age group 15-25 years seem to profit from health information given on the Internet and through telephone services and sms. These channels are particularly used by boys and young men. Thus regular health services for youth and adolescents need to be supplemented by Internet, telephone and sms services. Norway has a Internet based public youth health clinic www.klara.klok.no and www.ungohelse.no giving advice to youth on issues related to mental health, sexual health, violence and abuse, nutrition etc. From 2007 to 2008 the number of unique visitors increased from 531 022 to 584 986. In 2009 the number was 816 733. The total number of visitors increased from 1 001 071 in 2007 to 1 471 876 in 2009. In addition, the national telephone and sms service for youth (SUSS) had 22 000 inquiries in 2008. About 40% of the inquiries were related to unwanted pregnancies, abortion and STIs. The number of boys using the telephone and sms services is increasing.

3.1.2 b Comments on sexual education in schools from civil society

HIVNorway

The feedback HivNorway receives from our members and partners, and the report from Fafo (Fafo-report 2008:21), make us question the truth of the statement in the report that “*sexual education in schools starts in the fourth grade*. We know that HIV is not a subject that is easily discussed. It is a matter of chance if HIV even is mentioned at all during sexual education in schools. HivNorway has received reports from teachers that the quality of the information on HIV/AIDS in the sex education material is so deficient, that the teachers must obtain this information elsewhere.

3.1.3 Men having sex with men

Main prioritized strategic moves 2008-2009:

- Develop and make use of new, active interventions that address the connection between received information and behaviour, with the aim of changing risky behaviour among MSM.
- Increase the awareness of double discrimination issues among MSM along with links between high consumption of intoxicating substances and the risk of HIV infection.
- Easy access to condoms and lubricants.
- Increase the test frequency among MSM.
- Spread knowledge about the importance of early testing to at-risk groups in the population.
- Ensure good access to testing and counselling for groups that find the health systems relatively inaccessible or poorly adapted to their personal situation.

In the period 2008 and 2009, strategic preventive efforts with regard to sexually at-risk groups have been conducted under the direction of both the action plan for the prevention of unwanted pregnancies and abortions, the national HIV strategy (2002-2009 and 2009-2014) and the action plan for better life quality for lesbian, homosexuals, bisexuals and

transpersons (2009-2012).

Norway has a long tradition of collaborating closely with NGOs in developing and implementing HIV preventive strategies and measures. Both municipal health services and NGOs (particularly Gay & Lesbian Health Norway and the Norwegian LGBT association) have played important roles in the implementation of national and local HIV preventive initiatives targeted MSM.

Norway has not completed surveys on exposure/use of key prevention services among MSM. It is therefore difficult to assess to what extent the target group is reached by prevention programmes. However, given the increased incidence of HIV, syphilis, and gonorrhoea the past years in MSM group, MSM continues to be a great priority for the national HIV preventive work. A number of preventive measures have been pursued from the previous reporting period. These include extensive distribution of condoms, lubricants and information (on safer sex/HIV) on the Internet, in various bars, saunas and sex on premises venues (SOPV) for MSM, and capacity building workshops on e.g. living with HIV, safer sex, sexuality, negotiation and drugs.

However, increased incidence of HIV and STIs among MSM underline that today's preventive efforts have not been adequate in meeting the needs of sexually at-risk minority groups. Among MSM, information campaigns about safer sex and the use of condoms have been kept at a steady intensive level for many years, and the level of knowledge about the modes of infection with HIV has traditionally been high. Given that the median age for newly diagnosed MSM is 36 years, there is reason to believe that the assumption about information overload in MSM circles is serious since this group in particular has been a target group for HIV/AIDS information for many years. Knowledge alone is indeed important, but of limited value if it is not supplemented with other policy instruments. Knowledge needs to be addressed in combination with capacity building in e.g. negotiation and alcohol and drug use.

To address these challenges, a number of different interactive communication methods and networks for addressing LGBT issues such as living with HIV, risky sexual behaviour (and drugs), knowledge on HIV/STIs have been developed in the period;

- Homopositiv – network by and for MSM living with HIV, established in 2009. Organizing capacity building workshop and social gatherings.
- Hivmanifestgruppen – network of HIV positive MSM activists, established in 2009. Working for improving living conditions and rights for people living with HIV/AIDS.
- www.youchat.no/ (Gay & Lesbian Health Norway), peer-to-peer chat targeting young lesbian, homosexuals, bisexuals and transpersons.
- www.hvaskjernå.no (Gay & Lesbian Health Norway) website for information on health promotion and HIV prevention for MSM living with HIV. Anonymous chatting.
- www.besafebesexy.no (Gay & Lesbian Health Norway) test for assessing and communicating about attitudes and knowledge to HIV and STI testing, drugs and condoms.

Improving testing frequency in the MSM population has been a major priority. To address challenges related to existing barriers for proper accessibility of counselling and testing for MSM, low-threshold health clinics for MSM have been established in Oslo. However, even though these health services prove to be an important supplement to ordinary health services, improved knowledge of LGBT issues and sexual health in the ordinary health services has been a main concern. In 2009, The Norwegian Public Health Institute has developed guidelines for healthcare personnel e.g. MSM and STIs. In addition Norwegian LGBT Association has developed a capacity building tool (Rosa kompetanse) in collaboration with medical associations, for improving knowledge, focus and competence on LGBT issues among health professionals.

3.1.3 Sex workers

Main strategic moves 2008-2009:

- Easy access to condoms and lubricants.
- Prevent unintended consequences of the criminalisation of the purchase of sex services.
- Intensify preventive measures aimed at persons travelling abroad.
- Spread knowledge about the importance of early testing to at-risk groups in the population.
- Ensure good access to testing and counselling for groups that find the health systems relatively inaccessible or poorly adapted to their personal situation.

The sex market in Norway is changing constantly, thus preventive measures targeting sex workers has to be dynamic and easily adaptable to changes in mobility patterns and target groups. In addition, the new law from January 2009 prohibiting purchase of sex has posed new challenges to HIV preventive work. Subsequent to the introduction of a ban, there was an increasing concern that the preventive efforts targeting sex workers will be weakened. Experience shows that it has become more difficult to have a good overview of and gain admittance to prostitution circles. In addition, it is reported that individual sex workers no longer want to carry condoms and lubricants out of fear that they will be used by the police as indicators of sale of sexual services. The support and health services for sex workers in Norway, describe increased vulnerability for sex workers. They argue that due to increased competition and greater stress on the market, sex workers are forced to offer clients e.g. unprotected sex. In addition, sex workers in escort services are forced to sell sex at the customer's arena, which makes them more vulnerable to violence and abuse. In general, before the ban, the low threshold services for sex workers reported high rates of condom use among sex workers. Based on experience, it is feared that this might change as a consequence of the new law.

Even though there are different approaches to working with women and men in prostitution⁶, most initiatives run by municipalities and NGOs both before and after the ban, use health as an entry point. Easy access to condoms and lube, syringes and needles and low-threshold health services for sex workers for testing, counselling and treatment for HIV and sexually transmitted infections have been a priority in the period 2008-2009. Out-reach work has been strengthened in all the major cities (Oslo, Trondheim, Kristiansand, Stavanger, Haugesund, Bergen and Tromsø) targeting both street market and in door market.

Women have primarily been the target group for measures for sex workers. In 2009 the scope of male prostitution received increased attention. It is believed that male prostitution (men selling sex to both men and women) is fairly widespread. As male sex workers seem to work more individually and use other channels and arenas for selling sex than women, they are more difficult to reach with the established measures and services for sex workers. However, a few NGOs and municipalities are running projects targeting men selling sex, but there is limited systematic knowledge about the arenas and effective preventive measures targeting male sex workers.

⁶ Approaches to prostitution can be divided into two main trends depending on ideology. 1) Zero tolerance for sex work or a view of sex work as demeaning and damaging, with the aim of helping women and men leave prostitution (2) A harm reduction perspective with the aim of providing support for women and men involved in prostitution, reducing damaging effects and ensuring the rights of persons working in prostitution.

3.1.4 *Injecting drug users*

Main strategic moves 2008-2009

- Continue harm-reducing measures for substance abusers, e.g. low threshold health care, needle rooms
- Ensure that injecting substance abusers are offered an HIV test during detoxification and in treatment institutions.
- Evaluate recommendations concerning harm-reducing measures for inmates in prisons after a broad round of consultation in the health and justice sectors.
- Easy access to condoms and lubricants

IDUs are highly at risk for HIV, and in many countries they are the largest social group living with HIV. The mean annual HIV-incidence in this group in Norway during the last ten years has remained around ten to fifteen new infections. There is good reason to believe that targeted preventive efforts have contributed in keeping the epidemic under control. The most important measures include access to clean syringes/needles/other user equipment and access to medically assisted treatment (MAT).

IDU may experience barriers to ordinary health services for testing and counselling. Thus, low threshold health services for this group is an important priority area to reduce different health damages caused by drug addiction, improve health and care services for injecting drug users and access to MAT. In 2009, 52 municipalities had low threshold health services for drug users. The number has increased over the last few years.

A comprehensive evaluation of low threshold health services was carried out in 2007. The overriding goal was to answer the question of whether the services contribute to establishing an adequate service for substance users, mostly hardcore IDUs who do not use or are not reached by the ordinary health services. In the evaluation report it is stated that, in general, the services appear to succeed in providing good help for 80 per cent of the users, while 20 per cent still do not get sufficient help for various reasons. Although preventive efforts to reduce the spread of infectious diseases are a priority in these services, the effect of these efforts has not been measured.

Access to sterile user equipment is legal in Norway and needle exchange services were established in 1988. Free syringes, sterile equipment and condoms are mainly distributed through low threshold health services. In 2007, more than 2, 5 million syringes were distributed only in Oslo. In municipalities where low threshold services are not available, syringes are available through pharmacies (not free of charge).

MAT can undoubtedly be argued to be an important factor in the efforts to prevent infectious diseases and overdoses. It is assumed that the design of and participation in the Norwegian MAT programme contribute to reducing the annual number of overdose deaths and spread on communicable diseases to a considerable extent. The number of patients in MAT is steadily increasing. The programme which started in 1998 included 5383 patients by the end of 2009, mostly IDUs, compared to 2,500 in 2007. The annual retention remains high.

According to the National Guidelines for Substitution Therapy, patients admitted to MAT programs should be offered VCT and treatment for HIV. MAT will increase a HIV positive patient's compliance to HIV treatment, thus simultaneousness in MAT and HIV treatment may be a prerequisite for effective treatment of HIV and drug addiction. The new guidelines for treatment of HIV positive patients developed by the Norwegian association for infectious

diseases in 2009, do not address IDUs and MAT specifically. However, in practice IDUs testing positive for HIV are referred to MAT services for substitution therapy.

Oslo is the only municipality that has made use of the trial scheme for injection rooms⁷. The target group for the injection room scheme is «hardcore heroin users older than 18 years». The aims of the trial scheme are, in numerical order:

1. To assess the effect of freedom from prosecution for the possession and use of drugs in a limited area.
2. To contribute to more dignity for hardcore drug addicts.
3. To provide a better opportunity for contact and dialogue between drug users and the help services.
4. To contribute to preventing infections and the spread of infections.
5. To reduce the number of overdoses and overdose deaths.

On assignment for the Ministry of Health and Care Services, the Norwegian Institute for Alcohol and Drug Research has evaluated the trial scheme in Oslo in its first two years of operation, February 2005 - February 2007. The report (2008) concluded that there is a limited basis on which to conclude whether the injection room scheme has contributed to preventing infections and the spread of infections. However, the users have to comply with clear hygiene rules. They are also given concrete advice about how they can inject in ways that cause as little harm as possible with respect to sores and abscesses. They are given guidance on injecting in 13 % of the total number of injections, and 81 % of the users have received such guidance on one or more occasions. It must be assumed that the users take some of these «lessons» with them when they inject drugs elsewhere. Users also state that they have become generally more aware of hygiene when they inject.

3.1.5 Drugs in prison

Starting in 1997, a scheme was introduced for the prevention of communicable diseases where inmates were given access to disinfectants such as chlorine and/or chloramine so as to be able to clean used needles and needle tips. International experience from a number of European countries that have given inmates access to sterile needles and needle tips indicates that this is a measure that prevents the transmission of infection via blood in prison. Experience also shows that access to needles and needle tips has not resulted in an increase in use of intoxicating substances among IDUs, disciplinary problems or in the use of needles and needle tips as weapons. In 2009, the Norwegian Directorate of Health studied this matter on assignment from the Ministry of Health and Care Services and concluded by recommending the implementation of a scheme in the prisons that at least includes the exchange of used needles and needle tips. The Ministry of Health and Care Services has sent out the study for a broad round of consultation in the health and justice sectors.

⁷ The City of Oslo opened an injection room on 1 February 2005 after the Storting (=parliament) had passed a temporary act relating to a trial scheme for injection rooms. Oslo is the only municipality that made use of the trial scheme. The temporary act was originally intended to apply until December 2007, but it was subsequently prolonged by two years. The Act was made permanent in 2009.

1.3.7 Immigrants⁸

- Main strategic moves 2008-2009:
- Improve the communication of information to and the coping strategies for especially at-risk immigrant groups.
- Urge religious communities and voluntary organisations to conduct preventive work in the immigrant population as well.
- Spread knowledge about the importance of early testing to at-risk groups in the population
- Easy access to condoms and lubricants
- Help counteract social exclusion mechanisms that work against HIV positive persons in minority communities.
- Ensure good access to testing and counselling for groups that find the health systems relatively inaccessible or poorly adapted to their personal situation.
- Ensure necessary assistance in the prevention of communicable diseases for persons without a legal residence permit.

One third of HIV positive persons in Norway at present were infected before their arrival in Norway, and about half of these persons are women. Among certain groups of immigrants from countries with high prevalence of HIV, the risk of infection within in the group living in Norway may be almost as great as the risk in the country of origin. This relates to the fact many immigrants score very low on a number of living condition variables that indicate the likelihood of poor sexual health (e.g. level of education, degree of self-determination over one's own life and sexuality).

Reaching immigrants with effective HIV preventive measures is a great challenge. The Norwegian government has to a large extent failed in implementing effective HIV preventive initiatives in immigrant population in the period 2008-2009. There are many reasons for this. There are few collaborating partners such as NGOs and networks that work specifically with HIV prevention and living conditions for HIV-positive immigrants in Norway. Insufficient access for immigrants to adequate health services is another. This is especially relevant for undocumented migrants.

For refugees and asylum seekers, it is the health service in the transit centres for refugees that is supposed to offer voluntary HIV testing and counselling and information about HIV and STIs. In 2003, the Norwegian Board of Health carried out countrywide supervision of health services for newly-arrived asylum seekers, refugees and people reunited with their families⁹, showing major shortcomings in routines for testing and other follow-up were discovered in some centres. In addition, the Fafo Institute for Labour and Social Research study of living conditions from 2009, showed that about one out of three respondents with

⁸ According to Statistics Norway, (http://www.ssb.no/innvandring_en/main.shtml) the immigrant population (immigrants and those born in Norway to two immigrant parents) consists of people from 213 different countries and independent regions, and constitute pr 1st of January 2008 nearly 460 000 persons, or 9,7% of the total population in Norway. About 203 000 persons have European background (52 000 from countries outside EU/EEA), 174 000 persons have a background from Asia, 56 000 from Africa, 16 000 from Latin-America and 9000 from North America and Oceania. Of these are 381 000 persons born abroad. 79 000 are descendents, born in Norway.

⁹ 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.

immigrant background did not feel that the HIV test upon arrival was voluntary and a relatively large number said that HIV/AIDS was not something that was discussed at the reception centre for asylum seekers.

Even though there are many areas of improvement, a number of preventive measures have been implemented in the period. Some of these have particularly tried to address the lack of knowledge of follow-up in the health services in the transit centres. Aksept – the centre for everyone affected by HIV, which is run by the Church City Mission in Oslo, has 25 years of experience offering psychosocial follow-up of individuals and families living with HIV. In recent years, they have gained experience and developed methodologies relating to African groups. In 2009, the centre has developed a trainee program with the aim of ensuring that the experiences and methods can be transferred to and adapted in municipalities and especially in the municipal health services throughout the country.

HIV positive persons with an immigrant background, both men and women, report that it is difficult to be openly HIV positive in their own group. In 2008-2009, HIVNorway (NGO primarily working for securing rights and interests for PLWHA), Aksept and the Centre for Social Medicine in Norway (municipal low threshold health service in Tromsø) reported an increase in immigrants living with HIV seeking their help and support. A number of capacity building seminars targeting particularly women (HIV positive and negative) have been organized by HIVNorway and Primary Health care Workshop (The Church City Mission).

3.1.7 b Comments from civil society on immigrants

Aksept (City Church Mission)

Public policy and Migrants

Migrants have through Aksept been involved in public policy dialogue towards national authorities. As to local and regional authorities no data is available on how migrants have been involved in policy development.

Advocacy

Aksept has been advocating for harm reduction for asylum seekers and HIV positive Dublin Case deportees. There is a lack of initiatives in relation to advocacy for HIV positive migrants on national level, especially regarding legal support and in relation to resident permits.

Legislation

A lot needs to be done to change §155 in the Norwegian penal code with the aim of combating stigma and discrimination which obviously effects migrants.

3.2 Treatment, care and support

Main strategic moves 2008-2009:

- Develop and implement guidelines and instructions for good practices in the treatment of HIV infection.
- Improve the integration and teamwork between the treatment of infectious diseases and services for mental health and substance abuse.
- Develop a comprehensive training programme for living with HIV under the direction of the Centres for Learning and Coping.
- Develop methods that ensure a good transfer of empirical knowledge and methodologies for the psychosocial follow-up of HIV-positive persons.

The Norwegian Health Care System

The Norwegian health care system is organized on three levels, i.e. national, regional and local levels. Overall responsibility for the health care sector rests at the national level, with the Ministry of Health and Care Services. The regional level is represented by four regional health authorities, which have responsibility for specialist health care; and the local level represented by 430 municipalities has responsibility for primary health care.

The aim of primary care is to improve the general health of the population and to treat diseases and deal with health problems that do not require hospitalization. Each municipality has to decide how best to serve its population with primary care. Primary care is mainly publicly provided. Much of the spending in the municipalities is directed towards nursing, somatic health care and mental health care. Regular general practitioners (GPs) are in practice self-employed, but financed by the National Insurance Scheme, the municipalities and by the patient's out-of-pocket payments. Primary health services are financed through grants from the national government, local tax revenues, reimbursements from the National Social Security System and through out-of-pocket payments. Services of the pre- and antenatal clinics, youth clinics, school clinics, and all consultations for children under 12 years of age are free.

Specialist health care services include hospitals for patients with somatic or psychiatric/psychological disorders, out-patients departments, centers for training and rehabilitation, institutions for drug addicts, centres for re-education for chronically ill patients and disabled, pre-hospital services and private specialists, laboratories and x-ray facilities. Four regional health enterprises, owned by the state, administer the services (mostly hospitals) within each region. In 2007, there were 84 public hospitals in Norway.

The Norwegian health system is a tax-based system covering all inhabitants. Norway has one of the largest shares of public financing of health services per capita in the world. In 2006, the Norwegian per capita total health expenditure of USD 4,520 (adjusted for purchasing power parity) ranked second among the OECD countries (OECD Health Data 2008). In 2007, the total health expenditure, public and private, was 203 billion Norwegian kroner. The largest part of public health expenditure is incurred by the curative care provided in hospitals. At the local level, more than 80 percent of public health expenditure is related to care services. In 2006, only 2,7 percent of the total health expenditure was spent on prevention (including administration).

The Norwegian Institute of Public Health estimates that around 3 500 people are living with HIV in Norway today. 300-500 of these are unaware of their infection. Ensuring that people living with HIV in Norway feel that they have good living conditions, including good and well-adapted services, opportunities for openness and fellowship and freedom from fear of discrimination and social exclusion, is a right for the individual and a crucial preventive strategy for avoiding the spread of HIV.

Medical treatment and the follow up of HIV positive patients are an integrated part of the ordinary specialist and primary health care services and free of charge for the patient. Many patients with HIV get their primary medical follow-up in the specialist health service. The complexity of the treatment regimes, including interactions among the medicines and the development of resistance, means that the specialist health service has overriding responsibility to ensure the maximum effectiveness of the treatment.

However, it is important to have a good collaboration between the specialist health service and the regular GPs so that the benefits of the treatment shall be maintained. Patients with HIV also have a need for good, accessible health services at the municipal level for complaints and disorders that are not necessarily related to the HIV infection. More recent research indicates that HIV patients may have an increased risk of certain illnesses, such as diabetes, cardiovascular disease, high blood pressure and depression. These are conditions that the regular GP should take a lead in the follow-up.

It is reason to believe that most HIV positive patients receive adequate follow-up in relation to treatment in specialist health care. This has partly to do with the fact that a limited number of health trusts are following-up a majority of the HIV positive patients, thus securing a high level of knowledge and experience dealing with different treatment regimes. However, it is reason to question to what extent the health services provide an adequate programme of regular, repetitive conversations about prevention of infection and training in how to live with a chronic infectious disease. The health trusts have a statutory obligation to see that all HIV positive patients and their relatives are offered such a training programme.

In 2009, the Norwegian association for infectious medicine developed new guidelines for treatment of HIV positive patients. The guideline is emphasising the importance of a thorough anamnesis covering (in addition to medical issues) sexual relations, use of drugs etc. It is also underlining the importance of establishing close collaboration with the patient's GP.

Several NGOs and civil society organizations¹⁰ are actively involved in HIV/AIDS support work. Their efforts are seen by the government as very important and a necessary supplement to the public services. In the period 2008-2009, the organizations' work covers counselling, buddy programs, self-help groups, social gatherings and networks and legal advisory services. Psychosocial support services were offered in Tromsø, Stavanger, Bergen, Oslo and Trondheim.

Securing sufficient capacity and knowledge about HIV/AIDS in primary and specialist health services (outside of departments of infectious diseases) is a challenge. In addition, lack of good routines for collaboration between primary and specialist health services poses an additional challenge to adequate follow-up of HIV positive patients. To address these issues, two conferences for health personnel and NGOs on improving the overall care for people living with HIV/AIDS, have been organized by the Norwegian Directorate of Health in collaboration with Gay & Lesbian Health Norway. Gay & Lesbian Health Norway has a special programme for training nurses in LGBT and HIV issues, while Aksept (City church Mission) organize training programmes for health professionals working in health services for asylum seekers and refugees. In 2009, the Norwegian Public Health Institute revised their guideline for health professionals on prevention of diseases, including separate chapters on MSM, IDUs, people travelling abroad and immigrants.

¹⁰ HivNorge, Aksept, City church Mission in Bergen, Stavanger and Trondheim, Gay & Lesbian Health Norway, Homopositiv and Hivmanifestgruppa.

In Norway, it is estimated that there are about 30-40 children and adolescents living with HIV. A case of mother-to-child transmission has not been confirmed in Norway for many years, and the children and adolescents to whom it applies were primarily infected before their arrival in Norway. There is little or no systematic knowledge about this group. Concern has been expressed about the extent to which children and adolescents with HIV and their nearest relatives receive adequate follow-up of the psychosocial aspects of living with HIV. As a consequence of this, Aksept (City Church Mission) is planning to establish a HIV educational program for young people living with HIV/AIDS (HIV school after model from Karolinska University Hospital in Stockholm, Sweden).

3.2 b Comments to treatment, care and support from civil society

HIVNorway

HivNorway does see a serious lack of knowledge of HIV/AIDS among a large number of General Practitioners. This means that GPs are uncertain of how to treat even the simplest question related to HIV. Consequently GPs refer the patients to the specialist health service. An increasing number of PLWHA makes it a challenge for the specialist health service to cope with the tasks of the GPs. In such a situation there is a serious risk that the patients have to bounce back and fourth between the specialist health services and the GPs. Such treatment of hivpositive patients HivNorway considers discriminatory and as a refusal of accepting responsibility (for the patients).

3.3 Knowledge and behaviour change

Ensuring a high level of knowledge of HIV and sexually transmitted infections in the population and implementation of gender-specific methods for improving sexual autonomy and for training in behavioural skills in sexual situations, are fundamental principles in the Norwegian sexual health strategies.

A high level of knowledge about HIV in the general population is crucial to preventing new infection, but also in order to reduce stigma and discrimination against people living with HIV/AIDS. One of the main means to achieve these goals is through the school system, where knowledge about sexuality, human body and health should be provided to all children and youth. In addition, both public services and civil society play an important role in implementing capacity building measures targeting specific vulnerable groups. The government has the responsibility of ensuring that health and care workers as well as employees in the employment and welfare services have the right knowledge and skills to address sexuality and HIV in a comprehensive and professional manner.

The nationally representative survey HIV in Norway: Knowledge and Attitudes, was conducted by Fafo Institute for Labour and Social Research in collaboration with the NGO HIVNorway in 2008. The baseline study showed that the general knowledge about how HIV infects is very good. The greatest lack of knowledge in the population is related to the ways in which HIV does not infect. There is a fairly significant percentage of the population who

think that HIV infects by kissing a HIV positive person and by drinking from the same glass as a person living with HIV/AIDS. A summary of the results is presented in the table below

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

Statement	Agree	Dis-agree	Do not know
You can be infected by HIV by having sex without a condom	98 %	1 %	2 %
You can be infected by HIV by kissing a HIV-positive person on the mouth	24 %	65 %	15 %
You can be infected by HIV by drinking from the same glass of water	13 %	75 %	12 %
Persons who are HIV infected are obligated to inform their employer and colleagues of their HIV status	60 %	35 %	5 %
Employees who are HIV-positive must accept that their employer changes their job tasks out of consideration for their colleagues	50 %	43 %	7 %
It is okay for HIV-positive persons to have parental responsibility	88 %	7 %	5 %
I would not let someone who is HIV-positive take care of my own children	34 %	58 %	8 %

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

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

There is a lower level of knowledge about the ways in which HIV does not infect. Twenty-four and thirteen per cent respectively answered that you can be infected by kissing or drinking

from the same glass as an HIV-positive person. In addition to a relatively large percentage who answered incorrectly, there were also many who answered "do not know", especially among the youngest respondents (ages 15-24).

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

In the study HIV in Norway: Knowledge and Attitudes, the family and job are used in particular as arenas for measuring the population's attitudes, and key indicators are parental responsibility, childcare and safety in the workplace. The study shows that 88 per cent of the respondents thought it was okay that HIV-positive persons have parental responsibility, but 34 per cent would not let a HIV-positive person mind their own child. Sixty per cent of the respondents thought that HIV-positive persons had to be obligated to inform their employer of their HIV status, and 50 per cent thought that HIV-positive persons had to accept altered job tasks out of consideration for their colleagues' safety. Eighteen per cent would have avoided contact with a colleague if they found out he/she was HIV-positive.

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

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

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

3.3.1 Youth

The sex life and behaviour patterns of youth have altered since the turn of the millennium. Youth are more satisfied with their sex life; they have sex earlier, more sex, more experimental sex and sex with more partners. This is a general trend in Norway and in the rest of Europe. However, altered sexual behaviour patterns create new risk areas that require good skills in relational and sexual situations. Youth encounter sexuality in new arenas – on the Internet, mobile phones and through increased travel. One risk of the new sexual behaviour patterns is infection with STIs through unprotected sex.

Since the beginning of the 1990ties, the self-reported median intercourse debut age for girls and boys has declined with nearly one year, and is now 16,3-16,5 for girls and 17,2 years for boys. There are big geographical variations in Norway related to intercourse debut age. In the northernmost provinces of Norway nearly 36 % of boys and 50 % of girls have their

intercourse debut age around 15 years of age. In Oslo (capital) these numbers are 23 % (boys) and 21 % (girls). Studies show no variations in intercourse debut age among ethnic Norwegian boys and ethnic minority boys regardless of religious affiliation. However, there are big variations among girls with different ethnic and religious background, e.g. among Muslim girls only 7 % in the age group 14-17 years have had their first sexual intercourse, while one out of three girls with no religious affiliation had had sex.

We have limited reliable statistics on condom use in Norway. However, Norwegian surveys from 2001, 2003 and 2008 show increasing condom use among boys and young men. This corresponds with the rising sales figures from the biggest condom distributor in Norway (RFSU). In addition, the Norwegian Directorate of Health has through their free condom distribution scheme, distributed an increasing number of free condoms to vulnerable groups from 2 million annually in 2004 to 2,5 million in 2008 and 2,7 million in 2009.

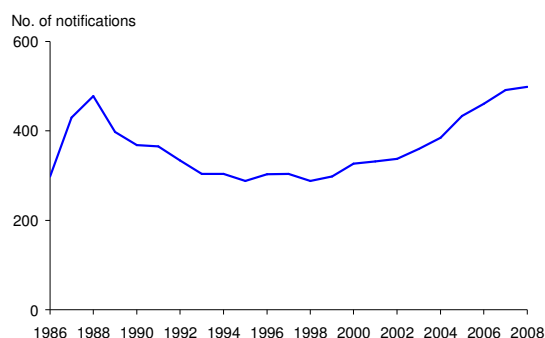
Norwegian surveys show that between 75 % and 84 % of youth and adolescents with sexual experience, used contraception the last time they had sexual intercourse. About 55 % used condom the first time they had sex with their last partner. In a web based survey on sexuality and contraception among 16-24 year olds conducted in 2009 by Synovate on commission for the Norwegian Directorate of Health¹¹, the respondents agreed to the following statements for why they did not use a condom the first time they had sexual intercourse with their last partner; I trust my partner (79 %); Condoms are needless since I know my partner well (32 %); We use an other type of contraception (71 %); Pulling up a condom is unromantic (29 %).

In the same study nearly 8 out of 10 assess the risk of being infected by Genital Chlamydia as very little or no risk at all. 96 % of the respondents assessed the risk for getting infected by HIV as none or very little.

The change in sex life and behaviour patterns of youth and the lack of awareness of the risk of getting a STIs, makes youth particularly vulnerable to unwanted pregnancies and STIs.

¹¹ Data collection was performed through a randomised selection of persons from Synovate`s e-panel, supplemented by a stratified selection of respondents from the same panel to ensure representativity (age, sex, geography). From 8 may to 15 June, the web based questionnaire was distributed to 3189 respondents. The response rate was 27,3%. The questionnaire covered status and experiences with relationships and contraception, assessment of risk for Chlamydia and HIV, sexual orientation, attitudes to own sexuality and sexual life, sexual experiences and relationship to sexual partner.

Figure 3 Notified cases of Genital Chlamydia infections in Norway 1986-2008 by year of diagnosis



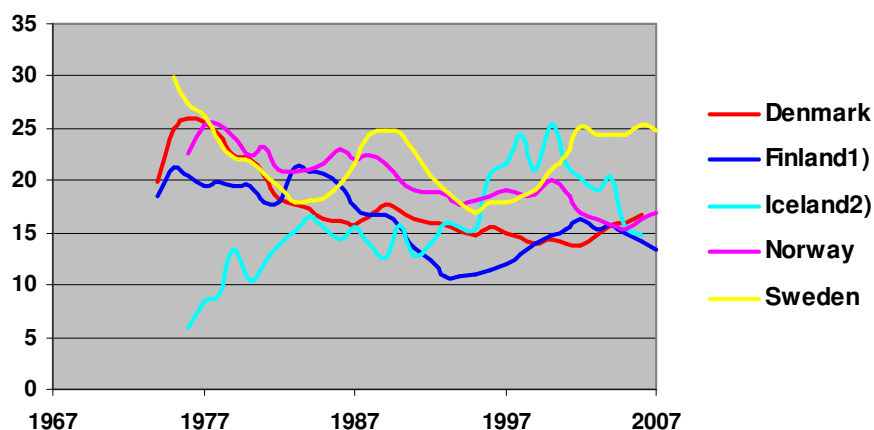
Source: Norwegian Institute of Public Health

In 2007, 23 488 cases were diagnosed with Genital Chlamydia. This is an increase of 2,7 % from previous year (22 847 cases). It is primarily youth and adolescence under 25 years who are diagnosed with Chlamydia. In 2008, 61 % of the diagnosed cases were women. This pattern has been fairly stable the past four years. The overrepresentation of girls and women in the statistics does not reflect the real incidence of Genital Chlamydia. It gives, however, an indication on who is testing for Chlamydia. In addition to variations in sex, there are big geographical variations in Chlamydia incidence, where the highest incidence rates are found in the northern parts of Norway the past years.

From 1990-2005, there was a significant decrease in abortions in the age group 15-19 years (from 20,1 in 1990 to 15,4 in 2005 per 1000 women). However, this pattern changed in 2006, and the number of abortions per 1000 women reached 18 in 2008.

Figure 4 Abortions in the Nordic countries per 1000 women aged 15-19 years, 1974-2007

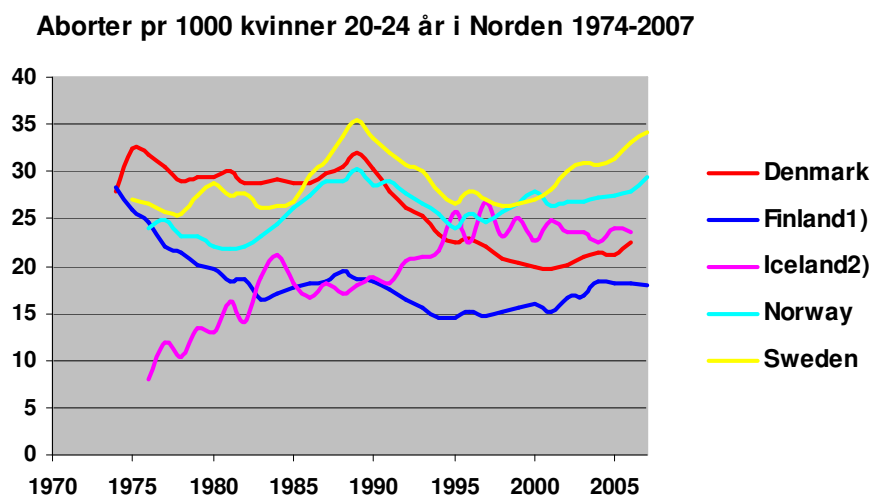
Abort i Norden pr 1000 kvinner 15-19 år 1974-2007



Source: Gissler M, STAKES 2008

Women in the age group 20-24 have the highest abortion rates in Norway. From 2001 – 2008 there has been an increase from 26,3 to 30,6 pr 1000.

Figure 5 Abortions in the Nordic countries per 1000 women aged 20-24 years, 1974-2007



Source: Gissler M, STAKES 2008

The HIV prevalence among youth is still very low in Norway. However, both Chlamydia and abortions in the age group 15-25 years, can be used as surrogate markers for sexual associated HIV risks among youth and adolescents. The development in Norway related to these surrogate markers, underline the vulnerability of young people 's sexual health.

3.3.2 Men having sex with men

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

The emergence of contact points on the Internet is mentioned in many international studies as a contributory factor to the increase in the spread of HIV among MSM. The reason for this may be that the ease of establishing contacts potentially increases the accessibility of many casual sex partners in circles with a high risk of infection. At the same time, it is also noted that the same contact points on the Internet are an important source for spreading necessary information about sexual health and protection strategies to the target groups. In 2007, the Norwegian Public Health Institute and the NGO Gay and Lesbian Health Norway conducted an anonymous internet survey on one of these contact points, the Norwegian gay Internet site gaysir.no, examining chatting on the Internet, e-dating and sexual risk behaviour among Norwegian MSM¹². This survey was first of its kind in Norway and represents the latest data

¹² The study was designed as a cross-sectional survey among a self-selected anonymous Internet sample. Study participants were enrolled in the period 1.10.2007-22.10.2007 via a prominent chat room that target MSM in Norway called Gaysir (www.gaysir.no). Gaysir is one of Norway's largest net-

we have on sexual risk behaviour among MSM in Norway.

Both the Norwegian Internet study and international research has documented considerable risky behaviour among MSM in recent years. This is in good agreement with the finding that over 60 per cent of newly HIV diagnosed MSM list unprotected anal sex with a casual partner as the source of infection. Of the 2431 MSM respondents in the Internet survey who live in Norway, 65% replied that they in the last 6 months had sex with an anonymous or previously unknown partner. Among these, 37% reported having unprotected anal sex with the partner. If new infection is to be reduced among MSM, there must be a significant change in behaviour with regard to increased use of condoms among MSM who have sex with casual or unknown partners.

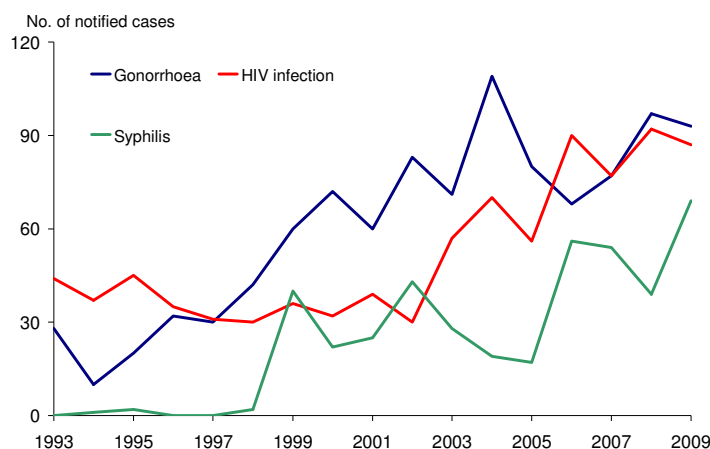
In the event of HIV infection, the prognosis can be improved considerably by early diagnosis and by commencing treatment prior to symptoms of the disease. Early diagnosis is also important in order for the individual to be able to avoid transmitting the disease further - HIV is most infectious in its early stages. Early detection of HIV is especially important in groups that are particularly at-risk of HIV. The Norwegian MSM Internet study showed that 22.5% of the respondents had never had an HIV test, whereas 74.7% (1418 respondents) had taken an HIV test. Out of the 1418 respondents, 56% had been tested in the last 12 months.

The Norwegian Public health Agency recommends that MSM should be offered yearly voluntary routine examination for STIs, vaccination for hepatitis A and B and counselling through their GP or at a low threshold health clinic. MSM with multiple partners should be offered examination more often. Rapid HIV and syphilis testing is offered in some outreach health clinics targeting MSM. As of 2009, the Norwegian health authorities have not developed a comprehensive testing strategy based on rapid testing in outreach and community setting. The improvement of access to rapid testing is however a prioritized area in 2010.

Research has discovered that in some MSM circles there are a number of people who are not properly informed about the current prevalence of HIV and other STIs. Data from the Norwegian Institute of Public Health and a number of experiences from clinical practice show that a substantial number of men who are diagnosed with HIV also have other sexually transmitted infections. Some men living with HIV have also been diagnosed with sexually transmitted infections such as gonorrhoea and syphilis, which indicates the practicing of unsafe sex. In 2009, about 30 % of the newly diagnosed cases of syphilis were HIV positive MSM.

community targeted at gay, lesbian and bisexuals with more than 31.000 active member profiles. It receives close to 40.000 unique visitors each week. The total number of respondents in the survey was 2573.

Figure 6 Notified cases of gonorrhoea, syphilis and HIV infection among men who have sex with men Norway 1993-2009 by year of diagnosis



Source: Norwegian Institute of Public Health

This shows that the group is in need of more information about the current situation and the high risk of infection with both HIV and other sexually transmitted infections. This also applies to information about how drug treatment of HIV affects the risk of infection. In the MSM Internet study, participants were asked to agree or disagree with the following statement: "Now that hiv medicines have improved, I do not to the same extent as before need to worry about being infected with hiv." 88% totally disagreed or disagreed a little with the statement whereas 7% totally agreed or agreed a little.

3.3.3 Sex workers

As of 1 January 2009, it has been illegal to purchase sex in Norway and also for Norwegian citizens to purchase sex abroad¹³. Norwegian citizens caught buying sex at home or abroad face fines or a six-month prison sentence (up to three years in the sex workers is a minor – under 18 years of age). The main objectives of the law is to influence the public's attitudes and beliefs about prostitution; reduce recruitment of customers; reduce the total prostitution market and prevent human trafficking.

The effects of the ban on purchase of sex are yet to be seen. For example, it is difficult to judge whether there has been a reduction in the number of women being trafficked into Norway, due to shortcomings in the methods for counting trafficking victims. Data on the laws' possible influence on the public's attitudes is still not available. The main social and health oriented services in Norway, report a reduction in the number of sex workers in street prostitution in Oslo by 58% from 2008 to 2009 (from 1200 to 500 persons), in Bergen by 7 % (from 125 to 116) and in Stavanger by 49% (from 61 to 31). In 2009, Pro-centre (low threshold harm reduction centre for men and women selling sex and national resource centre for prostitution) estimated that the number of sex workers on the indoor marked in Oslo is reduced by 16 % from 2008 (in total 900 persons in 2009). However, these estimates of persons in prostitution are based on those who have had contact with support services or placed advertisements, researchers maintain that these data are unreliable because not all prostitutes get counted and some might be counted twice. In addition, essential information about men selling sex is lacking. Knowledge on whether the ban has led to a reduction of the

¹³ Civic penal code §202 a

total sale of sex or if there are fewer clients, is not available. The police has issued 260 fines to individuals for buying sex in 2009.

According to Tampep (European Network for HIV/STI prevention and Health Promotion among Migrant Sex Workers) the European sex market is characterized by mobility and migration. In 2008, 60 different nationalities were selling sex in Europe compared to 16 in the mid 1990ties. The same pattern and development can be seen in Norway. In 2008, 70 % of sex workers in Norway were migrants mainly from Nigeria, Thailand, the Baltic States, Romania, Albania and Poland. Since the ban on purchase of sex was introduced there has been a significant reduction in registered sex workers from Nigeria and Central and Eastern Europe residing temporarily in Norway. It is not believed that these women have started in new professions in the Norwegian labour force. Reports from Denmark and Luxembourg indicated the e.g. many Nigerians have moved their business to this part of Europe. The number of registered Thai sex workers on the other hand, has increased. This can partly be explained by the fact that many Thai female, male and transpersons selling sex in Norway have permanent residence permit or Norwegian citizenship due to family reunification and are therefore less mobile.

Infection from prostitutes to buyers of sexual services in Norway has not been reported in recent years. However, a substantial increase in the number of sex workers who test positive for HIV has been reported in recent years. This is due to the increase in the number of foreign sex workers, especially from African countries, which began in the first half of the 2000 decade. The Pro centre reports a reduction in clients to their health services from 2008 to 2009. The reduction might be explained by the reduction in foreign sex workers. However, the clients using the health and social services come more often, indicating that it might be more difficult to work as a sex worker now than before the ban. Data on rates of HIV testing among sex workers and level of knowledge is unavailable. However, there has been a reduction in the number of blood tests conducted in 2009 (412) compared to in 2008 (746) at the Pro centre. The rates of HIV positive tests have decreased from 1 % in 2008 to 0,2 % (1 case) in 2009, which might reflect the reduction in sex workers from high prevalence countries in Norway.

3.3.4 Immigrants

As with the trend in the rest of the world, HIV and AIDS in Norway are very unevenly distributed among different groups in the population. The same can be said about the level of knowledge about HIV. No representative behavioural surveys on knowledge and behaviour among immigrants in Norway have been conducted. Thus there is limited representative data on the issue. However, international research, Norwegian studies and experiences indicate that the knowledge about HIV is low in some cases among immigrants from countries that have an especially high prevalence of HIV. The immigrant groups in Norway are very heterogeneous, but studies indicate that many of those who are infected, including those who are in communities with a risk of infection, have too little knowledge about the modes of infection and about sexual health in general.

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

In 2007, the University of Oslo conducted a pre-study on HIV/AIDS among Africans in

Norway¹⁴. Due to the relative low number of respondents and the sampling method used, the results must be interpreted with great care. The study showed that nearly all respondents identified sex as mode of HIV transmission and that using condoms reduce the risk of HIV transmission. However, knowledge about other modes of transmission such as contaminated needles and mother to child transmission was limited among a many of the respondents (40 %). In addition, 14 respondents thought that one could get infected with HIV by kissing, using the same toilet and drinking from the same cup as a person living with HIV/AIDS. In the study both men and women acknowledge the difficulty of negotiating the use of condom in a sexual relation and nearly half the respondents had taken an HIV test previously. Stigma and discrimination against people living with HIV/AIDS in Norway was identified as a major challenge.

Participants were also asked whether they have got any information on HIV/AIDS since they came to Norway. Overall the majority of respondents claimed not to have gotten any information on HIV/AIDS since they came to Norway. This corresponds with findings from an inspection of the municipal health services in reception centres for refugees and asylum seekers conducted by the Norwegian Board of Health Supervision in 2003. Major shortcomings in routines for testing and other follow-up were discovered in some centres. According to the Norwegian Directorate of Health guide to the above-mentioned services, newly arrived refugees and asylum seekers shall be offered a test for and guidance about HIV. A number of reports indicate that so far this has not been adequately implemented. Persons who are granted residence in Norway through family reunification should avail themselves of the ordinary health services, and at present there is little systematic knowledge about the extent to which members of reunified families are offered testing for HIV.

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

3.3.5 Injecting drug users

The number of IDUs increased dramatically in the 1990s and peaked in 2001. The number then fell gradually before levelling out. Summarising estimates from two methods, it was calculated that there were approximately 8,500 to 12,500 IDUs in Norway in 2006. It is believed that the number has remained fairly stable since then. It is estimated that 85% - 90 % of IDUs inject heroin.

Both the national police and *Statistics Norway* publish statistics on drug related deaths. According to the police statistics the number increased throughout the 1990, peaked in 2001 with 338 deaths and has levelled the last six years around 200 deaths annually (statistics up to 2008). The high number of drug related deaths remains a major concern.

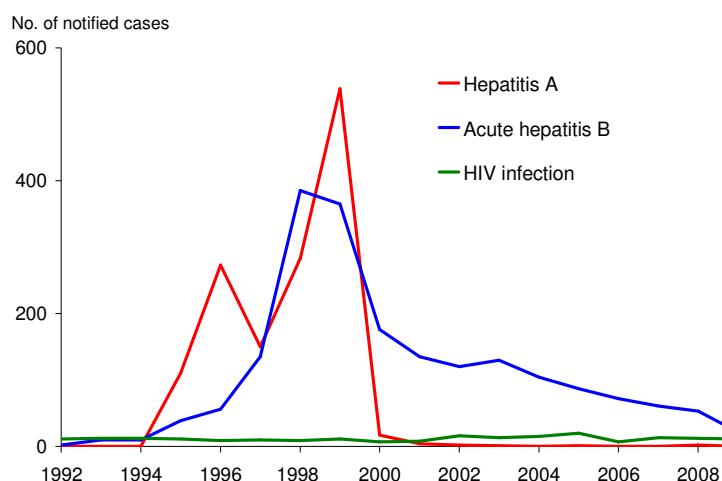
Limited prevalence studies (200-300 participants) among IDUs have been carried out in the city of Oslo the past years in relation to the municipality's needle exchange program. In addition to offering health checks, vaccination and clean needles, the program is screening

¹⁴ The University of Oslo conducted the pre-study on HIV/AIDS among Africans in Norway in the period July-December 2007. Target group was first and second generation immigrants from African countries above 18 years living in Oslo. Sample size; 72 HIV positive and negative Norwegians with African background, 34 women and 38 men. 85% in the age group 22-45 years. Twenty participants were interviewed after filling in the questionnaire.

for syphilis, tetanus, Hepatitis A, B and C, HIV and *Human T-lymphotropic virus*. The surveys the past years have showed only one case of undiagnosed HIV. These results indicate that the harm reduction strategies have a positive effect on incidence of HIV and that there are few hidden sources of error related to HIV diagnostics among IDUs.

On the other hand, there has been a considerable increase in hepatitis B since 1996. In 2007, 60 of a total of 118 reported cases of acute hepatitis B were among injecting drug users. In Norway, hepatitis C is not monitored to the same extent as hepatitis A and B, and the number of new cases of drug users being infected is therefore not known. From 1 January 2008, the notification criteria for hepatitis C have been changed, so the disease can be monitored more closely. However, as of today it is not possible to make a distinction between new and old cases of hepatitis C.

Figure 7 Notified cases of hepatitis A, acute hepatitis B and HIV infection among intravenous drug users in Norway 1992-2009 by year of diagnosis



Source: Norwegian Institute of Public Health

The annual questionnaire survey among young people aged between 15 and 20 in 2007 shows that cannabis, primarily hash, is still the drug most young people report having used. However, after peaking at the turn of the millennium, a clear reduction has been registered in recent years. The proportion who states that they have used other drugs also increased in the late 1990s before levelling/ declining in recent years. Among young adults in their twenties, the figures are substantially higher, both for ever having used and recent use. In a survey from 2006, lifetime prevalence among the 21–30 age group had increased considerably in the preceding eight years, both for cannabis and other commonly used drugs. However, the prevalence for recent use, during the past six months, has been quite stable overall. The next nationwide survey among the population as a whole is scheduled for 2009.

In general IDUs in Norway are older adults. A survey at a needle distribution in Oslo a few years showed that the mean age for starting injecting was 26 years. The mean age in MAT has remained stable around 40 years throughout the 00s. No other indicators show that drug injecting in lower age groups is increasing.

3.3.7 The living conditions of persons with HIV

In the spring of 2009, Fafo Institute for Labour and Social Research published the results of a new study of living conditions among people living with HIV in Norway conducted in 2008 in collaboration with HIVNorway. The report *Living with HIV in Norway – 2009* (Fafo-report 2009:43) follows up a previous study of living conditions from the beginning of the 2000 decade and is based on qualitative interviews and a quantitative questionnaire of HIV-positive persons. A total of 271 persons filled out the questionnaire, and if we use the estimate of the number of persons living with HIV in Norway at present, this amounts to a response rate on the order of magnitude of 10 per cent. In this sample, homosexual men, for example, are overrepresented and heterosexuals and IDUs are underrepresented. These factors mean that the report is not representative; it says something about the living conditions and the life situation of those who have answered the questionnaire, but not the population of HIV-positive persons as a whole. In light of the survey of attitudes and qualitative interviews, however, the study still provides an important understanding of relationships, experiences and insights into living as an HIV-positive person in Norway in the year 2009.

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

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

The study shows that 27 per cent of the HIV-positive persons have been in contact with a psychologist one or more times in the past year, and another 54 per cent say that they have needed psychological counselling and treatment in connection with being HIV-positive. The qualitative data may indicate that despite the fact that it is easy to get a referral from a doctor, it is difficult to gain admittance with a psychologist and that even with admittance it may be difficult for the HIV-positive person to find the necessary expertise. The study indicates a great demand for programmes that focus on the psychological needs.

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

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

knowledge among HIV-positive persons and that prevention of self-stigmatisation is an important gateway in the efforts to improve their living conditions.

Men who have sex with men (MSM) are the group that comes out best in many of the living condition indicators that are used in the study. Also in this group of respondents, however, there is a high percentage who report that they have financial problems that are partly related to the HIV diagnosis. The group of homosexually infected persons is the group that is most open about their HIV status. Nevertheless, there is also a high percentage in this group who limit their openness to a small group of persons. Many of the informants that define themselves as homosexual say that contacting HIV entailed a new "coming out" process. With regard to health, this group distinguishes itself by a relatively large use of psychological services compared with the other groups. Many make active use of the Internet to build a network and say that it is a place where it is easier to talk about their HIV status. However, HIV-positive homosexual men with an immigrant background, for example, say that they encounter a number of prejudices on these web sites.

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

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

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

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

The workplace is a challenge for openness. The survey of attitudes, "*Fortsatt farlig å kysse*"

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

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

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

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

4 Best practices

4.1 Political leadership

New multisectoral approach to HIV prevention

Acceptance and coping – National HIV strategy (2009-2014) is the first intersectoral strategic plan on HIV in Norway, involving six different ministries; Ministry of Labour and Social Inclusion, Ministry of Children and Equality, Ministry of Health and Care Services, Ministry of Justice and the Police, Ministry of Education and Ministry of the Environment and International Development. The four previous action and strategic plans have mainly been health focused. In this new strategy the six different ministries are responsible for building a society that accepts and copes with HIV in a way that both limits new infection and gives persons living with HIV good conditions for social inclusion in all phases of their lives. In the preface of Acceptance and coping it is stated that;

“The HIV epidemic has not reached the proportions that we feared. However, we have witnessed a situation similar to an outbreak among men that have sex with other men in Oslo during the last five years, and the number of newly diagnosed HIV-infected persons reached its highest level of the last few years in 2008 with nearly 300 cases. This amounts to a doubling of the number of new yearly HIV cases relative to the situation a decade ago. A study now exists that compares the current living conditions of persons living with HIV with the situation seven years ago when the previous HIV strategy was launched. The study shows that the progress in the development of medicines has improved the physical health of people living with HIV, but a similar improvement has not taken place with regard to openness, knowledge about HIV and attitudes to HIV as a phenomenon in the society. In many areas - especially the psychosocial - it feels just as difficult to be HIV positive today as it was seven years ago.

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

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

Among other things, this involves discussing sexuality and the driving forces that contribute to a further spread of HIV. It involves openness about HIV. The psychological costs of keeping one's HIV status secret are often great for both the individual and the society. Through openness, the disease can be demystified and new generations of HIV positive patients will have an easier time than the previous ones. Last but not least, it involves knowledge. Knowledge about the ways in which HIV infects and the ways in which HIV does not infect. This is important in order to avoid the spread of HIV, discrimination and social exclusion.

The strategy is based on important general principles, such as: human rights, the gender perspective, equal access to information and public services and the independent responsibility that all of us have to protect ourselves from infection and to avoid infecting other

people. The strategy focuses special attention on groups that are at-risk for more than one reason, persons who have HIV or are exposed to a great risk of HIV infection and who encounter barriers in their lives of a psychological, social and financial nature. The strategy is designed at a comprehensive level and is meant to consist of a framework that gives it a direction and provides a basis for follow-up of effective, knowledge-based measures.

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

4.2 Supportive policy environment

Improved sexuality education in Sør-Trøndelag

In 2006, the local newspaper Adresseavisa published a series of articles on sexual harassment and violence in schools. The theme gained a lot of attention and local politicians argued strongly for an increased focus on prevention of sexual harassment in primary and secondary schools in Sør-Trøndelag (County in central Norway).

In December 2006, the county authority of Sør-Trøndelag adopted a policy that the regional authorities should start a project against sexual harassment in schools and that sexual harassment should be integrated into the public health policies. The work should be a joint venture involving local authorities (the municipalities), regional authorities (the county), county governor (state level), the Ministry of Education and Ministry of Health and Care Services, technical experts and NGOs. The aim of the work was to increase capacity and focus on sexual harassment in schools and institutionalize this in the curriculum in schools. In 2007, the town government of Trondheim adopted an action plan on sexual harassment 2007-2009, stating that sexuality education on county level should be improved in collaboration with the Norwegian LGBT Association. A project on sexual health involving county, regional and local authorities and NGOs, was established in 2009-2014.

In order to measure the effect of the work, a project was completed to secure the quantitative baseline data on the prevalence of sexual harassment in schools. The study, conducted by Norwegian University of Science and Technology, showed that sexual harassment of both girls and boys is fairly widespread in high schools. A qualitative follow-up study was completed in 2009, showed similar results. In addition a study on quality and coverage of sexuality education conducted among teachers in lower secondary school in Trondheim was carried out in 2008. The study showed that the teaching in sexuality had many weaknesses, e.g. it is primarily hetero normative and pays little attention to gender aspects.

The project resulted in a comprehensive curriculum on sexual health for lower and upper secondary education and training and a capacity building implementation scheme targeting teachers. The curriculum put sexual harassment into a wider sexual health context and combined theoretical sections with exercises in skills based training. The curriculum is gender sensitive and includes sexual minority perspectives. HIV/AIDS is also covered in the curriculum. In 2009, relevant teachers in the lower and upper secondary schools in Trondheim were trained.

Some of the main success factors for this project were the widespread intersectoral and political support at local and regional level for increasing awareness of sexual harassment in schools. Sexual harassment was put in a wider public health context and integrated in to a

sexual health and discrimination approach to violence prevention.

4.3 Scale-up of effective prevention programmes

Masks – information and self-help among Africans living with HIV in Norway

Masks was a project run by Aksept, City Church Mission in the period 2006-2008. Aksept is a centre for everyone affected by HIV. The centre is financed by the municipality of Oslo.

The background for the project was an increase in the number of newly diagnosed HIV positive Africans living in Norway. Many of the HIV positive immigrants are infected before arrival in Norway, however, the percentage of immigrants infected while residing in Norway has increased in recent years, especially among women. From 2005 onwards, an increasing share of Aksept's users come from Africa.

The countrywide supervision of health services for newly-arrived asylum seekers, refugees and people reunited with their families conducted by the Norwegian Board of Health in 2003, has showed major shortcomings in routines for HIV testing and follow-up in some of the reception centres. As of today, there is little documentation on effect of measures aiming at increasing awareness, condom use, testing and access to health services for immigrants. To prevent a further increase of HIV transmission, immigrants are in need of targeted information and counselling.

The overall aim of the project was to run information work and help to self-help among HIV positive and negative Africans living in Norway through;

- Establishing a service at Aksept that is tailored African users.
- Build a competence network of PLWHA from Africa that is trained in peer-to-peer counselling, information and out-reach work.
- Run a self-help program for African users at Aksept.
- Build capacity in Aksept on how to reach African groups with HIV information and HIV preventive measures.

The methodological approach of the project was fourfold; peer-to-peer work, self-help groups, client participation, and outreaching work. The project had a reference group consisting of user's at Aksept, as well as representatives for a reception centre for refugees and asylum seekers (Løren), Primary Health Care Workshop (PMV) and Norwegian Centre for Minority health Research.

The results of the project has been an increase in African users at Aksept, and these users are now met with services and measures that are more in line with their needs. Networks at Aksept of African PLWHA in Norway have been established and have expanded beyond the original members. A pool of peer-educators has been trained in different counselling methods. These peer-educators have been counselling and following up Africans living with HIV e.g. through home visitation and visits to hospitals, reception centres for asylum seekers and refugees. In addition many have been facilitating communication between health professionals and patients both at Aksept and in the hospitals. Both people in the network and peer educators appear to have more self-confidence to tackle task related to their HIV-status.

Many of the experiences gained from the project has been used in capacity building measures targeting Norwegian Labour and Welfare Organisations and reception centres for refugees and asylum seekers. The experiences from the project have been presented at a

number of conferences and meetings. In addition, based on the experiences from the project, Aksept is now offering a 2-3 days trainee program for professionals working with immigrants. Thus, the project has proved to be sustainable and funding for the project has been partially incorporated into Aksept's routine work with its own resources.

4.4 Scale up of care, treatment and support programmes

Paperless irregular immigrants and human rights

In 2009, the Norwegian Directorate of Health published the report Migration and health - challenges and trends. In the report, challenges related to paperless irregular immigrants and the right to health, were highlighted. The chapter on paperless immigrants was based on a series of reports published by Aftenposten (newspaper) on living conditions of paperless immigrants in 2007¹⁵.

HIV-infected and in hiding (from Aftenposten's article series)

We are in contact with paperless immigrants who are living in hiding and who are HIV-positive, and the Church City Mission confirms that a number of people with HIV are living underground, including a number of prostitutes who work on the streets. The voluntary and independent organisation set up to help immigrants and refugees, Selvhjelp for innvandrere og flyktninger (SEIF), comes into contact with people who have communicable or chronic diseases, but who are afraid to seek medical help.

The county medical officer of Vest-Agder, Kristian Hagestad, has been involved for many years in dealing with the problem of the health of paperless immigrants. "In the interests of the individuals themselves and public health at large, it is important that they receive essential health care. The problem is that many of them are afraid, and do not dare to approach the health service even when they ought to for their own sake and that of society generally – especially when it comes to communicable diseases," asserts Hagestad.

The report states that anyone resident in Norway, legally or illegally, has the right to essential health care from the municipal health service. Such health care must be provided on condition that it is "urgently necessary". The question is, however, where the threshold in the right to essential health care within the municipal health service lies. This is especially relevant in cases of comprehensive long-term courses of treatment, rehabilitation, etc. Adults over the age of 18 residing illegally in Norway are generally not entitled to medical care from the specialist health service other than immediate treatment. Under the Convention on the Rights of the Child, pregnant women are entitled to medical care from the specialist health service before and after the birth of the child. Under the same Convention, children under the age of 18 have the same right to health care as anyone else even if they are not legally resident. Persons without legal residence are entitled to be informed of what health care they have a right to, and where they may receive it.

Everyone has the right to preventive treatment against communicable disease in accordance with Section 6-1 of the Act relating to control of communicable diseases. Medical care to prevent infection from communicable diseases presenting a public health risk is free for all

¹⁵ In autumn 2007, the journalists Per Kristian Aale, Olga Stokke and Reidun J. Samuelsen, wrote a large series of newspaper articles on paperless immigrants in Norway. For this series of articles, the three reporters received the Norwegian Government's human rights award for journalists 2008 and the Brostein Award 2008 from the Church City Mission.

persons residing in Norway even if they are not legally resident. The right to receive health care must be kept separate from payment to obtain that health care. The duty of professional confidentiality will as a rule prevent any information from being passed on to the police without the patient's consent.

Based on these challenges related to paperless irregular immigrants and the right to health, the report the Norwegian Directorate of Health recommended that:

- paperless immigrants must also be accorded the explicit right to preventive and curative health care within the primary and specialist health service
- for at-risk groups such as children, people with disabilities, pregnant women and elderly people, the provisions must be commensurate with those for the wider population.
- schemes must be devised for financing health care for paperless immigrants who have no financial means.

The heated public debate on the right to health showed strong support for expanding the rights for paperless irregular immigrants not only among governmental agencies, but also among a number of NGOs and professional associations. In 2009, the support was manifested in the establishment of a low threshold health service in Oslo for paperless irregular immigrants by the Norwegian Red Cross and the City Church Mission. In 2010, the government made important changes in the regulations expanding the right to health for paperless irregular immigrants from the following vulnerable groups; children, pregnant women, abortion seeking women and mentally unstable persons.

4.5 Capacity building

Rosa kompetanse (Pink capacity building)

The project Rosa kompetanse has been part of Norwegian LGBT Association's priority area since 2006. The main aim of the project is to increase focus, capacity and knowledge on LGBT issues related to health, living conditions and access to health services, among health care professionals.

The project started off by assessing the main challenges related to the LGBT population's meeting with the health sector. This has primarily been done through mapping of inquiries from health professionals to the LGBT Association, Queer Youth (Skeiv ungdom) and Gay Youth Hotline (Homofiles ungdomstelefon), and mapping of health system related inquiries from LGBT persons to the same channels.

In collaboration with medical associations, research communities and NGOs, Rosa Kompetanse has developed a capacity building tool. Special tailored curricula for different health professions including different methodological approaches, has been prepared by the parties involved. This has been implemented through a series of seminars for health professionals. The aim is to get the curriculum institutionalized in teaching for medical students, nurses and psychologists and continuous training for health professionals. In addition, Rosa kompetanse has developed a intersectoral educational program for e.g. municipalities.

Rosa kompetanse has also developed special tailored programmes for the child welfare authorities and a LGBT program for the police will be completed in 2010.

4.6 Norwegian international response to HIV/AIDS

Norad and Ministry of Foreign Affairs' role in HIV prevention, treatment, care and support

Norway is a partner in the global HIV work, and in providing financial support to HIV related interventions in many countries around the world. Norway is an important contributor to international programmes and funds, such as UNAIDS, the Global Fund to fight AIDS, TB and Malaria, UNITAID, International AIDS Vaccine Initiative, International Partnership for Microbiocides and others. A Norwegian and Swedish regional HIV/AIDS team for Africa provides financial and technical support to many African partners, and support is also given through Norwegian and International NGOs, as well as multilateral organizations. More than 750 million NOK was contributed through these channels in 2008.

The general Norwegian partner policy is to give core support to trusted partners, and partners may be selected based on their profile and priorities. In the Norwegian Policy Position Paper for HIV, priority is given to the following groups or areas of work:

- women, gender and power, including sexual and reproductive health and rights;
- particularly vulnerable groups (men who have sex with men, IDUs etc.);
- young people;
- legislation relating to HIV and AIDS;
- local communities and local democracy in an HIV and AIDS perspective;
- health personnel and health systems;
- prevention of mother-to-child transmission.

An AIDS ambassador is based in the Ministry of Foreign Affairs (MFA), and she leads the international AIDS work together with a joint HIV team at Norad and MFA. The AIDS Ambassador cooperates closely with the AIDS ambassadors from other countries in global advocacy and strategy development. In 2008 and 2009 a particular focus has been on youth, and on developing youth leadership. HRH Crown Princess Mette-Marit is involved in this work, as a special representative/ Goodwill ambassador of UNAIDS.

Norad supports the coordination of the Norwegian network of people involved in HIV related work in Norway and internationally, called Aidsnett. The network is a space for sharing of information and experiences, for joint capacity building, and also for joint advocacy.

5 Major changes and remedial action

5.1 Progress made in key challenges reported in the 2007 UNGASS country progress report

Norway has achieved most of the national targets set in the UNGASS declaration in 2001. However, Norway did not submit a 2007 UNGASS country progress report, thus progress made in key challenges based on previously reported data, is difficult to access.

The main changes in the last reporting period is an institutionalized intersectoral approach to HIV prevention through the new National HIV strategy (2009-2014) involving six different ministries. The new intersectoral collaborative approach emphasises the need to integrate and institutionalize HIV prevention in regular measures targeting the educational system, labour market, health sector and judiciary system.

Additional focus has been put on addressing challenges related to existing barriers for proper accessibility of counselling, testing and treatment for vulnerable groups. This is particularly relevant for paperless immigrants where there has been an increasing pressure to give this group their right to health.

There are still a number of challenges related to implementing effective measures targeting immigrants and MSM particularly, that needs to be addressed. People living with HIV/AIDS are still facing the same challenges regarding openness and stigma and discrimination as they did 10 years ago. Knowledge in the population of how HIV does not transmit and attitudes to people living with HIV is unacceptably low. These challenges still need further attention and responses.

5.2 Challenges faced throughout reporting period that hindered the national response in general, and the progress towards achieving the UNGASS targets in particular

Some of the challenges faced in the reporting period that may have hindered a national response are related to the following areas:

5.2.1 Collaboration between primary and specialist health care services

As previously highlighted in the report, medical treatment and the follow up of HIV positive patients are an integrated part of the ordinary specialist and primary health care services and free of charge for the patient. Many patients with HIV get their primary medical follow-up in the specialist health service. It is reason to believe that the specialist health care providers in many cases function as the HIV positive patient's GP because of the lack of adequate knowledge of HIV in the primary health care services.

Creating good routines and systems for a closer link and collaboration between the different levels in the health sector, is of great importance. This is especially relevant since recent

research indicates that HIV patients may have an increased risk of certain conditions (diabetes, cardiovascular disease, high blood pressure and depression) that the regular GP should take a lead in following up. In addition, the ageing of PLWHA due to effective HAART treatment, highlights the need for more knowledge on the complex interactions between HIV infection and diseases related to ageing (e.g. neuropsychiatric disease and osteoporosis). Increased knowledge of HIV treatment, care and prevention in old-people's homes will be needed.

The Ministry of Health and Care Services has the overall responsibility for improving collaboration between primary and specialist health services. However, professional associations and health enterprises need to take an active part in this work. Creating arenas and meeting points for the two sectors where HIV and HIV related issues can be discussed, will continue to be a priority.

5.2.2 Lack of knowledge on HIV in public sector

Norway is a small country with 4,8 million inhabitants divided into 430 municipalities ranging in size from 216 (Utsira) to 585 000 inhabitants (Oslo). There are four health regions and 84 public hospitals in Norway (2007). There are about 4000 GPs having on average 1200 of patients on their list (3-4 % up to 18 000 patients). In addition, there are 460 different Norwegian Labour and Welfare Organisations (NAV - 2010 figures) spread out in the country. In mid 2009, there were 118 refugee reception centres in Norway located in 108 different municipalities.

We have no data on where PLWHA live or which hospitals or GPs are treating PLWHA. In areas with low prevalence of HIV, where PLWHA are few, it might be difficult to secure a high level of knowledge in public services. This is especially true of the generalists, such as the regular GPs or the professional staff at NAV, where there are reports of insufficient knowledge about the psychological and social factors related to HIV.

This lack of knowledge might not only lead to unsatisfactory treatment, counselling and follow-up of PLWHA, it might also pose a serious challenge to effective HIV prevention and care. In addition, it might result in discrimination and stigma against PLWHA, and create barriers for a socially inclusive labour market. Capacity building in the public sector is a priority.

5.2.3 Ensuring a balanced approach to sexual health in educational settings

Children, youth and adolescents have a right to proper education and training in sexual health that is gender and LGBT sensitive and targeted their developmental needs. Knowledge and information about HIV/AIDS and STIs combined with training, counselling and education that emphasise training in ownership, self-confidence and pride of own body, sexuality and the use of condoms, are all important components in prevention of HIV transmission.

We lack proper data on the coverage of HIV in educational settings. Based on experiences and reports from the low-threshold health services, there is little coverage of HIV in sexuality education for youth and adolescents. In relation to STIs, it is mainly Genital Chlamydia that is being emphasised. In addition, data on use of condoms indicate that many young people are too little concerned about protecting themselves against STIs.

There have still been very few confirmed cases of HIV infection among heterosexual youth in Norway and there are no definite signs that more young MSM are now being infected. However, in order to prevent the spread of HIV among youth, and especially young MSM and youth travelling abroad, a high level of knowledge on HIV needs to be secured. Increased knowledge of HIV among youth is also very important in combating stigma and discrimination against PLWHA. The emphasis on HIV in sexuality education needs to be balanced in order not to create a twisted picture of Norwegian youth's vulnerability to HIV. The educational sector has a key role to play in doing this.

5.2.4 Lack of rights to health

Estimates put the number of undocumented, illegal, irregular or paperless immigrants in Europe at between 5 and 8 million. Norway is thought to have some 18,000 paperless immigrants. These are individuals who are often not visible to the authorities. Because of this, they scarcely receive the help they have a right to in accordance with the human rights the countries have pledged to respect – including the right to health care.

Many of paperless immigrants suffer, many are exploited, the risk of the spread of communicable diseases increases (HIV), and emergency medical care tends to be more costly than early intervention. In Norway, in the period 2008-2009, few special measures were in place to look after the health needs of paperless immigrants. In addition it is assumed that many may not be aware of their rights (especially related to HIV information, testing, treatment and counselling for HIV – ref Communicable Disease Control Act) and have difficulty understanding the Norwegian health service.

These barriers need to be addressed properly in order to improve HIV prevention in the immigrant population. New policies implemented in 2010, improves the right to health for paperless immigrants. However, the accessibility of health services for these immigrants needs to be seen.

5.2.5 Financial predictability for civil society organizations

Civil society has since the beginning of the HIV epidemic played a very important role in development and implementation of HIV preventive policies in Norway. Their work has been and still is instrumental for reaching specific target groups with HIV preventive measures. In addition, a number of NGOs have developed judicial and psychosocial support and counselling services which are important supplements to the public services.

These initiatives are mainly funded through public funds, either through the municipalities or through the national financial scheme covering the follow-up of the National HIV strategy or other relevant policy documents. A main challenge for the NGOs is predictability related to funding. The state is primarily allocating funds to national, regional and local projects run by NGOs on a yearly basis and based on applications. The allocations may often come late in the year, thus complicating the planning of activities for the NGOs. The funding may also come from a number of different sources that are not necessary very well coordinated. The NGOs are therefore spending a lot of their resources on writing and following-up applications and reporting on funding, extracting valuable time and energy from their HIV preventive work.

Thus improving the predictability of funding for NGOs involved in HIV prevention is a major

concern and should be followed-up.

5.2.6 Monitoring and evaluation

There is still a lack of second generation surveillance data on a number of key indicators. This has partly to do with the fact that there Norway has not conducted any behavioural studies related to knowledge and behaviour among e.g. IDUs and sex workers. In 2008 a follow-up study of the sexual behaviour studies among Norwegians 18-49 years old was conducted. However, the response rate was too low for the results to be included in the reporting.

There has been an improvement in data gathering on key indicators the past years. However, there is still a need for improved monitoring of indicators covering behaviour and knowledge in especially high risk groups.

5.2 b Comments to major challenges faced throughout the reporting period from civil society

HIVNorway

There has been no increase in the funding in the HIV and AIDS field since 1998. An ambitious new strategy requires proper funding if the ambitious goals are to be met.

The main challenge in Norway, as various research reports testify to, is to inform the general public about how HIV is transmitted how it is not transmitted, and what a HIV positive status means for the life quality of those infected and affected. A better informed general public on these and similar issues would be an important contribution towards improving the life quality of people living with HIV.

5.3 Concrete remedial actions that are planned to ensure achievement of agreed UNGASS targets

A number of new strategic moves and remedial actions are planned for the strategic plan period covering 2009-2014. Here is a selection of some of them.

5.3.1 Improve the follow-up of PLWHA in the health care services

Improved collaboration between primary health care and specialist health care providers is a priority in 2010. Improved follow-up of PLWHA in the health care services also include it is provision of adequate programmes of regular, repetitive conversations about prevention of infection and training in how to live with a chronic infectious disease.

The Ministry of Health and Care services are responsible for implementing activities related to the following strategic moves in 2010-2014:

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

5.3.2 Establish follow-up programs for children and adolescents living with HIV

As previously reported it is estimated that there are about 30-40 children and adolescents living with HIV in Norway. Concern has been expressed about the extent to which children and adolescents with HIV and their nearest relatives receive adequate follow-up of the psychosocial aspects of living with HIV.

Aksept (City Church Mission) in collaboration with the Norwegian Directorate of Health and South-Eastern Norway Regional Health Authority, are planning the establishment of an educational and capacity building program for youth living with HIV. The program will follow the model from a similar measure in Sweden run by Karolinska University Hospital in Stockholm (Hiv skolan).

In addition Aksept (City Church Mission) will continue its work on young leadership in 2010.

5.3.3 Introduce quick test for HIV

Reducing hidden sources of error, through early testing, diagnostics and appropriate counselling, has been defined as an important area of improvement. Improving targeting measures increasing test frequency in target groups will particularly be emphasised.

A collaborative project between NGOs for MSM and health services will be established offering quick test to especially at-risk groups. This will be done adjacent to targeted information measures focusing on highlighting the importance of early testing to at-risk groups in the population.

6 Monitoring and evaluation environment

6.1 Overview of the current monitoring and evaluation system (M&E system)

The main monitoring instrument used in relation to HIV, is outcome monitoring. Surveillance of HIV (including surrogate markers such as Gonorrhoea, Syphilis (infectious)), is 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. Patient data reported includes gender, month and year of birth and place of residence. In addition a variety of epidemiological data is reported including country of birth, diagnostic methods, isolation site, drug resistance, indication for testing, place of infection, clinical picture, and information on gender and relationship to source partner. In addition, the number of HIV tests is surveyed annually.

Some behavioural studies are conducted regularly. These involve annual school based surveys on drug use among youth aged 15-20 years and limited prevalence studies among IDUs conducted in the city of Oslo in relation to the municipality's needle exchange program. Regular sexual behavioural studies have been conducted in 1987, 1992, 1997, 2002 and 2008. However, the response rate for the latest survey was so low that the results could not be used.

Two comprehensive studies on living conditions of persons living with HIV/AIDS were completed in 2002 and 2009. In 2007, a study on Internet, e-dating and sexual risk behaviour among Norwegian MSM was conducted. A representative study on people's knowledge about and attitudes to HIV was carried out in 2008, and a web-survey among youth on sexuality and contraception in 2009.

In addition considerable effort has been made to evaluate the strategic plan in the period 2008-2009. Econ Pöyry conducted an evaluation of the strategic plan in 2008, while Agenda evaluated the Norwegian Directorate for Health and Social Affairs' national scheme providing free condoms to adolescents, young adults and particularly at-risk groups and the two biggest recipients of subsidies throughout the whole planning period HivNorway and Gay & Lesbian Health Norway.

6.2 Challenges faced in the implementation of a comprehensive M&E system

The main challenge faced in implementing a comprehensive M&E system is related to the lack of a systematic approach to data gathering across sectors. There is a limited overview of data on relevant indicators from other sectors. One of the main tasks of the newly established coordinating group at the directorate level will be to establish a reporting/evaluation system. In addition, there is not centralized quality register on HIV in the health services which makes it difficult to extract relevant data on HIV from the health sector.

Another area of improvement is the development and implementation of regular studies on sexual behaviour, risk perception and risk taking among the general population and at-risk-populations.

6.3 Remedial actions planned to overcome the challenges

In the National HIV strategy, improving research on the prevention and treatment of HIV and monitoring and evaluation of prevalence, risk factors and effects of measures is defined as a specific objective (objective 8). The strategy underlines that a good system of epidemiological monitoring is crucial for identifying issues related to risk factors for various demographic groups and defining priorities for the effort. The data function as work tools for both preventive actors and planners of measures and for the dimensioning of health and care services.

A number of areas with a special need for research knowledge are identified. These include:

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

The Ministry of Health and Care Services are responsible for improvement in the following areas in the period 2010-2014:

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

6.4 Need for M&E assistance and capacity building

There is a clear need for improvement in M&E. In the development of a more comprehensive M&E systems, Norway will look at experiences from other countries such as Sweden, Denmark, Switzerland and the United Kingdom, as well as relevant international agencies such as UNAIDS, European Centre for Disease Control and WHO Regional Office for Europe.

Appendix 1 Norwegian Aids Council

the norwegian aids council

In Norway, the responsibility for national AIDS programmes and services lies in the Ministry of Health and Care Services, together with the Directorate for Health, while the Ministry of Foreign Affairs and Norad, the Agency for Development Cooperation, is responsible for International AIDS cooperation.

There used to be limited cooperation between the services and stakeholders involved in AIDS nationally and those concerned with AIDS as part of international development cooperation. Therefore an AIDS Forum was established in 2001 under the leadership of the Minister for International Development to advise on the international support for AIDS, and to also mobilise the Norwegian public on international AIDS issues.

On World AIDS Day in 2006, the Ministry of Foreign Affairs and the Ministry of Health and Care Services called together a new Norwegian AIDS Council (NAC) with a broader mandate, to enable a coherent approach between Norway's work at home and abroad and facilitate better dialogue, experience sharing and cooperation. The NAC has no decision making power on how the government works with AIDS, it acts as an advisory board to both Ministries.

The NAC is multisectoral and its 15 members represent government, civil society, private sector, PLHAs etc, both those working in Norway and abroad. It is co-chaired by the Ministry of Foreign Affairs and the Ministry of Health and Care Services. NAC meets twice per year.

the nac's main objectives/goals:

- Improving communication and making strategies coherent.
- Contribute to information exchange on new strategies on health and HIV, development and foreign policy.
- Making sure that strategies are evaluated and followed up by the responsible organisations/institutions.
- Contribute to more openness around AIDS and fight stigma and discrimination of people infected and affected by HIV.

The Council has so far engaged and given input to several processes including the development of a new national strategic plan on HIV and AIDS, Norway's engagement in the GFATM and UNAIDS boards and a new policy paper on narcotics, including harm reduction.

the norwegian youth council on hiv and aids

The Norwegian Children and Youth Council (LNU) and other youth organisations in Norway have for a long time shown interest in coordinating and strengthening collaboration between children and youth organisations working on HIV and AIDS. They wanted to enhance the cooperation both between organisations working within Norway, as well as between organisations in Norway and internationally. This has led to more joint activities. In 2007 they established a youth council on HIV and AIDS to further engage in Norwegian AIDS politics and in particular to contribute to the National AIDS Council. LNU is the youth representative in the Norwegian AIDS Council;
<http://www.lnu.no/english>



Appendix 2 Aidsnett



What is Aidsnett?

Aidsnett started in 2001 and is an informal network of over 170 Norwegians working with AIDS internationally and in Norway. The purpose of the network is to strengthen participants' knowledge and understanding of the current issues that arise in connection with the changing nature of the AIDS epidemic. Aidsnett also plays an advocacy role with regard to the management of Norwegian development cooperation, and towards other aid organisations.

The key characteristics of the network are that it is inclusive, informal, and non-bureaucratic. A Core Group of 20 active participants meet 4–6 times a year for meetings to exchange information about emerging professional issues, activities, and developments. Participation in the Core Group is open to groups and individuals who wish to be actively involved; are interested in strengthening their competence in AIDS; and feel they have something to contribute and something to learn. Individual members/organisations take turns hosting the group and leading the meetings.

How is Information shared?

Much of the information is shared through an email list with the larger Aidsnett and sent out by the Coordinator Marilyn Lauglo, who may be reached at marilyn.lauglo@heso.no.

Aidsnett provides an excellent way to reach a wide audience by extending invitations to their events. In 2008, meetings and seminars have been held that have covered: recent research on attitudes among the Norwegian public to PLWA; preparations for the Mexico Conference; efforts to change a Norwegian law relating to the spread of HIV; research findings on the links between men's roles, alcohol, and HIV in African countries, and sexuality and HIV prevention work. Aidsnett has also produced (in 2003) a booklet on AIDS and gender.

Who are members?

Participants in the network come from:

- Non-governmental organisations working in development cooperation
- Non-governmental organisations working for PLHA in Norway
- Norwegian government development cooperation administration
- Norwegian government institutions
- Norwegian research institutions

Aidsnett and cooperation with Norad and the Ministry of Foreign Affairs

Norad and MFA cooperates with Aidsnett on a regular basis, sharing information about current work and plans. The network is consulted on policy issues, and members from Aidsnett are included in Norwegian delegations to conferences or High level meetings. Norad regularly assists financially in arranging seminars and meetings, and pays a honorarium to the coordinator.

For more information, see Aidsnett's website on www.global.no/aidsnett

Appendix 3 Contributors to the report

Civil society

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

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

HIV Manifesto Group is a network of PLWHA working for a better quality of life for people diagnosed with HIV in Norway and globally.

HivNorway is a national interest organisation for HIV-positive persons, which has no affiliation with any political party or religion. HivNorway's task is to safeguard the rights and interests of HIV-positive persons in the society and to help promote a greater understanding of the situation of HIV-positive persons and to combat fear, prejudice and discrimination. The organisation works to protect the rights and interests of HIV-positive persons, contribute to preventive efforts and provide follow-up programmes to HIV-positive persons. HivNorway is a programme for everyone and includes individual counselling related to guidance and work to protect rights, seminar activities and efforts to spread information through conferences, the media, etc. HivNorway's efforts to spread information are aimed at HIV-positive persons, professional personnel and the general public through lectures, web sites and general use of the media. The organisation publishes the quarterly magazine, POSITIV.

HOMOPOSITIV is a self-help organisation for, by and with HIV-positive homosexual and bi-sexual

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

PION - Prostitutes' Interest Organisation in Norway – was founded in 1990 and works to protect prostitutes' interests and social and civil rights. PION conducts preventive health care and information campaigns in the prostitution communities and provides individual legal advice and guidance. PION publishes the magazine *Albertine* and disseminates information about prostitution. In its efforts to prevent the spread of HIV and sexually transmitted infection, PION performs outreach services in the prostitution community.

Public agencies

Norwegian Agency for Development Cooperation (NORAD)

Norwegian Institute of Public Health

Norwegian Directorate of Health

Norwegian Ministry of Health

Appendix 4 National Composite Policy Index

Response Details

Page 1

- 1) **Country**
Norway (0)
- 2) **Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted for questions, if any:**
Ms Hedda Bie / Mr Arild Johan Myrberg
- 3) **Postal address:**
P.O. Box 7000 St. Olavs plass N-0130 Oslo Norway
- 4) **Telephone:**
Please include country code
+47 24163660 (Bie) +47 24163560 (Myrberg) +47 810 200 50 (Switch board)
- 5) **Fax:**
Please include country code
+ 47 24163001
- 6) **E-mail:**
ajm@helsedir.no

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- 7) **Describe the process used for NCPI data gathering and validation:**
Relevant governmental institutions (Norwegian Institute of Public Health, Ministry of Defence and Directorate of Education and Training) and NGOs have been asked to contribute with relevant data. The NCPI report has been discussed in the National Aids Council.
- 8) **Describe the process used for resolving disagreements, if any, with respect to the responses to specific questions:**
Discrepancies in responses provided by NGOs in section B, have been discussed in an open meeting chaired by the coordinating consultant. In addition, the document has been circulated for final comments to the NGOs.
- 9) **Highlight concerns -if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like):**

The multiple choice structure of the questionnaire did not always provide relevant alternative answers to the situation in Norway (e.g. 7), thus resulting in incomplete answering of some questions.

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- 10) **NCPI - PART A [to be administered to government officials]**

	Organization	Names/Positions	Respondents to Part A [Indicate which parts each respondent was queried]

			on]
Respondent 1	Norwegian Directorate of Health	Hedda Bie / Senior Adviser	A.I, A.II, A.III, A.IV, A.V

11)

	Organization	Names/Positions	Respondents to Part A [Indicate which parts each respondent was queried on]
Respondent 2	Norwegian Directorate of Health	Arild Johan Myrberg / Senior Adviser	A.I, A.II, A.III, A.IV, A.V
Respondent 3	Ministry of Defence	Helle Schwartz Falkman / Adviser	A.I
Respondent 4	Norwegian Directorate of Education and Training	Anders Gimse / Senior Adviser	A.I

12) **NCPI - PART B [to be administered to civil society organizations, bilateral agencies, and UN organizations]**

	Organization	Names/Positions	Respondents to Part B [Indicate which parts each respondent was queried on]
Respondent 1	Aidsnett	Ellen Marie Hansen / Coordinator	B.I, B.II, B.III, B.IV

13)

	Organization	Names/Positions	Respondents to Part B [Indicate which parts each respondent was queried on]
Respondent 2	HivNorway	Evy Ainia Røed / General Secretary	B.I, B.II, B.III, B.IV
Respondent 3	Aksept	Roger Cassidy / Director	B.I, B.II, B.III, B.IV
Respondent 4	PION	Astrid Renland / Director	B.I, B.II, B.III, B.IV

Respondent 5	Helseutvalget	Rolf Angeltvedt / Director	B.I, B.II, B.III, B.IV
Respondent 6	Homopositiv	Vidar Monsen / Director	B.I, B.II, B.III, B.IV

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- 14) **1. Has the country developed a national multisectoral strategy to respond to HIV?**

(Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.2)

Yes (0)

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- 15) **Period covered:**
2009-2014

- 16) **1.1 How long has the country had a multisectoral strategy?**

Number of Years

1

- 17) **1.2 Which sectors are included in the multisectoral strategy with a specific HIV budget for their activities?**

	Included in strategy	Earmarked budget
Health	Yes	Yes
Education	Yes	No
Labour	Yes	No
Transportation	No	No
Military/Police	Yes	No
Women	Yes	
Young people	Yes	
Other*	Yes	Yes

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- 18) **If "Other" sectors are included, please specify:**
Ministry of Foreign Affairs

- 19) **IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specific activities?**

HIV prevention, care and support are integrated parts of the health and social services and educational system at state, regional and municipal level. There are no specific budget lines related to HIV prevention, treatment, care and support since the different sectors' responses to HIV is an integrated part of their ordinary services. However, there is an earmarked budget for the implementation of the National HIV strategy. These earmarked funds are allocated to HIV preventive measures and initiatives strengthening support and care for PLWHA. Even though the Ministry of Health and Care services is the budget holder of the funds, the funds also cover measures targeting other sectors than health. The funds are mainly allocated to NGOs.

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20) **1.3 Does the multisectoral strategy address the following target populations, settings and crosscutting issues?**

Target populations	
a. Women and girls	Yes
b. Young women/young men	Yes
c. Injecting drug users	Yes
d. Men who have sex with men	Yes
e. Sex workers	Yes
f. Orphans and other vulnerable children	Yes
g. Other specific vulnerable subpopulations*	Yes
Settings	
h. Workplace	Yes
i. Schools	Yes
j. Prisons	Yes
Cross-cutting issues	
k. HIV and poverty	No
l. Human rights protection	Yes
m. Involvement of people living with HIV	Yes
n. Addressing stigma and discrimination	Yes
o. Gender empowerment and/or gender equality	Yes

21) **1.4 Were target populations identified through a needs assessment?**

Yes (0)

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22) **IF YES, when was this needs assessment conducted?**

Please enter the year in yyyy format
2008

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23) **1.5 What are the identified target populations for HIV programmes in the country?**

People living with HIV/AIDS, men having sex with men, injecting drug users, youth and adolescents, immigrants and sex workers.

24) **1.6 Does the multisectoral strategy include an operational plan?**

Yes (0)

25) **1.7 Does the multisectoral strategy or operational plan include:**

a. Formal programme goals?	Yes
b. Clear targets or milestones?	Yes
c. Detailed costs for each programmatic area?	No
d. An indication of funding sources to support programme?	No
e. A monitoring and evaluation framework?	Yes

26) **1.8 Has the country ensured “full involvement and participation” of civil society* in the development of the multisectoral strategy?**

Active involvement (0)

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27) **IF active involvement, briefly explain how this was organised:**

Civil society was invited to take part in the drafting process of the national HIV strategy through a two days seminar, bilateral meetings and written contributions. Civil society also took part in the reviewing process before the launching of the plan. In addition, civil society contributed to evaluations that were conducted as part of the development of the new HIV strategy.

Page 14

28) **2. Has the country integrated HIV into its general development plans such as in: (a) National Development Plan; (b) Common Country Assessment / UN Development Assistance Framework; (c) Poverty Reduction Strategy; and (d) sector-wide approach?**

N/A (0)

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29) **3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?**

N/A (0)

Page 17

30) **4. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)?**

Yes (0)

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31) **4.1 IF YES, which of the following programmes have been implemented beyond the pilot stage to reach a significant proportion of the uniformed services?**

Behavioural change communication	Yes
Condom provision	Yes
HIV testing and counselling	Yes
Sexually transmitted infection services	Yes
Antiretroviral treatment	Yes
Care and support	Yes
Other: Please specify	

Page 19

32) **If HIV testing and counselling is provided to uniformed services, briefly describe the approach taken to HIV testing and counselling (e.g, indicate if**

HIV testing is voluntary or mandatory etc):

Voluntary testing and counselling is offered to uniformed services as part of the introductory and other relevant health examinations. Condoms are available through the health services for the uniformed services.

- 33) **5. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations or other vulnerable subpopulations?**

Yes (0)

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- 34) **5.1 IF YES, for which subpopulations?**

a. Women	Yes
b. Young people	Yes
c. Injecting drug users	Yes
d. Men who have sex with men	Yes
e. Sex Workers	No
f. Prison inmates	No
g. Migrants/mobile populations	Yes

- 35) **IF YES, briefly explain what mechanisms are in place to ensure these laws are implemented:**

The Equality and Anti-discrimination Ombud (established 1 January 2006) contributes to the promotion of equal opportunity and fights discrimination. The Ombud combats discrimination based on gender, ethnic origin, sexual orientation, religion, disability and age. The Ombud upholds the law and acts as a proactive agent for equal opportunity throughout society. The Equality and Anti-discrimination Ombud enforces the following acts: The Anti-discrimination and Accessibility Act, The Gender Equality Act; The Act on Prohibition of Discrimination on the basis of ethnicity, religion etc. (the Discrimination Act); The regulations regarding equal treatment provided in the Labour Environment Act; The anti-discrimination regulations provided in the housing legislation. The Parliamentary Ombudsman supervises public administration agencies. Supervision is carried out on the basis of complaints from citizens concerning any maladministration or injustice on the part of a public agency. The Parliamentary Ombudsman processes complaints that apply to government, municipal or county administrations. The Ombudsman may also address issues on his own initiative

- 36) **Briefly comment on the degree to which these laws are currently implemented:**

The Equality and Anti-discrimination Ombud publishes a yearly status report (SALDO) which gives a through assessment of the level of discrimination in the Norwegian Society. According to their 2009 report, discrimination and exclusion of vulnerable groups is still a challenge in the Norwegian society. However, improvement can be seen. In 2009, protection of people with disabilities has been improved through the new Anti-discrimination and Accessibility Act. In addition, in 2009 the Commission established to develop a comprehensive anti-discrimination legislation, submitted their proposal for new legislation. A public reviewing process has been conducted in 2009.

Page 21

- 37) **6. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations or other vulnerable subpopulations?**

Yes (0)

Page 22

- 38) **6.1 IF YES, for which subpopulations?**

a. Women	No
b. Young people	No
c. Injecting drug users	No
d. Men who have sex with men	No
e. Sex Workers	Yes
f. Prison inmates	Yes
g. Migrants/mobile populations	Yes
Other: Please specify	

- 39) **IF YES, briefly describe the content of these laws, regulations or policies:**

Article 202 of the General Civil Penal code prohibits all kind of activity related to prostitution, like advertising and renting out premises, while article 202 A criminalizes the purchase of sexual activity or a sexual act. The potential negative consequences the new law against buying sex presents for the HIV preventive work, is unclear. The General Civil Penal Code section 155 imposes penalties on those who have reason to believe that they are infected with a communicable disease that are hazardous to public health and who wilfully or negligently transmit that infection or expose someone to the risk of becoming infected. As of today, it is only cases of HIV transmission and exposure which has been prosecuted under this section in the Penal Code. The government has pointed to the need for more research-based knowledge to assess the implication of the penal code, hereunder possible discrimination against PLWHA and negative effects on the individual's behaviour, protective strategies and willingness to be tested. The prohibition against needle exchange programs in prisons might present a hindrance for effective HIV preventive work for IDUs in prisons.

Page 23

- 40) **7. Has the country followed up on commitments towards universal access made during the High-Level AIDS Review in June 2006?**

Yes (0)

Page 25

- 41) **7.3 Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?**

No (0)

- 42) **7.4 Is HIV programme coverage being monitored?**

No (0)

Page 30

43) **Overall, how would you rate strategy planning efforts in the HIV programmes in 2009?**

6 (6)

44) **Since 2007, what have been key achievements in this area:**

From 2009, the National HIV Strategy - Acceptance and Coping (2009-2014) involves six different ministries; Ministry of Labour and Social Inclusion, Ministry of Children and Equality, Ministry of Health and Care Services, Ministry of Justice and the Police, Ministry of Education and Ministry of the Environment and International Development. The interministerial working group established in relation to the work on the current strategy, continues its work as a steering group in the follow-up of the strategy at a senior official level. A coordinating group is established at the directorate level. The tasks of this group will be to develop early annual operational plans, secure intersectoral collaboration, and establish and follow-up an evaluation system.

45) **What are remaining challenges in this area:**

The main challenge is to establish well functioning intersectoral collaboration at governmental level to ensure adequate strategic planning and prioritization across sectors.

Page 31

46) **1. Do high officials speak publicly and favourably about HIV efforts in major domestic forums at least twice a year?**

President/Head of government	No
Other high officials	Yes
Other officials in regions and/or districts	Yes

47) **2. Does the country have an officially recognized national multisectoral AIDS coordination body (i.e., a National AIDS Council or equivalent)?**

Yes (0)

Page 32

48) **2.1 IF YES, when was it created?**

Please enter the year in yyyy format
2006

49) **2.2 IF YES, who is the Chair?**

Name	Anne-Grete Strøm-Erichsen / Erik Solheim
Position/title	Minister of Health and Care Services and Minister of Environment and International Development

50) **2.3 IF YES, does the national multisectoral AIDS coordination body:**

have terms of reference?	Yes
have active government leadership and participation?	Yes

have a defined membership?	Yes
include civil society representatives?	Yes
include people living with HIV?	Yes
include the private sector?	Yes
have an action plan?	No
have a functional Secretariat?	Yes
meet at least quarterly?	No
review actions on policy decisions regularly?	Yes
actively promote policy decisions?	No
provide opportunity for civil society to influence decision-making?	Yes
strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	

Page 33

51) **If you answer "yes" to the question "does the National multisectoral AIDS coordination body have a defined membership", how many members?**

Please enter an integer greater than or equal to 1
21

52) **If you answer "yes" to the question "does the National multisectoral AIDS coordination body include civil society representatives", how many?**

Please enter an integer greater than or equal to 1
12

53) **If you answer "yes" to the question "does the National multisectoral AIDS coordination body include people living with HIV", how many?**

Please enter an integer greater than or equal to 1
2

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54) **3. Does the country have a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies/programmes?**

Yes (0)

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55) **IF YES, briefly describe the main achievements:**

There is close collaboration between the government and civil society both in policy development (the new National HIV Strategy 2009-2014) and the implementation of the policies (NGO activities are funded through the budget allocated for the implementation of the strategy). In addition, the government and different NGOs conduct a number of HIV preventive collaborative activities where both parties are involved as equal partners. The collaboration is manifested in the National Aids Council and in formal and informal meeting arenas for government and civil society. There is little collaboration with private sector.

56) **4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?**

Please enter the rounded percentage (0-100)

- 57) **5. What kind of support does the National AIDS Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?**

Information on priority needs	Yes
Technical guidance	Yes
Procurement and distribution of drugs or other supplies	No
Coordination with other implementing partners	Yes
Capacity-building	Yes
Other: Please specify	

- 58) **6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National AIDS Control policies?**

Yes (0)

Page 36

- 59) **6.1 IF YES, were policies and laws amended to be consistent with the National AIDS Control policies?**

No (0)

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- 60) **Overall, how would you rate the political support for the HIV programmes in 2009?**

7 (7)

- 61) **Since 2007, what have been key achievements in this area:**

From 2009, the National HIV Strategy is intersectoral and involves six different ministries. The previous national HIV strategies/action plans have been rooted in the health sector only. Objectives and strategies in Acceptance and Coping involve stakeholders at all administrative levels and many sectors in society, including national, regional and local levels, civil society and NGOs.

- 62) **What are remaining challenges in this area:**

Traditionally, it has been the Ministry of Health and Care Services which has taken a lead in the HIV preventive work nationally and it might be a challenge to get the other sectors adequately involved. In addition, a lot of responsibility for HIV prevention through the primary health care services is allocated to the municipalities. Even though the municipalities are obliged by law to offer adequate HIV preventive services and activities, the degree of focus in the municipalities is depending on local prioritization and funding.

Page 39

- 63) **1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the *general population*?**

Yes (0)

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64) 1.1 IF YES, what key messages are explicitly promoted?

Check for key message explicitly promoted (multiple options allowed)

- e. Use condoms consistently (0)
- f. Engage in safe(r) sex (0)
- i. Use clean needles and syringes (0)
- j. Fight against violence against women (0)
- k. Greater acceptance and involvement of people living with HIV (0)
- l. Greater involvement of men in reproductive health programmes (0)
- n. Know your HIV status (0)

65) 1.2 In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?

No (0)

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66) 2. Does the country have a policy or strategy promoting HIV-related reproductive and sexual health education for young people?

Yes (0)

67) 2.1 Is HIV education part of the curriculum in:

primary schools?	Yes
secondary schools?	Yes
teacher training?	

68) 2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?

Yes (0)

69) 2.3 Does the country have an HIV education strategy for out-of-school young people?

Yes (0)

70) 3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for most-at-risk or other vulnerable sub-populations?

Yes (0)

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71) 3.1 IF YES, which populations and what elements of HIV prevention do the policy/strategy address?

Check which specific populations and elements are included in the policy/strategy

Targeted information on risk reduction and HIV education	Injecting drug user, Men having sex with men, Sex workers, Prison inmates, Other populations
Stigma and discrimination reduction	Injecting drug user, Men having sex

	with men, Sex workers, Other populations
Condom promotion	Injecting drug user, Men having sex with men, Sex workers, Prison inmates, Other populations
HIV testing and counselling	Injecting drug user, Men having sex with men, Sex workers, Prison inmates, Other populations
Reproductive health, including sexually transmitted infections prevention and treatment	Injecting drug user, Men having sex with men, Sex workers, Prison inmates, Other populations
Vulnerability reduction (e.g. income generation)	
Drug substitution therapy	Injecting drug user, Prison inmates
Needle & syringe exchange	Injecting drug user

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- 72) **You have checked one or more policy/strategy for "Other populations". Please specify what are "other populations".**
Immigrants

Page 44

- 73) **Overall, how would you rate the policy efforts in support of HIV prevention in 2009?**

7 (7)

- 74) **Since 2007, what have been key achievements in this area:**

The main achievement is the development of a multisectional National HIV Strategy. The strategy includes eight specific goals which again are specified into strategic moves with clear sectoral

Page 45

- 75) **4. Has the country identified specific needs for HIV prevention programmes?**

Yes (0)

Page 46

- 76) **IF YES, how were these specific needs determined?**

The specific needs of the HIV prevention programmes were identified through evidence- and experience-based knowledge, more specifically: A) "Living with HIV in Norway - 2009" study on living conditions among people living with HIV in Norway conducted by Fafo in 2008/2009 B) Experience-based knowledge from health care services and NGOs C) Norwegian and international research on HIV prevention among MSM D) International research E) Evaluation of the National HIV/STI Strategic Plan from 2002-2008 conducted by Econ Pöry in 2008 F) International knowledge review on measures to increase the use of condoms among boys and young men, Norwegian Knowledge Centre for the Health Services (2007); Evaluation of the National HIV/STI Strategic Plan 2002-2008, Econ Pöry in 2008; Evaluation of the Norwegian Directorate of Health national free condom scheme, Agenda 2008

77) **4.1 To what extent has HIV prevention been implemented?**

	The majority of people in need have access
HIV prevention component	
Blood safety	Agree
Universal precautions in health care settings	Agree
Prevention of mother-to-child transmission of HIV	Agree
IEC* on risk reduction	Agree
IEC* on stigma and discrimination reduction	Don't agree
Condom promotion	Agree
HIV testing and counselling	Agree
Harm reduction for injecting drug users	Agree
Risk reduction for men who have sex with men	Agree
Risk reduction for sex workers	Agree
Reproductive health services including sexually transmitted infections prevention and treatment	Agree
School-based HIV education for young people	Don't agree
HIV prevention for out-of-school young people	Agree
HIV prevention in the workplace	Agree
Other: please specify	

Page 47

78) **Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2009?**

6 (6)

79) **Since 2007, what have been key achievements in this area:**

Increased involvement of people living with HIV, especially MSM in the HIV preventive work. Increased focus in the health services on improved comprehensive treatment programmes based on good teamwork among health services actors involved. Two national conferences has been conducted for health personnel, NGOs and PLWHA on HIV counselling and follow-up of PLWHA. Improved knowledge about immigrants' knowledge and attitudes to HIV/AIDS.

80) **What are remaining challenges in this area:**

Since 2002, Increase in newly diagnosed HIV cases since with the highest number registered in 2008 (299); From 2003 onwards, Norway has witnessed an ongoing HIV epidemic among MSM with an epicentre in Oslo; Study show that a relatively high percentage of the Norwegian population has restrictive attitudes to HIV positive person's rights and opportunities to participate in society; People living with HIV find it as difficult to be open about their HIV status as they did 7 years ago; Preventive measures targeting ethnic minority groups are too weak and needs to be strengthened; No needle exchange programs in Norwegian prisons; Possible weakening of preventive measures targeting sex workers as a result of the ban on purchase of sexual services (2009 -).

Page 48

- 81) **1. Does the country have a policy or strategy to promote comprehensive HIV treatment, care and support? (Comprehensive care includes, but is not limited to, treatment, HIV testing and counselling, psychosocial care, and home and community-based care).**

Yes (0)

Page 49

- 82) **1.1 IF YES, does it address barriers for women?**

Yes (0)

- 83) **1.2 IF YES, does it address barriers for most-at-risk populations?**

Yes (0)

- 84) **2. Has the country identified the specific needs for HIV treatment, care and support services?**

Yes (0)

Page 50

- 85) **IF YES, how were these determined?**

The needs were determined through studies on living conditions among people living with HIV in Norway conducted by Fafo in 2008/2009 and in 2002 and through experienced based knowledge provided by different NGOs and health services.

- 86) **2.1 To what extent have the following HIV treatment, care and support services been implemented?**

	The majority of people in need have access
HIV treatment, care and support service	
Antiretroviral therapy	Agree
Nutritional care	Agree
Paediatric AIDS treatment	Agree
Sexually transmitted infection management	Agree
Psychosocial support for people living with HIV and their families	Don't agree
Home-based care	N/A
Palliative care and treatment of common HIV-related infections	Agree
HIV testing and counselling for TB patients	Agree
TB screening for HIV-infected people	Agree
TB preventive therapy for HIV-infected people	N/A
TB infection control in HIV treatment and care facilities	N/A
Cotrimoxazole prophylaxis in HIV-infected people	
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Don't agree
HIV treatment services in the workplace or	N/A

treatment referral systems through the workplace

HIV care and support in the workplace (including alternative working arrangements)

N/A

Other: please specify

Page 51

87) **3. Does the country have a policy for developing/using generic drugs or parallel importing of drugs for HIV?**

No (0)

88) **4. Does the country have access to *regional* procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy drugs, condoms, and substitution drugs?**

No (0)

Page 53

89) **Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2009?**

8 (8)

90) **Since 2007, what have been key achievements in this area:**

Improved access to VCT for MSM in Oslo through the establishment of a health clinique for MSM one evening a week in a GP office. New guidelines for health services for refugees and asylum seekers in reception centres underlining the importance of VCT for HIV in transit.

91) **What are remaining challenges in this area:**

A fairly high number of undiagnosed HIV infections is an obstacle to start treatment prior to symptoms of the disease and for preventing HIV transmission to other individuals. A challenge is thus to reach at-risk groups with information on the importance of early testing. HIV-positive undiagnosed refugees and immigrants are especially vulnerable due to shortcomings in testing routines in health services in reception centres, while undocumented migrants lack access to proper health services. The health services fall short in their follow-up on PLWHA in relation to life skill training with a special emphasis on sexual health. A number of NGOs are doing important work related to psychosocial follow-up of PLWHA, but these services are only reaching a minority of PLWHA. Thus the health sector needs to improve its efforts. In addition, improved collaboration between primary and specialist health services is needed to ensure comprehensive and adequate follow-up of the health situation of PLWHA

Page 54

92) **5. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?**

N/A (0)

Page 57

93) **1. Does the country have *one* national Monitoring and Evaluation (M&E) plan?**

In progress (0)

Page 63

94) 4. Are M&E priorities determined through a national M&E system assessment?

No (0)

Page 64

95) IF NO, briefly describe how priorities for M&E are determined:

The government has since mid 1980ties given priority outcome monitoring through the establishment of 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. Thus, incidence and prevalence of HIV and surrogate markers such as Gonorrhoea, Syphilis (infectious) are monitored continuously. In addition, the number of HIV tests is surveyed annually.

96) 5. Is there a functional national M&E Unit?

In progress (0)

Page 68

97) What are the major challenges?

The main challenge faced in implementing a comprehensive M&E system is related to the lack of a systematic approach to data gathering across sectors. There is a limited overview of data on relevant indicators from other sectors.

Page 69

98) 6. Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities?

No (0)

Page 70

99) 7. Is there a central national database with HIV- related data?

Yes (0)

Page 71

100) 7.1 IF YES, briefly describe the national database and who manages it

Surveillance of HIV is done by the Norwegian Institute of Public Health. Patient data reported includes gender, month and year of birth and place of residence. In addition a variety of epidemiological data is reported including country of birth, diagnostic methods, isolation site, drug resistance, indication for testing, place of infection, clinical picture, and information on gender and relationship to source partner. The data is available through yearly reports and through the database www.msis.no.

101) 7.2 IF YES, does it include information about the content, target populations and geographical coverage of HIV services, as well as their

implementing organizations?

No, none of the above (0)

Page 72

102) 7.3 Is there a functional* Health Information System?

At national level	Yes
At subnational level	No

Page 73

103) 8. Does the country publish at least once a year an M&E report on HIV, including HIV surveillance data?

Yes (0)

104) 9. To what extent are M&E data used

9.1 in developing / revising the national AIDS strategy?:

4 (4)

105) Provide a specific example:

Considerable effort was made to evaluate the strategic plan in the period 2008-2009. Econ Pöyry conducted an evaluation of the strategic plan in 2008, while Agenda evaluated the Norwegian Directorate for Health's national scheme providing free condoms to adolescents, young adults and particularly at-risk groups and the two biggest recipients of subsidies throughout the whole planning period HivNorway and Gay & Lesbian Health Norway.

106) What are the main challenges, if any?

A (centralized) quality register on HIV in the health services does not exist, which makes it difficult to extract relevant data on HIV from the health sector.

Page 74

107) 9. To what extent are M&E data used

9.2 for resource allocation?:

4 (4)

108) Provide a specific example:

Increased incidence of HIV among MSM since 2003, have led to continuous focus and funding of HIV preventive activities targeting MSM.

109) What are the main challenges, if any?

There has been an increase in PLWHA from ethnic minority groups the past years. This development has however not been reflected in the strengthening of targeted measures for this vulnerable group.

Page 75

110) **9. To what extent are M&E data used**

9.3 for programme improvement?:

2 (2)

Page 76

111) **10. Is there a plan for increasing human capacity in M&E at national, subnational and service-delivery levels?:**

No (0)

Page 77

112) **10.1 In the last year, was training in M&E conducted**

At national level?	No
At subnational level?	No
At service delivery level including civil society?	No

Page 79

113) **10.2 Were other M&E capacity-building activities conducted other than training?**

No (0)

Page 81

114) **Overall, how would you rate the M&E efforts of the HIV programme in 2009?**

5 (5)

115) **Since 2007, what have been key achievements in this area:**

A comprehensive study on living conditions of persons living with HIV/AIDS were completed in 2009. In 2007, a study on Internet, e-dating and sexual risk behaviour among Norwegian MSM was conducted. A representative study on people's knowledge about and attitudes to HIV was carried out in 2008, and a web-survey among youth on sexuality and contraception in 2009. In addition, see information provided in 9.1 regarding evaluation of the National Strategic Plan (2002-2008).

116) **What are remaining challenges in this area:**

The main challenge faced in implementing a comprehensive M&E system is related to the lack of a systematic approach to data gathering across sectors. There is a limited overview of data on relevant indicators from other sectors.

Page 82

117) **1. Does the country have laws and regulations that protect people living with HIV against discrimination? (including both general non-discrimination provisions and provisions that specifically mention HIV, focus on schooling, housing, employment, health care etc.)**

Yes (0)

Page 83

118) 1.1 IF YES, specify if HIV is specifically mentioned and how or if this is a general nondiscrimination provision:

An Anti-discrimination and Accessibility Act was introduced in January 2009, tailored to curb discrimination on the basis of disabilities. This is a general act, given the fact that it encompasses most social spheres. It is however specific in the sense that it only applies to people with disabilities. Due to a broad definition of disabilities, people living with HIV (PLHIV) are implicitly protected by this Anti-discrimination and Accessibility Act. However, a new law against discrimination has been proposed. This proposed law aims at providing a common basis against all forms of discrimination a person or a group can be exposed to. If this law is passed, it will reduce the protection against discrimination PLHIV enjoy under the present Anti-discrimination and Accessibility Act.

119) 2. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations and other vulnerable subpopulations?

Yes (0)

Page 84

120) 2.1 IF YES, for which subpopulations?

a. Women	Yes
b. Young people	Yes
c. Injecting drug users	Yes
d. Men who have sex with men	Yes
e. Sex Workers	No
f. prison inmates	No
g. Migrants/mobile populations	Yes
Other: Please specify	

121) IF YES, briefly explain what mechanisms are in place to ensure these laws are implemented:

Since January 2006, the Norwegian Authorities have established an Equality and Anti-Discrimination Ombud, as a joint effort to increase equality and non-discrimination. This Ombud operates independently within his or her field of expertise but is administratively integrated within the Ministry of Children and Equality. The Ombud serves dual purposes, as enforcer of the laws listed below, and as a promoter of efforts to encounter discrimination and promote equality regardless of factors like gender, ethnicity, disability, sexual orientation and age. The before-mentioned list of most-at-risk-populations are implicitly part of their mandate. Additionally, NGOs working for the protection of different at-risk-populations and other vulnerable subpopulations (incl. PLHIV), attempt to offer some degree of legal aid assistance and expertise to their target groups (e.g. The Norwegian LGBT Association, HIV-Norway, Sex-workers Association in Norway and The Norwegian Federation of Organizations of Disabled People).

122) Briefly describe the content of these laws:

We have four important Acts in Norway prohibiting discrimination: The Gender Equality and Anti-discrimination Law, the Anti-discrimination and Accessibility Act, the Act prohibiting discrimination on the basis of ethnicity, religion, a.o., and the Law on Work Environment and Equal treatment (chapter13), prohibiting discrimination in the work environment (under which PLHIV are classified under the category “disabled”). These Acts apply to all areas of society, with the exception of family life and other matters of a personal nature. Men who have sex with men (MSM) are however not encompassed by these Acts, but are protected under the Penal Code § 135a, on discriminatory and malicious statements (meaning to threaten or disdain someone, or promote hatred, persecution or scorn due to a) color of skin or national or ethnic origins; b) religion or lifestyle, or c) homosexual orientation or lifestyle).

123) Briefly comment on the degree to which they are currently implemented:

For both legal provisions mentioned, the main challenge lies in establishing sufficient level of proof of discrimination. I.e. the laws primarily protect against the most blatant, explicit and non-negotiable kind of discrimination and harassment, where as more subtle forms of discrimination will be much harder to prove in the court system and hence less likely to be tried.

Page 85

124) 3. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations and other vulnerable subpopulations?

Yes (0)

Page 86

125) 3.1 IF YES, for which subpopulations?

a. Women	No
b. Young people	No
c. Injecting drug users	Yes
d. Men who have sex with men	No
e. Sex Workers	Yes
f. prison inmates	Yes
g. Migrants/mobile populations	Yes
Other: All HIV positive people	Yes

126) IF YES, briefly describe the content of these laws, regulations or policies:

*Section 155 of the Penal Code has the purpose of protecting the society against the spread of communicable diseases that are hazardous to public health. This provision imposes penalties of maximum 6 years imprisonment on those who have good reason to believe that they are infected with a communicable disease that is hazardous to public health and who willfully or negligently transmit that infection or expose someone else to the risk of becoming infected. *Penal code article 202a prohibits the act of buying sexual services. This law came into effect on January 1. 2009, and has made the practice of paying for sex illegal, but not the act of selling sex. *Penal code article 202 prohibits all kind of activity related to prostitution including advertising and renting out premises. Norway has recently experienced a

radical shift in the political approach to prostitution, from traditionally being seen as a social problem to becoming an arena for combating international organized crime and human trafficking.

127) Briefly comment on how they pose barriers:

§155: Obviously, the aspect of criminalization of their status complicates an open and trusting relation with the support structure for PLHIV, and may lead to serious reluctance to testing for HIV among the general public and groups at risk. Fear of being handed over to the police has also lead HIV-positive women to linger in violent, discordant relationships. § 155 places responsibility for protection against infection solely on the shoulders of the HIV-positive person, thus relieving the supposedly HIV-negative person of all responsibility, hence creating a divide, and possible discrimination. §202 and 202a: The effects of police enforcement has affected the sex workers' relation to other services, such as harm reduction services, as many refuse to associate with anything or anyone that may give the police a suspicion of sex work. Condoms are used as evidence, hence the sex workers position for negotiation with the client about safe sex as been weakened.

Page 87

128) 4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?

Yes (0)

Page 88

129) IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:

In 2009, Acceptance and coping – National HIV strategy (2009-2014) was launched. The strategy states that "it is based on important general principles, such as: Human Rights, the gender perspective, equal access to information and public services and the independent responsibility that all of us have to protect ourselves from infection and to avoid infecting other people".

130) 5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, most-at-risk populations and/or other vulnerable subpopulations?

No (0)

Page 89

131) 6. Has the Government, through political and financial support, involved people living with HIV, most-at-risk populations and/or other vulnerable subpopulations in governmental HIV-policy design and programme implementation?

Yes (0)

Page 90

132) IF YES, describe some examples:

The Norwegian Health Authorities at present support NGOs working with HIV and health promotion among prostitutes, men who have sex with men, immigrants etc. Some of these will from time to time be involved in policy-making processes (eg. The mentioned strategic plan). However, this is not a regulated routine or a mandate explicitly delegated to certain NGOs.

133) **7. Does the country have a policy of free services for the following:**

a. HIV prevention services	Yes
b. Antiretroviral treatment	Yes
c. HIV-related care and support interventions	Yes

Page 91

134) **IF YES, given resource constraints, briefly describe what steps are in place to implement these policies and include information on any restrictions or barriers to access for different populations:**

The Communicable Disease Control Act is meant to safeguard free medical assistance and health services to all people living with HIV, regardless of status of legal residency in the country. Some barriers to be mentioned are: *Geographic challenges, as some services only exist in the larger cities, and local health institutions struggle to offer expertise on the field. *PLHIV report that they need to be relatively resourceful and knowledgeable to claim their full rights, as proficiency on HIV does not cut across all parts of the health- and social services. *HIV-related treatment is hard to define, and the contents of "support intervention" is conceived unclear. *Reported widespread prejudice in health- and social- service-institutions against drug users complicates access to and maintenance of treatment for this most-at-risk group. *Lack of culture-sensitive approaches to treatment, care and information may discourage easy access to services and information for migrants, who may also lack experience from rights-based societies like Norway. The requirement of a personal security number for easy access to treatment also makes it hard for asylum seekers and illegal aliens to claim their rights.

135) **8. Does the country have a policy to ensure equal access for women and men to HIV prevention, treatment, care and support?**

Yes (0)

Page 92

136) **8.1 In particular, does the country have a policy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?**

Yes (0)

137) **9. Does the country have a policy to ensure equal access for most-at-risk populations and/or other vulnerable subpopulations to HIV prevention, treatment, care and support?**

Yes (0)

Page 93

138) **IF YES, briefly describe the content of this policy:**

The Norwegian health system is based on the principle of "universal access". However, putting this principle into practice poses some problems, e.g. in the case of prisons, where free access to disposable injecting equipment is denied. The principle of "holistic plans for care and support" is also reported most difficult in practice, and the services offered vary a lot depending on where you live.

- 139) **9.1 IF YES, does this policy include different types of approaches to ensure equal access for different most-at-risk populations and/or other vulnerable sub-populations?**

Yes (0)

Page 94

- 140) **IF YES, briefly explain the different types of approaches to ensure equal access for different populations:**

NGOs put in a lot of effort to try and assist the needs of their respective target groups, but ultimately, location of residency determine a lot of the services. Access to free, clean injecting equipment to drug users etc. organized by the authorities and NGOs, is part of preventive measures and equal access to safe injections for all. In prisons, inmates are offered chlorine as a cleansing device.

- 141) **10.Does the country have a policy prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?**

Yes (0)

- 142) **11.Does the country have a policy to ensure that HIV research protocols involving human subjects are reviewed and approved by a national/local ethical review committee?**

Yes (0)

Page 95

- 143) **11.1 IF YES, does the ethical review committee include representatives of civil society including people living with HIV?**

No (0)

- 144) **IF YES, describe the approach and effectiveness of this review committee:**

Norway has three National Committees for Research Ethics. The three independent but coordinated national committees for research ethics cover all scientific disciplines. It is a characteristic feature of the Norwegian model that the committees do not only deal with issues within the more narrowly defined field of research ethics, but include the broader field of the ethics of science. This includes issues of scientific responsibility for larger social concerns. The members of the committees are appointed by the Ministry of Education, Research and Church Affairs upon recommendation from the Research Council of Norway. This procedure ensures both political independence and scientific competence. All members are selected on the basis of personal qualifications, none function as representatives of interest groups. In each committee the main fields of the committee's area of responsibility are covered. In addition, representation from the fields of ethics and law is included, as well as a number of lay members. The committees work is open to public inspection.

Page 96

- 145) **– Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work**

No (0)

146) – Focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment

No (0)

147) – Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts

No (0)

Page 98

148) 13. In the last 2 years, have members of the judiciary (including labour courts/ employment tribunals) been trained/sensitized to HIV and human rights issues that may come up in the context of their work?

No (0)

149) – Legal aid systems for HIV casework

No (0)

150) – Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV

No (0)

151) 15. Are there programmes in place to reduce HIV-related stigma and discrimination?

Yes (0)

Page 99

152) IF YES, what types of programmes?

Media	No
School education	No
Personalities regularly speaking out	Yes
Other: Some NGOs	Yes

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153) Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2009?

3 (3)

154) Since 2007, what have been key achievements in this area:

The development and launching of the new National HIV-strategy- "Acceptance and Coping" and the following explicit delegation of responsibilities among six ministries, is seen as a major achievement on policy level

155) What are remaining challenges in this area:

The introduction and enforcement of new laws and regulations, like penal code §155 (see abbreviation under 3.1.) and §202/a represent a clear negative set-

back. The lack of a system to record and document cases of discrimination on the grounds of HIV-status also remain a challenge.

Page 101

156) **Overall, how would you rate the efforts to enforce the existing policies, laws and regulations in 2009?**

3 (3)

157) **Since 2007, what have been key achievements in this area:**

The development and launching of the new National HIV-strategy- "Acceptance and Coping" and the following explicit delegation of responsibilities among six ministries, is seen as a major achievement on policy level.

158) **What are remaining challenges in this area:**

The main challenge in Norway, as various research reports testify to, is to inform the general public about how HIV is transmitted, and how it is not transmitted, and what an HIV-positive status means for the quality of life of those infected and affected. A better informed general public on these and similar issues would be an important contribution towards improving the life quality of people living with HIV. Additionally, the introduction and enforcement of new laws and regulations, like penal code §155 (see abbreviation under 3.1.) and §202/a represent a clear negative set-back. The lack of systems to record and document cases of discrimination on the grounds of HIV-status also remain a challenge

Page 102

159) **1. To what extent has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?**

2 (2)

160) **Comments and examples:**

Civil society institutions were to some degree included in the process of finalizing the National HIV strategy, and appreciate this opportunity to influence policy formulations. The general interest for and in debt knowledge about HIV as a field is however conceived to be lacking among Norwegian politicians, and the lobby and advocacy opportunities are hence rather limited.

Page 103

161) **2. To what extent have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?**

2 (2)

162) **Comments and examples:**

Civil society institutions were to some degree included in the process of finalizing the National HIV strategy, and appreciate this opportunity to influence policy formulations. The general interest for and in debt knowledge about HIV as a field is however conceived to be lacking among Norwegian politicians, and the lobby and advocacy opportunities are hence rather limited.

Page 104

163) a. the national AIDS strategy?

4 (4)

164) b. the national AIDS budget?

3 (3)

165) c. national AIDS reports?

4 (4)

166) Comments and examples:

Civil society institutions are well integrated in the total services and work dedicated to PLHIV and preventive efforts in Norway, and hence comply well with the Norwegian civil democracy model typical for many aspects of our society.

Page 105

167) a. developing the national M&E plan?

1 (1)

168) b. participating in the national M&E committee / working group responsible for coordination of M&E activities?

1 (1)

169) c. M&E efforts at local level?

0

170) Comments and examples:

Civil society in Norway is at present not included in monitoring and evaluation of the HIV response.

Page 106

171) 5. To what extent is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. networks of people living with HIV, organizations of sex workers, faith-based organizations)?

4 (4)

172) Comments and examples:

The group of organizations and individuals involved in HIV-related efforts is quite diverse and representative of a huge variety of civil society institutions, ranging from organizations for people living with HIV, organizations for sex workers, international development aid/solidarity based organizations, youth federations, etc. Most of these institutions participate in/are included in the informal structure called "Aidsnett". Aidsnett was started in 2001, and comprises over 170 Norwegians working with HIV/AIDS internationally or in Norway. The net work of organizations and individuals is seen as a benefit for information sharing and facilitation of advocacy efforts. The relative lack of clear mandates of representation or constituency and systematic and coherent lobby- and advocacy efforts do however limit the powers to influence on policy levels somewhat, and may explain some sense of lack of achievements and

involvement felt by many of the organizations.

Page 107

173) **a. adequate financial support to implement its HIV activities?**

1 (1)

174) **b. adequate technical support to implement its HIV activities?**

3 (3)

175) **Comments and examples:**

There has been no increase in the funding in the HIV and aids field in Norway since 1998. An ambitious new strategy that focuses on the participation of NGOs as a strategic factor in fighting the epidemic requires appropriate funding. Since 2003 Norway has witnessed a worrying increase in HIV infections among men who have sex with men. The Norwegian national HIV strategy focuses on men who have sex with men and immigrants as minority groups in Norway as especially vulnerable to HIV. Targeting MSM as a strategic group in the Norwegian HIV prevention plans is of no value, without an adequate and increased funding. For example, Gay and Lesbian Health Norway, the leading HIV prevention NGO among MSM in Norway, has since the launching of the new strategy not experienced an increased level of founding and is at present serving the target group with the same resources as in the early 1990s. This is the case for most HIV-related NGOs in Norway.

Page 108

176) **7. What percentage of the following HIV programmes/services is estimated to be provided by civil society?**

Prevention for youth	<25%
Prevention for most-at-risk-populations	
- Injecting drug users	<25%
- Men who have sex with men	>75%
- Sex workers	25-50%
Testing and Counselling	<25%
Reduction of Stigma and Discrimination	>75%
Clinical services (ART/OI)*	<25%
Home-based care	<25%
Programmes for OVC**	<25%

Page 109

177) **Overall, how would you rate the efforts to increase civil society participation in 2009?**

3 (3)

178) **Since 2007, what have been key achievements in this area:**

Since 2007, what have been key achievements in this area: Given the budget constraints/stagnant financial framework for civil society participation the past decade, no radical changes or staggering national achievements may be listed, but the following are seen as positive contributions: *The foundation of "Homopositiv" in 2009, and organization for HIV-positive, gay men; *The Health

Authorities' increased focus on marginalized minority groups, especially immigrants and men who have sex with men.

179) What are remaining challenges in this area:

*The limited financial support remains a huge obstacle. Other challenges are:
 *Inclusion of community based organizations in the HIV preventive work and especially in the construction of community based testing and counseling. Such non-governmental intervention provided by the civil society among men who have sex with men have met with success in Denmark and England
 *Improved organization of vulnerable groups, to voice their specific needs and challenges.

Page 110

180) 1. Has the country identified the specific needs for HIV prevention programmes?

Yes (0)

Page 111

181) IF YES, how were these specific needs determined?

In the process of forming the Norwegian National HIV strategy, "Acceptance and Coping" (2009-2014), specific needs for HIV prevention programs were identified and explored. The work on the strategy has been rooted in an interministerial steering group at the state secretary and senior official level, chaired by the Ministry of Health and Care Services, with representatives from the six different ministries. The strategy development process has involved civil society, relevant research institutes as well as public authorities. A draft of the strategy was also submitted to the National AIDS Council. Research material and evaluations of relevant NGOs also formed the background for determining these needs. A report on Living conditions and quality of life among people living with HIV in Norway (2009) by The Institute for Labor and Social Research (FAFO) is one example.

182) 1.1 To what extent has HIV prevention been implemented?

	The majority of people in need have access
HIV prevention component	
Blood safety	Agree
Universal precautions in health care settings	Agree
Prevention of mother-to-child transmission of HIV	Agree
IEC* on risk reduction	Don't agree
IEC* on stigma and discrimination reduction	Don't agree
Condom promotion	Agree
HIV testing and counselling	Agree
Harm reduction for injecting drug users	Agree
Risk reduction for men who have sex with men	Agree
Risk reduction for sex workers	Agree
Reproductive health services including sexually transmitted infections prevention and treatment	Agree
School-based HIV education for young people	Don't agree

HIV prevention for out-of-school young people	Don't agree
HIV prevention in the workplace	Don't agree
Other: Immigrants	Don't agree

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183) Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2009?

6 (6)

184) Since 2007, what have been key achievements in this area:

The making of the National Aids strategy in 2009 is perceived the one key achievement during this period in time.

185) What are remaining challenges in this area:

*Accessing the general public with information remains a major challenge, as the topic is not prioritized or sensitized by the media, nor by vocal politicians etc. *The implementation of the HIV prevention programs in Norway is not well tailored according to the specific needs of the at risk groups. NGOs involved in the implementation could ground their HIV intervention better in scientific data and evaluation on a yearly basis. *Penal code § 202 (prohibiting the act of buying sex), makes it increasingly difficult to reach sex workers with prevention work and information. *The availability of drop-in-testing in areas outside the capital is an uncovered need. *Access for clean injecting equipment and condoms for sex workers and drug users outside the major cities remains a challenge.

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186) 1. Has the country identified the specific needs for HIV treatment, care and support services?

Yes (0)

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187) IF YES, how were these specific needs determined?

Research material like the report on Living conditions and quality of life among people living with HIV in Norway (2009) by The Institute for Labor and Social Research (FAFO) form the basis of needs assessments like these.

188) 1.1 To what extent have the following HIV treatment, care and support services been implemented?

	The majority of people in need have access
HIV treatment, care and support service	
Antiretroviral therapy	Agree
Nutritional care	Don't agree
Paediatric AIDS treatment	Agree
Sexually transmitted infection management	Agree
Psychosocial support for people living with HIV and their families	Don't agree
Home-based care	Don't agree

Palliative care and treatment of common HIV-related infections	Agree
HIV testing and counselling for TB patients	Agree
TB screening for HIV-infected people	Agree
TB preventive therapy for HIV-infected people	Agree
TB infection control in HIV treatment and care facilities	Agree
Cotrimoxazole prophylaxis in HIV-infected people	Agree
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Agree
HIV treatment services in the workplace or treatment referral systems through the workplace	N/A
HIV care and support in the workplace (including alternative working arrangements)	N/A
Other: PEP Post-exposure prophylaxis for non-occupational/non-rape, "private" exposures; X – available since 2009 but not accessible to the majority of people in need	Don't agree

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189) **Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2009?**

5 (5)

190) **What are remaining challenges in this area:**

A holistic approach and complementing services, with more emphasis on the psycho-social aspect of the care and support needs of PLHIV remain a huge challenge in the Norwegian health care system. Children and elderly people living with HIV represent a particular challenge to tailored treatment, care and support.

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191) **2. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?**

No (0)

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...mesker i verden lever
...04-2005



...Afrika
...15 millioner

...arisk Afrika
... millioner

Vest
610

...Østen 540 000

