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Government Offices of Sweden

UNGASS

Country Progress Report 2010

SWEDEN

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The Unit for National Coordination of HIV Prevention, at the National Board of Health and Welfare, together with a number of partners from different sectors, has contributed to the UNGASS Report, 2010. The following agencies, institutions and organisations have contributed to this report:

SMI	Swedish Institute for Infectious Disease Control
KV	Swedish Prison and Probation Service
KI	Karolinska Institutet
KS	Karolinska University Hospital
SHP	Swedish Prison Project
NBHW	National Board of Health and Welfare
MFA	Ministry for Foreign Affairs (UD)
SIDA	Swedish International Development Agency
Skolverket	Swedish National Agency for Education
FHI	Swedish National Institute of Public Health
GU	University of Gothenburg
DFR	Dalarna Research Institute (Herlitz)
MAH	Malmö Högskola
InfCare	
RAV	Swedish Reference Group for Antiviral Therapy

The following organisations were invited to participate in the work with the National Composite Policy Index Part B:

AFRICANET
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SHAI
Stockholm Gay Life
Swedish Hemophilia Society
The Somali Health Team

Including the stakeholders in the report writing process

The writing process began in December, 2008 at a stakeholders meeting where a project plan for the UNGASS writing process was presented. The project plan included the necessity for the different stakeholders to develop additional data sets and collection mechanisms to support the UNGASS writing process. The NBHW assumed responsibility for compiling data from relevant actors as well as coordinating the writing process. The aim was to ensure that the process was transparent, inclusive and that all actors received an opportunity to influence the final product. Parallel to the key stakeholders meeting, two meetings were held with the NGO community where the project plan was presented. The NGO community chose a representative who has functioned as a reference person concerning the NBHW work with UNGASS during the writing process.

In December 2009, the National Composite Policy Index (NCPI) Questionnaire, Part B was submitted by the NGO representative. At the same time, the UN released their online reporting tool, including the 'observer' function. The log-in information was shared with the reference person as well as with other key stakeholders. Since the major epidemiological data could only be finished by late January, 2010, a review process with key stakeholders was held in late February in order to provide an opportunity for final comments and remarks.

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TABEL OF CONTENT

ACKNOWLEDGEMENTS **2**
Including the stakeholders in the report writing process 3

List of Figures 7

List of Tables 8

List of Abbreviations 9

STATUS AT A GLANCE 11

The Status of the Epidemic 11
Surveillance of HIV and AIDS 12
Second generation surveillance in Sweden 12
The HIV epidemic 12
AIDS and AIDS deaths 13
Current HIV prevalence and incidence estimates 13

National Strategic Policy and Programmatic Response 14
Strategic policy 14
Primary objectives of Swedish HIV and AIDS prevention 15
Leadership and coordination 16
Central government 17
Municipal and regional government 17
The National HIV council 17
Main public actors 17
Main Public International Actors 19
Non-governmental organisations (NGO) 19
National HIV/AIDS prevention policy – primary MARPs 20
Primary approaches to HIV/AIDS prevention 20

Funding for HIV/AIDS prevention, Treatment, Care and Support 21

OVERVIEW OF THE HIV/AIDS EPIDEMIC IN SWEDEN 2008–2009 22

Access to Voluntary Counselling and Testing 22

HIV Screening 23

HIV/AIDS Case Reporting 24

Access to ART 24

UNGASS Indicator Data 24

HIV/AIDS in Major and Minor Transmission MARPS 2008–2009 26
General population 27
Heterosexual population 27
Youth and young adults 27
Men who have sex with men 27
Migrants to Sweden 28
People travelling abroad 28
Injecting drug use 28
Correctional facilities 29

Persons buying and selling sex 29
Mother-to-child transmission 29
Blood and organ donations 29

NATIONAL RESPONSE TO THE HIV/AIDS EPIDEMIC *30*

Prevention for MARPs **30**

Research and Development **31**

National Response for MARP **33**

Youth and Young Adults **39**

Men who have Sex with Men **48**

Migrants to Sweden **53**

People Travelling Abroad **57**

Injecting Drug Use **57**

Persons Buying and Selling Sex **63**

Mother-to-Child-Transmission **65**

Nosocomial Transmission **65**

Treatment and Care **67**

Support **67**

Stigma and Discrimination **68**

National Communications Strategy **71**

Legal and Policy Framework for HIV/AIDS **72**

NATIONAL BEST PRACTISES *79*

The Prevention Resources Allocation Index Model – 'Fördelningsindex' **79**

Colour of Love – An Annual Outreach Campaign **81**

OVERALL CHALLENGES *83*

Progress made on Key Challenges Reported in the Previous UNGASS Report **83**

Challenges Faced Throughout the Reporting Period 2008–2009 **84**

Concrete Remedial Actions Planned to Ensure Achievement of Agreed UNGASS Targets **84**

SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS *86*

SUPPORT FOR GLOBAL COMMITMENTS *87*

International Development Policy **87**

International Cooperation Policy **88**

Global Fund **88**

Regional Activities **88**

MONITORING AND EVALUATION ENVIRONMENT *90*

Overview of the Current Monitoring and Evaluation (M&E) System **90**

Challenges faced in the Implementation of a Comprehensive M&E System **91**

Remedial Actions Planned to Overcome the Challenges **92**

The Need for M&E Technical Assistance and Capacity Building **92**

REFERENCES *93*

A. UNGASS INDICATORS *96*

Commitment and action **96**

National Programs **96**

Knowledge and behavior **103**

Impact **109**

B. NATIONAL COMPOSITE POLICY INDEX (NCPI) *113*

List of Figures

Figure 1: Number of AIDS cases reported ... 13
Figure 2: HIV incidence per 100 000 people... 14
Figure 3: Population in Sweden... 30
Figure 4: Number of people testing positive per origin of transmission .. 34
Figure 5a: Total number of HIV positive domestic and non-domestic cases ... 35
Figure 5b: Number of domestic people testing HIV positive... 36
Figure 6: Number of people infected prior to arrival tested ... 36
Figure 7: Percentage of 16–44 who have taken an HIV test. ... 37
Figure 8: Percentage of respondents 16–44 who have had sexual intercourse with more than one partner... 38
Figure 9: Percentages of respondents 16–44 who have had sexual intercourse on a first date without condom... 39
Figure 10: Number of Youth & Young Adults testing positive. ... 40
Figure 11: Number of domestic Youth & Young Adults testing HIV positive ... 41
Figure 12: Chlamydia incidence... 42
Figure 13: Percent of young women and men who have had sexual intercourse with more than one partner... 46
Figure 14: Percentage of young women and men who have had casual sex without using a condom ... 47
Figure 15: Number of abortions per 1 000 women... 48
Figure 16: Number of MSM testing positive per origin of transmission... 49
Figure 17: Number of domestic MSM and General Public testing HIV positive. ... 50
Figure 18: Domestic HIV infection compared to the group of people infected with HIV prior to arrival ... 54
Figure 19: Number of domestic and non-domestic people testing HIV positive... 55
Figure 20: Number of IDU testing positive per origin of transmission... 58
Figure 21: Number of domestic IDU and General Public testing HIV positive. ... 59
Figure 22: Number of IDU cases testing positive per major county council... 62
Figure 23: Percentage of women and men who answered whether they would avoid close contact with HIVpositive... 69

List of Tables

Table 1: Percentage per sex and age groups of domestic HIV cases 22
Table 2: Percentage of respondents aged who have been tested for HIV. 45
Table 3: Percentage of young women and men who have experienced their first intercourse before the age of 15 years... 45
Table 4: Percentage of respondents who have had sexual intercourse with more than one partner.......... 45
Table 5: Estimated number of PDU per 1000 inhabitants and county council........ 61

List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
CMO	County Medical Officer
CT	Chlamydia Trachomatis
ECDC	European Centre for Disease Control
FHI	Swedish National Institute of Public Health
GFATM	Global Fund against AIDS, TB and Malaria
GU	University of Gothenburg
HBV	Hepatitis B
HCV	Hepatitis C
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug User
KAP(B)	Knowledge, Attitude, Practise (& Belief)
KI	Karolinska Institutet
KS	Karolinska University Hospital
KV	Swedish Prison and Probation Service
LAFA	Stockholm County AIDS Prevention Programme
LGBT	Lesbian, Gay, Bisexual and Transgender
LTS	Low-Threshold Services
M&E	Monitoring and Evaluation
MARP	Most at Risk Population
MFA	Ministry for Foreign Affairs (UD)
MHSA	Ministry of Health and Social Affairs
MTCT	Mother to Child Transmission
MSM	Men who have Sex with Men
NAP	National Action Plan
NAS	National Action Strategy
NBHW	National Board of Health and Welfare
NCPI	National Composite Policy Index
NCS	National Communications Strategy
NGO	Non-Governmental Organization
NSEP	Needle and Syringe Exchange Program
PDU	Problematic Drug Use
PLWHA	People Living With HIV/AIDS
R&D	Research and Development
RAP	Regional Action Plan
RAV	Swedish Reference Group for Antiviral Therapy

RFSL	Swedish Federation for Lesbian, Gay, Bisexual and Transgender Rights
RFSU	Swedish Association for Sexuality Education
SALAR	Swedish Association of Local Authorities and Region (SKL)
SEK	Swedish Crown
SGS	Second Generation Surveillance
SHP	Swedish Prison Project
SIDA	Swedish International Development Agency
Skolverket	Swedish National Agency for Education
SMI	Swedish Institute for Infectious Disease Control
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
SW	Sex Worker
UB	The Youth Barometer (Ungdomsbarometern)
UMO	Youth Clinics (online)
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNGKAB	Young & Young Adults study
VCT	Voluntary Counselling and Testing
WAD	World Aids Day
YC	Youth Clinics

STATUS AT A GLANCE

The epidemic is increasing slowly; 8 935 reported cases in total since the beginning,

- The HIV is endemic in the MSM population
- Latest IDU peak was in 2007.
- Since 2002, the majority of new cases have been immigrants = a new face of the epidemic.
- Youth demonstrate high risk behaviour patterns in general and have high levels of Chlamydia.

Several national initiatives have been launched during 2007–2009:

- The National HIV Council with chairperson appointed by the Government has become active.
- NBHW has built up National Coordination during the last 3 years
- Systematic MARP studies for MSM, Youth and IDU with built-in monitoring functions.
- Chlamydia NAP targeting youth and young adults.
- National Overall Communications strategy for HIV and STI prevention.
- A system for increased regional/national/international networking and information sharing including a web portal www.hivportalen.se launched by the National HIV Council.
- A research and development approach with the purpose of increasing evidence-based interventions.

The Status of the Epidemic

By the end of 2009, a total of 8 935 HIV positive cases had been detected in Sweden. 6206, or 70%, are men [1]. Of the 8 935 HIV positive persons, approximately 5 240 are living with HIV today. The number of new cases detected has been relatively stable over time with a slowly increasing trend since 2002. Since the late 1980s up to 2002, approximately 300 new cases have been detected annually; while after this date the annual number of new cases has been approximately 400. Since 2002, more than half of the newly detected cases are people who are infected prior to arrival in Sweden. Of the endemic most at risk population (MARP) the MSM population is the only population showing a more or less steadily increasing trend since 2002.

Surveillance of HIV and AIDS

The epidemiological surveillance of HIV/AIDS in Sweden is a mandatory reporting system in accordance with the Communicable Disease Prevention and Control Act. Surveillance is carried out by the Swedish Institute for Infectious Disease Control (SMI) in collaboration with the county councils. The system used is an electronic reporting system database called SmiNet [1]. All new HIV/AIDS cases detected must be noted in this system by the patient's doctor and by the microbiological laboratory who detects the case. The National Board of Health and Welfare (NBHW) complement the SmiNet system by monitoring knowledge, attitude and practice (KAP) in the general population and, in certain MARP on national level, and together SMI and the NBHW form a national second generation surveillance system (SGS). A national quality register for care run by the primary clinics for infectious diseases in the country is the main source of information for data concerning treatment and care.

Second generation surveillance in Sweden

During the last 2 years the NBHW has led a process to create a Second Generation Surveillance (SGS) system in Sweden. Contracts with leading researchers and universities have led to three systematic and reoccurring population studies and one sentinel study on KAP patterns for:

- The general public
- MSM
- Youth & Young Adults
- IDU (sentinel study)

Studies concerning KAP for people living with HIV/AIDS (PLWHA), quality of life and experiences of discrimination and stigma are currently under development. Opportunities to investigate KAP patterns of important new immigrant populations and asylum seekers are also being examined. Whilst the sentinel studies are continuous, the aim is to have the population-based surveys at four-year intervals. Many of the data in this report come from the above-mentioned studies.

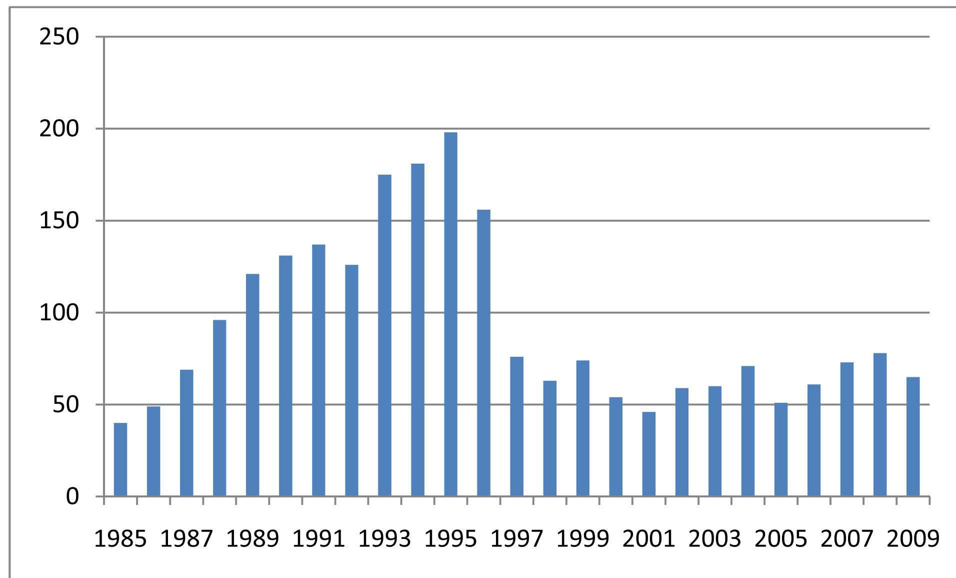
The HIV epidemic

Sweden was reached by the HIV epidemic in the late 1970s and the first clinical AIDS case was detected in 1982 (retrospectively 1976). The Swedish epidemic has, over the years, followed the same pattern as most western European countries, with low incidence after the initial peak in the mid 1980s followed by a slow increase over the last decade. Initially, the epidemic was prominent foremost within the MSM and IDU MARP. Since 1990, the largest proportion of new cases originates from people infected heterosexually prior to arrival in Sweden. Of the domestic cases, the MSM population still accounts for the greatest proportion.

AIDS and AIDS deaths

Between 1985 and 2000 it was mandatory to report AIDS to the authorities and then this became a voluntary supplement to the current mandatory HIV reporting surveillance system. The same system applies when reporting deaths, where information concerning an HIV/AIDS-related death only comes as a supplement. Up to 2009, a total of 2 310 cases have been reported as AIDS cases and out of the total HIV reported cases, 2 045 have been registered as deceased. After a peak of reported AIDS cases in 1995, new reported cases have stabilised and average between 40 and 70 new AIDS cases per year. The decline in new AIDS cases after 1995 can be explained by HIV patients gaining access to effective antiretroviral therapy (ARV) since 1996 and a relatively low proportion of undetected HIV cases in the Swedish population, which results in a low number of diagnoses at a late stage of advanced HIV infection/AIDS ("late testers") (Figure 1).

Figure 1: Number of AIDS cases reported per year, 1985–2009.

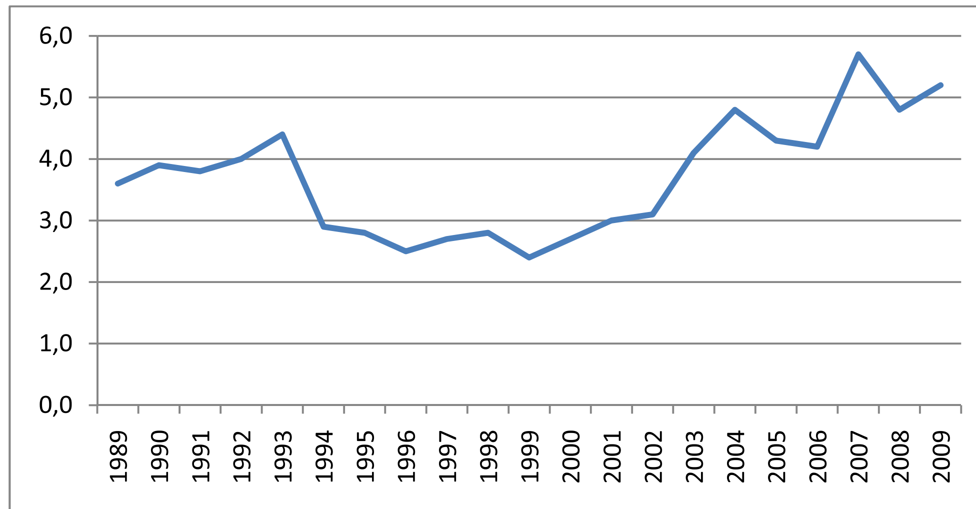


Source: SMI

Current HIV prevalence and incidence estimates

The number of PLWHA in Sweden who are in contact with an infectious disease clinic was, at the end of Dec 2009, 5 240 people. The Swedish Institute for Infectious Disease Control (SMI) and Karolinska Institutet (KI) has estimated the proportion of undiagnosed PLWHA in Sweden to be approximately 15% of all HIV infected persons living in Sweden, which gives a total number of approximately 6 020 PLWHA [2] and a prevalence rate of 645 PLWHA per 1 million inhabitants (or about 0.064% of the total population of Sweden) at the end of 2009. The annual incidence rate of reported HIV cases in Sweden has fluctuated from 2 cases to 6 cases per 100 000 inhabitants over the last 20 years. In 2009 the incidence rate was 5.2 cases per 100 000 inhabitants (Figure 2 below).

Figure 2: HIV incidence per 100 000 people in Sweden, 1989–2009.



Source: SMI

National Strategic Policy and Programmatic Response

Following a process of review, investigation and consultation with all the relevant stakeholders in the field of HIV/AIDS, the Swedish Parliament passed the bill, "A National Strategy Against HIV/AIDS and Certain Other Contagious Diseases" in late 2005. The review concluded that globalisation, new methods of communication and evident changes in sexual behaviour placed new and more serious demands on preventive work which was to be coordinated with other public health measures at all levels of society.

Strategic policy

In an international perspective, domestic HIV infection rates in Sweden are very low and levels remain stable. In Western Europe only Finland has lower rates. Despite this, there are a number of reasons why a new National Strategy was necessary.

- The number of people in Sweden becoming infected with sexually-transmitted infections has grown drastically over the past ten-year period. This shows increased risk behaviour patterns in the population, particularly among youth and young adults.
- The rapid spread of HIV infection in countries in the immediate vicinity during the first decade of the 21st century together with increased mobility in the region means that Sweden needs to maintain a high level of preparedness.
- The number of HIV infected people who have migrated to Sweden from areas of the world where HIV infection is more widespread among the general population is increasing substantially. Offering voluntary health checkups to migrants in order to identify infected individuals and assisting them by providing treatment and psychosocial support is a challenge

for society, and essential in order to prevent the further spread of infection.

An increasing number of people are living with HIV infection in Sweden and the rest of the world. These people are a possible source of continued spread of HIV infection, particularly if they are not aware of their HIV status, or when both infected and uninfected people are lulled into believing that treatment eliminates the risk of transmission, and consequently the condom use rates may decline both in risk populations and in the general population.

The National Strategy aims at mainstreaming prevention and health promotion for HIV/AIDS and STIs in the relevant sectors Sweden. The strategy also underscores the need to combat stigma and discrimination, underlining the fact that an increasing number of people are living with the disease. Whilst Sweden already has an integrated approach to treatment, the National Strategy suggests that all aspects of preventive efforts need to be better integrated with the overall work of health care institutions and that this should be done in close cooperation with other Sexual and Reproductive Health and Rights (SRHR) efforts.. The focus on long-term preventive work remains a priority for the Government. However, in addition, special efforts are needed to upgrade these activities in response to new needs. These include: better epidemiology, better access to health checkups for asylum seekers and other immigrants especially from high endemic areas and closer collaboration and coordination between key stakeholders. The strategy especially notes the necessity of making better use of the knowledge and capacity of Non-Governmental Organisations (NGOs). Efforts should be permeated by the gender perspective and views on sexuality should be elucidated.

Primary objectives of Swedish HIV and AIDS prevention

The National Strategy, stretching from 2006 to 2016, has one overall objective.

> *To restrict the spread of HIV infections and other sexually-transmitted and blood-borne infections and to limit the consequences of these infections for the individual and for society.*

In order to achieve this, the strategy also includes three interim objectives:

1. The number of newly identified cases of HIV infection in which transmission of the disease occurs in Sweden must be reduced by half by 2016.
2. Asylum seekers and newly arrived close relatives of previous immigrants must be offered testing and counselling within two months of arrival. The same services must be offered within six months to other groups of people who have stayed in high endemic areas.

3. Knowledge about HIV/AIDS and what it is like living with the disease must be improved in the public sector, in working life and society as a whole.

Leadership and coordination

The National Strategy emphasises the integration of responses from the relevant sectors e.g. health care including infectious disease control, the education and social welfare sectors as well as the prison and probation services and migration services sectors. The cooperation and coordination of different government bodies and various NGOs are also included. The National Strategy provides a framework for health promotion, prevention and support for the prevention of HIV and STIs, including common policy frameworks and clear plans of action where necessary. A National HIV Council, consisting of key stakeholders, with a chairperson nominated by the Government, is instrumental to this purpose by serving as an advisory board to the NBHW. The NBHW is the lead agency that plans, coordinates and monitors preventive activities as well as distributing national grants.

The Swedish education, health and social care system is very decentralised and responsibility for HIV/STI preventive measures aimed at the population at large and to MARP lies with the county councils (health care) and the municipalities (schools and social services). NGOs also contribute to this work, primarily by being closer to grass root activities, reaching hard-to-reach MARP, being able to advocate for the needs of the MARP and by being able to pilot new strategies. Guidelines for care, as well as the monitoring of treatment, are not included in the National Strategy but are already fully integrated into the health care system and the responsibility of the county councils. (A system of quality control for the care of patients with HIV/AIDS was launched 2009.) From the National Strategy, national action plans for prevention and to combat stigma and discrimination are developed for the various MARP. The county councils and municipalities use and adapt these plans according to local circumstances.

Every county council and the three major metropolitan cities[1] have a nominated contact person, altogether 24 persons employed by the metropolitan cities and the county councils who form a consultative group for the NBHW and who apply and monitor national prevention grants. 20 national NGOs form an NGO consultative group who also meet regularly with the NBHW.

For the period 2008–2009 the following policy frameworks have been established:

- An overall communication strategy for prevention of HIV and STIs.
- An action plan for Chlamydia prevention with a focus on youth and young adults.

[1] Stockholm, Malmö and Gothenburg.

Central government

The Ministry of Health and Social Affairs is responsible for areas such as health and medical care, public health and social services policy and also bears the overall responsibility for HIV policy and prevention. Several government agencies have been allocated different tasks and carry out the daytoday activities according to their instructions. The NBHW, SMI and FHI bear direct responsibility for different parts of national HIV prevention. Other ministries, such as the Ministry of Education and Research, the Ministry of Integration and Gender Equality and the Ministry of Justice, have subjects related to HIV prevention included in their areas of responsibility.

Municipal and regional government

The responsibility for carrying out preventive measures for treatment and support to PLWHA lies with the county councils and is regulated by the Communicable Disease Prevention and Control Act (SFS 2004:168) and the Health and Medical Services Act (SFS 1982:763).[2] The municipalities have also been allocated preventive and supportive responsibilities, mainly concerning socially vulnerable groups, the school sector, social support and home-based care in general. The funding for these measures is integrated into regular budgets for education, health care and social services in over 270 different entities. They are not reported separately and consequently it is not possible to monitor them nationally.

The National HIV council

The National HIV Council serves as an advisory board on policy level to the NBHW and has the function to coordinate and monitor activities in Sweden. It consists of government agencies. The Swedish Association of Local Authorities and Regions (SALAR) as well as NGOs with an umbrella function to represent NGO activities in Sweden. The chairperson of the National HIV Council is appointed by the Government and the NBHW appoints the members of the council. It consists of nine regular members and four affiliated members, six national authorities and five NGOs. Together the National HIV Council constitutes one of the primary policymakers/implementers of policies and key stakeholders within the HIV/AIDS field in Sweden.

Main public actors

- **The National Board of Health and Welfare (NBHW)**
  NBHW is a central government body under the Ministry of Health and Social Affairs carrying out different duties within the fields of social services, health and medical services, environmental health, communicable disease prevention and epidemiology. The NBHW collects, compiles, analyses and distributes information, develops regulations, recommendations and standards based on legislation and information collected, exer-

[2] For more information see the Legal Framework for HIV/AIDS section.

cises supervision to ensure that standards are observed in order to minimise risk and improve patient safety. The agency has a mandate to coordinate national preventive activities and is also responsible for the HIV grant.

- **The Swedish Institute for Infectious Disease Control (SMI)**
  SMI is a government expert agency tasked to monitor the epidemiology of infectious diseases among Swedish citizens and promote control and prevention of these diseases. SMI gives expert advice and support to local, regional and central authorities with operative or political responsibilities for infectious disease control.
- **The Swedish Association of Local Authorities and Region (SALAR)**
  SALAR represents the governmental, professional and employer-related interests of Sweden's 290 municipalities, 18 county councils and two regions (Västra Götaland and Skåne). Municipalities and county councils are responsible for providing health care services, welfare services and education to their citizens. Most of the tasks of municipalities and county councils are regulated in special legislation (e.g. the Social Services Act and the Health and Medical Services Act).[3]
- **Swedish National Agency for Education (Skolverket)**
  The Swedish National Agency for Education is the central administrative authority for the Swedish public school system for children, young people and adults, as well as for preschool activities and child care for school children. The Agency also has responsibility for coordinating national initiatives for pupils with disabilities, environmental issues and issues relating to pupils who have just arrived in Sweden. The government specifies goals and guidelines for preschool and school through the Education Act [3]. The task of the Agency is to work actively for the achievement of these goals. The Agency governs, supports, follows up and evaluates the work of municipalities and schools with the purpose of improving the quality and results of activities in order to ensure that all pupils gain access to equal education.
- **Swedish Prison and Probation Service (KV)**
  The Prison and Probation Service is a part of the legal system. The main tasks of the Prison and Probation Service are to execute prison and probation sentences, to supervise conditionally released persons, to implement instructions for community service and to carry out pre-sentence investigations in criminal cases. The Prison and Probation Service is also responsible for activities at remand prisons and for their transport service.
- **The Swedish Migration Board**
  The Swedish Migration Board is the authority that receives applications from people wishing to visit or settle in Sweden. The Migration Board also offers many people protection from persecution and conflict. Its mandate includes accepting asylum seekers and defending their right to protection. In conjunction with the UN Refugee Agency (UNHCR), refu-

[3] For more information see the Legal Framework for HIV/AIDS section.

gees from camps around the world are helped to start a new life in Sweden.

- **The Swedish National Institute of Public Health (FHI)**
  FHI works to promote health and prevent ill health and injury, especially for population groups most vulnerable to health risks. Further, the agency monitors and coordinates the implementation of the national public health policy and acts as a national expert agency for the development and dissemination of methods and strategies in the field of public health based on scientific evidence.

Main Public International Actors

- **The Ministry for Foreign Affairs (MFA) and the Swedish Development Cooperation Agency (Sida)**
  The MFA is responsible for coordinating Swedish foreign policy within the Government Offices, e.g. security, aid and development, trade, international law and human rights and organisations and cooperation bodies. Sida is responsible for managing Sweden's overseas development cooperation. Sweden has prioritised HIV/AIDS and SRHR as a primary focus area for international support. Efforts are made to balance international policy and national policy development and knowledge exchange.

Non-governmental organisations (NGO)

Major NGOs active in the field of HIV/AIDS maintain close contacts with the MARP and are able to provide information and insights that can be difficult for society to communicate. NGOs are therefore important partners in producing plans and strategies for measures to prevent HIV and STIs. NGOs may apply for activity grants. Conditions for receiving such grants are set out in the Ordinance (2006:93) on Government Grants to Activities to Combat HIV/AIDS and Certain Other Communicable Diseases [4] and are governed by the NBHW. The aim of these grants is to strengthen and supplement central and local government measures. Around 25 NGOs receive national support for HIV/Aids prevention work. They are listed under Acknowledgements. On the national level, emphasis is placed on capacity building for local branches, the production and dissemination of information adapted to special MARP and their needs, method development and advocacy. Regional authorities and major cities also fund local NGOs for preventive and supportive interventions.

The activities of NGOs are monitored and have been evaluated. In 2008 and 2009, an evaluation of the activities of NGOs with national funding concluded that NGO activities contribute to the overall aim of national governmental prevention strategy, that their preventive efforts reached the targeted MARP-although somewhat disproportionately-and that funding reached the intended MARP. All the NGOs that are members of the National HIV Council also contribute to advocacy efforts to improve knowledge and awareness among decision-makers and society at large.

Twice a year, the NBHW holds a 'forum for organisations' meetings where all NGOs that receive grants are invited to discuss policies, strategies and experience concerning prevention. NGOs are also regularly invited to partake in reference groups for different aspects of policy development, as well as development of communication interventions.

National HIV/AIDS prevention policy – primary MARPs

One important point of departure for preventive and supportive efforts is to make the MARPs visible. It is vital that targeted measures are implemented to reduce their vulnerability. The MARPs considered most in need of targeted measures in the National Strategy are:

- Men who have sex with men (MSM)
- Injecting drug users, (IDU)
- Youth and Young Adults
- Migrants to Sweden
- People travelling abroad
- People who buy and sell sex
- Pregnant women

Primary approaches to HIV/AIDS prevention

The overall aim of the National Public Health Policy in Sweden is to create health promoting environments and good health on equal terms for the entire population. The HIV MARPs are often also more vulnerable to other health risks. Preventative activities against HIV and STIs should therefore be coordinated with other public health measures at all levels in society. The following primary approaches have been developed since 2005:

- Focus on integration of HIV/STI health promotion and preventive approaches in relevant sectors such as the education and health care sectors, complemented by targeted efforts by NGOs.
- Prevention of STIs as well as unwanted pregnancies, including sexual and reproductive health and rights.
- Increased knowledge about, and use of, condoms.
- Increased skills in assessing and managing sexual risk situations.
- Reach the general population (mainly youth) through compulsory sex education in schools in grades 1–9 and through the availability of youth-friendly services complemented by outreach activities from NGOs.
- Reach specific prevention MARPs through adapted combinations of efforts from relevant public sector actors plus specific NGO interventions.
- Develop the national Second Generation Surveillance [5].
- Construct six regional networks for training and knowledge support.
- Develop an HIV Portal [6], a website linking and providing easy access to information and activities for main staff groups on national and regional level, and NGOs, throughout the country.

- Promote VCT and social support via the regional health care authorities.
- Support SGS for Needle and Syringe Exchange Programmes (NSEP).
- Efforts to counteract discrimination of vulnerable MARP and PLWHA especially within the health care sector.
- Provide national and regional funding for social support of PLWHA as well as efforts to protect their rights.
- Promote research and development (R&D) in new areas of intervention.

Funding for HIV/AIDS prevention, Treatment, Care and Support

The political system in Sweden is decentralised, with independent government authorities at both regional and local level, each with the power to collect tax. Consequently, the national government is not able to direct the regional and local level to carry out initiatives that are not provided with funding or that are not legally regulated.

Government funding

The government has allocated an annual HIV grant since 2006 aimed at supporting HIV preventive work at national and regional level. The size of this grant has remained constant since its inception at SEK 146 million, (approximately USD 20 million). This grant is designated for three areas; SEK 21 million to national NGOs, SEK 95 million to support the work of regional and some local authorities and SEK 30 million for different measures at national level. The national grant of SEK 95 million is used as a guiding mechanism for prioritised areas according to an agreement between the Government and the Swedish Association of Local Authorities and Regions (SALAR). The NBHW distributes the funding according to government instruction. Apart from this grant there is no special funding on the national government level, however national authorities, as well as regional municipal agencies, integrate many measures for HIV and STI prevention and support into their regular budgets. It is therefore not possible to estimate the total cost of the national of HIV/AIDS prevention at large at central government level.

OVERVIEW OF THE HIV/AIDS EPIDEMIC IN SWEDEN 2008–2009

In 2009 a total of 486 new cases were reported of which 262, or 53.9%, have most likely been infected prior to arrival to Sweden, mostly migrants from countries with a generalised HIV epidemic in Sub Saharan Africa and Asia. This may be compared to 2008 where 442 new cases were reported, of which 247, or 55.9%, were infected prior to arrival. In 2009, of the 221 domestic cases detected, 81% are men and 19% women, compared to 2008 when of the 194 domestic cases detected, 82% were men and 18% women (Table 1). In the last two years, the domestic Swedish epidemic has shown a tendency to increase, most likely due to the increasing trend observed in the domestic MSM population over the last decade.

Table 1: Percentage per sex and age groups of domestic HIV cases reported in 2008–2009.*

	2008			
	0–29 years	30–49 years	+50 years	**Total**
M	10%	48%	23%	**82%**
F	6%	8%	4%	**18%**
Total	**16%**	**57%**	**27%**	**100%**

	2009			
	0–29 years	30–49 years	+50 years	**Total**
M	14%	45%	22%	**81%**
F	7%	9%	3%	**19%**
Total	**21%**	**54%**	**25%**	**100%**

* Domestic refers to all new HIV cases except for cases infected prior to arrival in Sweden.
Source: SMI

Access to Voluntary Counselling and Testing

In accordance with the Swedish Communicable Disease Prevention Act, HIV testing is free of charge [7]. Anonymous HIV testing, if requested, is sanctioned by law [8]. Epidemiological reporting of positive cases is mandatory for clinicians and laboratories; however this must be done using a special code instead of the full identity, to protect the confidentiality of the individual. Voluntary Counselling and Testing, VCT, for HIV is available all over Sweden, mainly offered in the primary health care centres in the municipalities and in the STI clinics, infectious disease clinics and gynaecological clinics in public hospitals.

There are 21 county councils in Sweden operating the majority of the about 1 000 primary health care centres located in 290 municipalities. The 28 infectious disease clinics and about 45 STI clinics are located at university hospitals, county hospitals and sexual health services in the cities. VCT for HIV directed to youth and young adults up to 23 years of age is offered

in the approximately 270 youth clinics which are operated by the county councils or the municipalities and in some cases by NGOs.

In addition, there are private healthcare services, as well as specialised clinics offering VCT for HIV, in the latter case targeting people, foremost corporate, governmental and humanitarian staff, working in high-prevalence countries. Specialised clinics for HIV and STI VCT directed at MSM are available in Stockholm and Gothenburg. VCT for HIV directed at IDU is offered in drug addiction treatment centres and health care centres for homeless people, as well as in correctional facilities and remand prisons.

In Stockholm there is also a NGO-based VCT service for IDU. Repeated HIV testing every 6 months is an integral part of routines in the Needle and Syringe Exchange Programs (NSEP) in the cities of Malmö and Lund in the south of Sweden. Today these two are the only operating NSEPs in Sweden. There are approximately 30 clinical microbiological laboratories in Sweden which perform analysis and diagnostics of HIV.

Rapid point-of-care testing for HIV is so far not in use in Sweden except in some services in Stockholm where it is available in a couple of specialised HIV and STI clinics directed at the general population and at MSM, as well as in two NGO-based VCT services directed mainly at immigrants.

HIV Screening

There are no MARP-based or population-based screening programs for HIV testing in Sweden, except the requirement for repeated HIV testing every 6 month for IDU that are active in the NSEPs in Malmö and Lund. However all blood donors are universally screened for HIV on every occasion they donate blood or plasma. Screening tests for HIV are also mandatory for donors of organs, tissue and cells, including reproductive cells, in accordance with EU directives and national Swedish regulations. In order to prevent mother-to-child HIV transmission (MTCT), the health care should offer all pregnant women HIV testing which is performed as an opt-out routine. Also there is a new law, The Health and Medical Care for Asylum Seekers and Others Ordinance (2008:347), that county councils must offer all newly arrived refugees and asylum seekers voluntary health counselling and a health check including HIV testing.

Apart from these testing programs, contact tracing/partner notification is mandatory for all clinician who diagnose HIV. A patient diagnosed with HIV infection is obliged to provide all information he or she is able to provide about sexual partners or contacts that he or she has shared non-sterile injecting equipment with and who may be consequently infected or exposed to HIV. These partners and contacts at risk, who are reported by the index patient, are obliged to undergo HIV testing in accordance to the Communicable Disease Prevention Act [7], which also states that everyone who suspects that he or she may be HIV infected should undergo HIV testing.

HIV/AIDS Case Reporting

In 1985 HIV was made a mandatory notifiable disease in the Swedish Communicable Disease Prevention and Control Act then in force, and is still mandatory notifiable in the present act from 2004 [7]. Both the doctor who detects a HIV case and the diagnosing laboratory are obliged to report a detected case to SMI and to the County Medical Officer (CMO). The report has to contain information about age, sex, route of transmission and country where the person was infected, as well as reason for testing and testing clinic, but not the identity of the patient. When a case is detected and notified the case report is made anonymously using a special non-unique code containing age and sex. Approximately 50% of all cases are immigrants who are assigned a temporary code which then might be changed if they obtain a residency permit.

Access to ART

98% of applicable HIV/AIDS patients receive ART free of charge and the remaining are people living with drug addiction who have been found to be unable to maintain adherence to ART or who have declined treatment for other reasons.

Any person who is legally present in Sweden and needs antiretroviral therapy (ART) has access to treatment. Although undocumented persons can obtain emergency care they have no direct access to prevention, treatment, counselling and support for HIV and STI. Solutions are sought locally.

UNGASS Indicator Data

Data presented below comes from national monitoring systems, national surveys as well as regional and local studies. Please refer to the annex for a detailed description of the respective indicator and its result.

UNGASS INDICATOR DATA: OVERVIEW TABLE

Commitment and action

Indicator	Description	Value
1.	Domestic and international AIDS spending by categories and financing	Supplied in Annex
2.	NCPI	Supplied in Annex

National Programs

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	98%
5.	Percentage of HIV-infected pregnant women who received anti-retroviral to reduce the risk of mother-to-child transmission	100%
6.	Percentage of estimated HIV-positive incident TB cases that	100%

	received treatment for TB and HIV	
7.	HIV Testing in the General Population	17.7%
8. MSM	Percentage of **MSM** that have received an HIV test in the last 12 months and who know the results	39.1%
8. IDU	Percentage of **IDU** that have received an HIV test in the last 12 months and who know the results	82.3%
8. SW	Percentage of **SW** that have received an HIV test in the last 12 months and who know the results	78.4%
9. MSM	Percentage of **MSM** reached with HIV prevention programmes	54.2%
9. IDU	Percentage of **IDU** reached with HIV prevention programmes	8.5%
9. SW	Percentage of **SW** reached with HIV prevention programmes	43.2%
10.	Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child	not available
11.	Percentage of schools that provided life-skills based HIV education in the last academic year.	100%

Knowledge and Behaviour

12.	Current school attendance among orphans and among non-orphans aged 10–14	not available
13.	Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	59.7%
14. MSM	Percentage of MSM who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Supplied in Annex
14. IDU	Percentage of IDU who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	65.5%
14. SW	Percentage of SW who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	71.4%
15.	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	21.6%
16.	Percentage of respondents aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	47% (only 15–24 years)
17.	Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse	31.1%
18.	Percentage of female and male sex workers reporting the use of a condom with their most recent client	18.5%
19.	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	51.1%
20.	Percentage of injecting drug users who report the use of a condom at last sexual intercourse	6.6%
21.	Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected	58.3%

Impact

22.	Percentage of young women and men aged 15–24 who are HIV infected	131 new cases in 2009 (108 new cases in 2008). Supplied in Annex.
23. MSM	Percentage of MSM who test positive for HIV	134 new cases in 2009 (116 new cases in 2008). Supplied in Annex.
23. IDU	Percentage of IDU who test positive for HIV	27 new cases in 2009 (28 new cases in 2008) Supplied in Annex
23. SW	Percentage of SW who test positive for HIV	0%
24.	Percentage of adults and children with HIV known to be on treatment 12 months after initiating antiretroviral therapy	98.8%
25.	Percentage of infants born to HIV-infected mothers who are infected	2 cases in 2009 and 0 in 2008.

HIV/AIDS in Major and Minor Transmission MARPS 2008–2009

All though the general prevalence of HIV is low in Sweden, the epidemic and its dynamic stretch beyond the MARPs that are found in the UNGASS indicators. As in many other European countries, Sweden's epidemic is dual as approximately 53.9% of newly detected cases belong to people who are estimated to be HIV positive prior to arrival in Sweden, mostly coming from countries with a generalised HIV epidemic, leaving out many opportunities for pro-active preventive efforts. Given the different faces of the epidemic, surveillance becomes a complex issue especially when being translated into preventive action. For the purpose of understanding the epidemic and in order to be able to monitor and evaluate preventive action, SMI surveys the epidemic from two aspects of transmission:

- MARP and other vulnerable groups according to the National Strategy.
- Whether a person has been infected whilst residing in Sweden or infected prior to arrival in Sweden.

Since the SmiNet system [1] used for reporting is a 'living' database, some cases reported could be subject to change if complementary data is submitted. This primarily applies to the people who reside in Sweden at the time of detection where the origin of infection is unknown. Consequently, data reported per 2009-12-31 are preliminary.

However it is clear that there are two simultaneous, but very different, epidemics in Sweden at present. One contained in Sweden among MSM and another that is a part of the heterosexual pattern in high endemic areas of the world.

Below is a short summary of people infected with HIV in different MARP. Clearly the different MARP overlap each other and it is sometimes difficult to distinguish between them.

General population

In 2009 a total of 486 new cases were detected in the general population compared to 442 new cases in 2008. Of the 486 new cases, 154 cases were detected in the group residing in Sweden when infected and 262 cases in the group infected prior to arrival in Sweden. For 70 cases the origin of infection is still unknown. Of the 442 new cases in 2008, 164 cases were detected in the group residing in Sweden when infected and 247 cases in the group infected prior to arrival in Sweden. For 31 cases, the origin of infection is unknown.

Heterosexual population

In 2009 a total of 221 new cases were detected in the heterosexual population compared to 218 new cases in 2008. Of the 221 new cases, 52 cases were detected in the group residing in Sweden when infected and the majority, 151 cases, in the group infected prior to arrival in Sweden. For 18 cases, the origin of infection is unknown. Of the 218 new cases in 2008, 71 cases were detected in the group residing in Sweden when infected and 139 cases in the group infected prior to arrival in Sweden. For eight cases, the origin of infection is unknown.

Youth and young adults

In 2009 a total of 131 new cases were detected in the youth and young adult population (15–29 years) compared to 108 new cases in 2008. Of the 131 new cases, 31 cases were detected in the group residing in Sweden when infected and 88 cases in the group infected prior to arrival in Sweden. For 12 cases, the origin of infection is unknown. Of the 108 new cases in 2008, 26 cases were detected in the group residing in Sweden when infected and 79 cases in the group infected prior to arrival in Sweden. For three cases, the origin of infection is unknown.

Men who have sex with men

In 2009 a total of 134 new cases were detected in the MSM population compared to 116 new cases in 2008. Of the 134 new cases, 79 cases were detected in the group residing in Sweden when infected and 32 cases in the group infected prior to arrival in Sweden. For 23 cases, the origin of infection is unknown. Of the 116 new cases in 2008, 73 cases were detected in the group residing in Sweden when infected and 33 cases in the group infected prior to arrival in Sweden. For 10 cases, the origin of infection is unknown. The MSM population continues to be the only MARP with a steady and continued increasing trend in new HIV infections after 2000.

Migrants to Sweden

People with a foreign background[4] are obviously not monitored as a specific MARP since they are a part of the general population although certain vulnerable groups might require special prevention and outreach efforts. However it is possible to monitor persons infected prior to arrival in Sweden. It is of significant importance to reach this MARP and to monitor access to prevention, counselling, testing, treatment and support since many studies demonstrate that migration in itself will be an obstacle to accessing such services. The size of the population and the number of new cases detected varies according to migration patterns and events taking place outside Sweden. In 2009, and of the 486 new cases detected, 262 cases, or 53.9%, were classified as infected prior to arrival. In 2008, and of the 442 new cases detected, 247 cases, or 55.9%, were classified as infected prior to arrival. The majority of the cases detected as infected prior to arrival are people coming from countries with a generalised HIV epidemic, mostly Sub-Saharan Africa and Asia.

People travelling abroad

People travelling in and to high endemic areas are currently not monitored as a specific MARP, but captured via other MARP. Studies indicate that people residing in Sweden but working and travelling long-term demonstrate higher risk factors than the average population [9]. In 2009, and of the 486 new cases detected, 46 cases were detected as infected abroad. In 2008, and of the 442 new cases detected, 49 cases were detected as infected abroad. These cases are equally distributed between heterosexual and homosexual transmission. The majority of the cases are men, travelling to Asia primarily Thailand, and people who return to their country of origin for holidays, primarily high-prevalence countries in Africa.

Injecting drug use

In 2009 a total of 27 new cases were detected in the IDU population compared to 28 new cases in 2008. Of the 27 new cases, 18 cases were detected in the group residing in Sweden when infected and six cases in the group infected prior to arrival in Sweden. For three cases living in Sweden, the origin of infection is unknown. Of the 28 new cases in 2008, 16 cases were detected in the group residing in Sweden when infected and 11 cases in the group infected prior to arrival in Sweden. Only one case lacks origin of infection.

[4] The English word migrant has no real translation in Swedish. Two words are used describing people migrating to and from Sweden, immigrant meaning people coming to Sweden and emigrants meaning people leaving Sweden. The official terminology in the National Strategy is people with a foreign background including recent immigrants, asylum seekers, refugees, people from other countries living long term in Sweden as well as long term visitors and undocumented people.

Correctional facilities

The Swedish Prison and Probation Service (KV) cooperate with the public health system when reporting new HIV cases. Consequently all cases, both new and old, detected within correctional facilities are reported and registered in the national HIV surveillance system.

Persons buying and selling sex

Due to complications concerning the accessibility of the SW population, no comprehensive system is in place on national level which is able to collect epidemiological SGS data. Local projects run by NGOs and the metropolitan county councils, together with a few research projects, currently contribute to a partial understanding of the SW population. This MARP is contained in the general population figures as well as in heterosexual and MSM figures.

Mother-to-child transmission

In 2008, 12 cases of MTCT were reported in Sweden, however all 12 cases were migrants infected prior to arrival in Sweden. In 2009, two cases were reported as residing in Sweden. Only four cases of MTCT that occurred in Sweden have been detected since 2000.

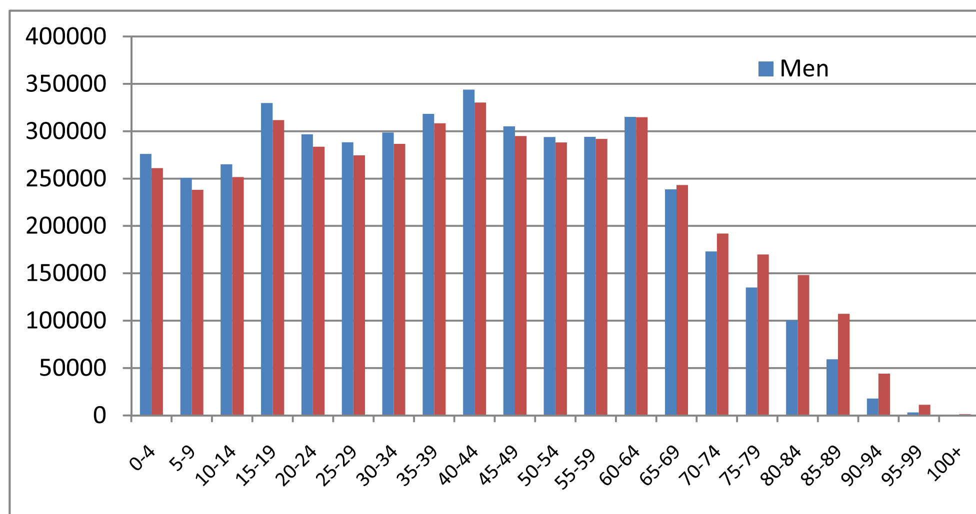
Blood and organ donations

In the autumn of 1985, a mandatory screening process was introduced for all blood donated in Sweden. Each year, approximately 40 000 people register as new blood donors. In 2008, a total of 246 967 people donated blood one or several times during the year. Since 1985, a total of 68 people have been identified as HIV positive via the blood screening process. Of these 68 cases, 37 men state that their route of infection was having sex with other men (MSM). 29 men and women state that they have been infected via heterosexual sex and for the remaining two cases the route of infection is unknown. On average, two or three HIV positive cases are detected every year via the blood screening process. No transmission via donated blood in Sweden has been detected since 1986. However cases are reported now and then in the surveillance system of people who have contracted HIV via blood transfusion or blood products abroad, primarily in countries with a generalised epidemic.

NATIONAL RESPONSE TO THE HIV/AIDS EPIDEMIC

At the end of 2008, the Swedish population consisted of 9 256 347 people. Of these 4 603 710, or 49.7%, were men and 4 652 637, or 50.3% were women; 4 271 029, or 46%, were between 15–49 years old and 3 442 916, or 37.2%, were 50 years or older (Figure 3).

Figure 3: Population in Sweden per sex and age strata, at the end of 2008.



Source: SCB [10]

Prevention for MARPs

The National Strategy acknowledges the need to base health promotion and prevention of HIV/AIDS on the different needs of the MARPs and for youth and young adults. It emphasises, as does the UNGASS Declaration of 2001[11], the importance of specially considering the circumstances under which the epidemic continues to make certain MARPs in society more vulnerable to HIV infection. According to the government's assessment, one key starting point for preventive activities is to reduce MARP vulnerability through targeted interventions. However, when aiming interventions towards certain MARPs, caution needs to be exercised in order to avoid the possible risk of augmenting discrimination. To monitor the progress of the National Strategy and its first interim objective, to reduce the number of new infections by half by 2016, the indicators developed by UNGASS [12] for each MARP have been adopted by the NBHW. The indicators are adjusted where necessary and where no indicators exist, new ones are developed and monitored.

Research and Development

The NBHW continuously develops its Research and Development (R&D) function concerning HIV/AIDS and STIs. This work may be divided into two main approaches.

Research on Knowledge, Attitudes and Practices

One part of the R&D system consists of larger quantitative studies aimed at increasing know-how around Knowledge, Attitude and Practice (i.e. behaviour) and Beliefs KAP(B) in the targeted MARP. The R&D system also support the regular SGS monitoring of MARPs by including indicators in the large studies, that are set up by the UNGASS Declaration as well as other international reporting systems and indicators for monitoring different national action plans (NAP), such as the Chlamydia NAP. The studies also collect extended information in areas where little or nothing is known. Consequently the R&D function serves as a probing mechanism, complementary to the epidemiological surveillance of infections. Currently, the NBHW supports four major national quantitative studies, each covering its own MARP. Each year one of the four studies is conducted, creating a four-year cycle between them, which helps to understand whether trends within the MARP manifest themselves as behaviour change over time. These studies are:

The UNGKAB study

This study is conducted through a self-selected survey on Internet. The survey is advertised through a number of popular youth web sites, e. g. Facebook. The questionnaire consists of 63 main questions which, including attendant questions, result in over 400 unique variables. The study ran from November 2009–January 2010. 6 487 respondents between 15 and 24 years completed the questionnaire.[5]

The Youth Barometer (UB)

The UB, a complementary study to UngKAB, is conducted through a self-selected and quota-based sample on Internet. The UB is advertised through a number of popular youth web sites, e.g. Facebook, the Swedish site "Lunarstorm" etc. The questionnaire had open access on Internet from 28th September–28th October, 2009. 4 699 respondents aged 15 to 24 completed the part containing questions about sexuality. 58% were women and 42% were men [13].

HIV/AIDS in Sweden, 1987–2007

This study is a national survey that has been repeated six times since 1989. The study uses questionnaires which are mailed, randomly, to a sample of the Swedish general population. The study has been conducted in 1989,

[5] Results are not published at the time of reporting.

1994, 1997, 2000, 2003 and 2007 (total n = 16 773). Each sample consists of some 4 000–6 000 participants aged 16–44, stratified by age: 16–17, 18–19, 20–24, 25–34 and 35–44. The overall participation rate in age groups 15–24, varies between 45 and 55%. The 2007 survey showed a response rate of only 37% among men 18–19 years old [9].

The MSM Study

The MSM study surveys knowledge, attitudes, behaviours and beliefs in the MSM population. It has been conducted through a self-selected survey on Internet in 2006 and 2008. The survey was advertised on Sweden's largest LGBT site with 100 000 members of whom around 58 000 met the criteria to be included in the study population in 2008 and 51 000 in 2006. In 2008 4 715 answered the study and in 2006 response rate was 3 202 [14].

IDU sentinel surveillance

The SHP program is designed as a sentinel surveillance system within the remand prison system i.e. an active surveillance system that collects data from a selected target group, from specifically chosen sites which covers a representative subset of the monitored population. The SHP program is currently running at 2 sites (of 4 planned) and is used to reach a representative sample of IDU in Sweden, of which 7 000–7 500 pass through the remand prison structure each year. At least 60% of all individuals who pass through remand prison use illegal drugs. During the period 2002–2008, approximately 2 000 IDU have participated in the program and 46 new HIV infections have been detected.

Further, the NBHW plans to conduct similar studies concerning PLWHA and persons buying and selling sex. Within the R&D system, research also aims at reaching a deeper understanding of factors concerning risks of infection by HIV/AIDS and STIs. This is carried out by supporting both quantitative and qualitative research within the field, and by reviewing existing national and international research, e.g.

- Risk-taking connected with alcohol use.
- Factors behind repeated Chlamydia infection.
- A review on international literature concerning sexual risk behaviour in the migration process.

Intervention studies and reviews of interventions for specific MARPs

The other part of the R&D system is built on studies concerning methods for primary and secondary prevention work, e.g. a three-year research project to develop evidence-based sex and relationship education in schools. Another example is research around the development of a risk-screening instrument and extended treatment of most at-risk patients for Chlamydia in a regional clinic setting. Examples of reviews of preventive work are two published reports that summarise a number of international reviews on effective pre-

vention activities aimed at MSM [14] and youth and young adults [15]. Other studies are cited in different parts of this report.

National Response for MARP

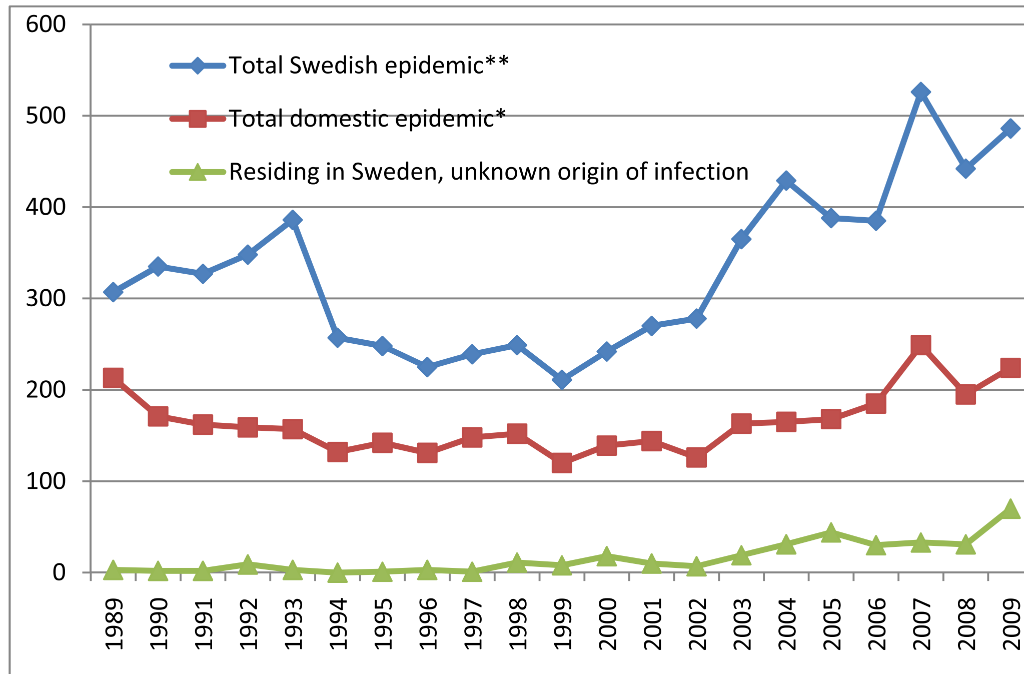
General population

As stated above the Swedish National Strategy does not define the General Population as a MARP as such; however the Strategy acknowledges the need to monitor the KAB on HIV/AIDS in the population in a broad sense.

Overall epidemiology 1989–2009

At the end of 2009, a total of 8 935 HIV positive people had been detected in Sweden. 6 206, or 70%, are men. Of the 8 935 people who were HIV positive at the end of 2009, 5 240 people were living with HIV. In 2009 a total of 486 HIV positive people were detected compared to 442 in 2008. Of the 486 cases detected in 2009, 262 were infected prior to arrival compared to 247 cases in 2008 [1]. The tendency of the domestic epidemic is that it continues to increase slowly, despite a temporary dip in 2008, where 195 HIV positive people were detected compared to 2009 where a total of 224 people were detected. The 2009 figures are preliminary since the origin of infection for 51 cases at the time of reporting is unknown (Figure 4).

Figure 4: Number of people testing positive per origin of transmission, 1989–2009.



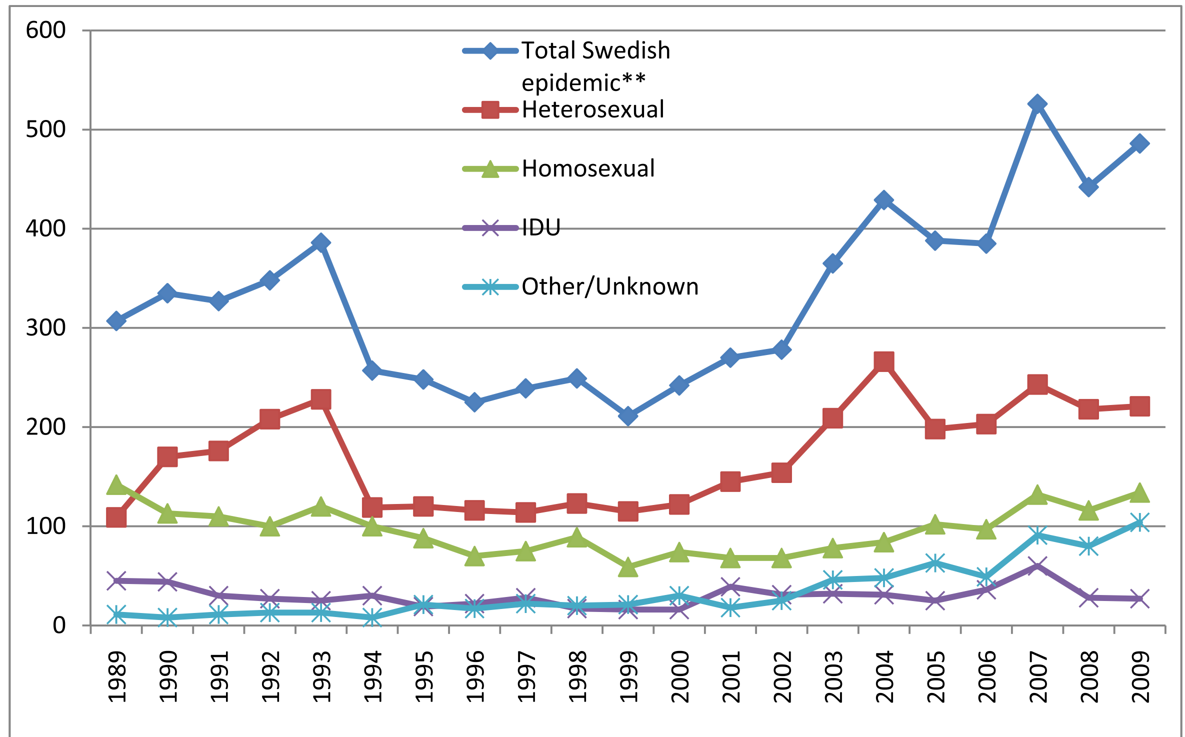
* The total domestic epidemic includes HIV positive people residing in Sweden when infected.

** Total Swedish epidemic includes all HIV positive people including people who are infected prior to arrival.

Source: SMI

The average age at diagnosis of HIV infection for the three most common routes of infection (heterosexual, MSM and IDU) varies between 35 and 40 years. The domestic HIV epidemic is dominated by heterosexuals, people infected prior to arrival and by the MSM MARP (Figure 5a).

Figure 5a: Total number of HIV positive domestic and non-domestic cases per route of transmission, 1989–2009.

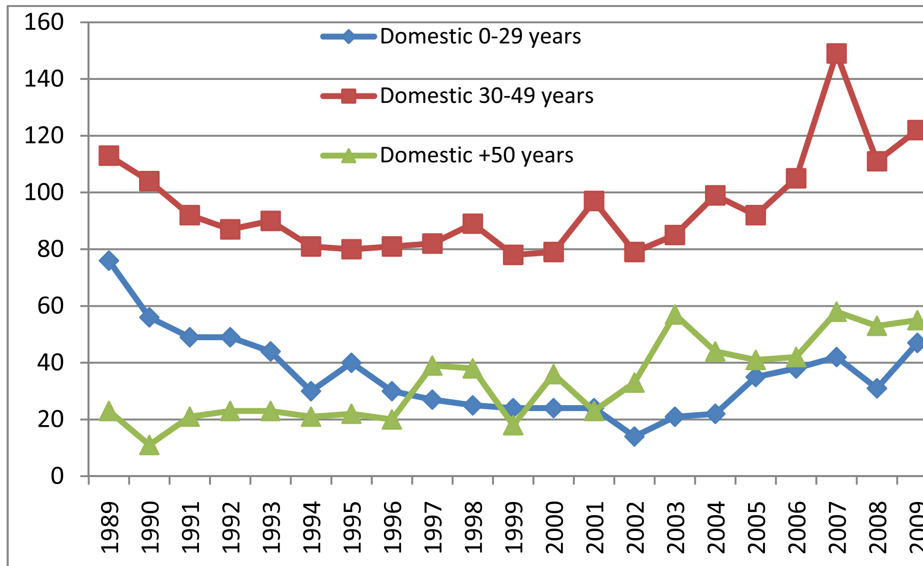


** Total Swedish epidemic includes all HIV positive people including people who are infected prior to arrival.

Source: SMI

When examining the age groups it is evident that, within the domestic epidemic, it is the age group 30–49 that is predominant. Since 2001 more cases are generally found within the age group + 50, compared to the age group 0–29 (Figure 5b).

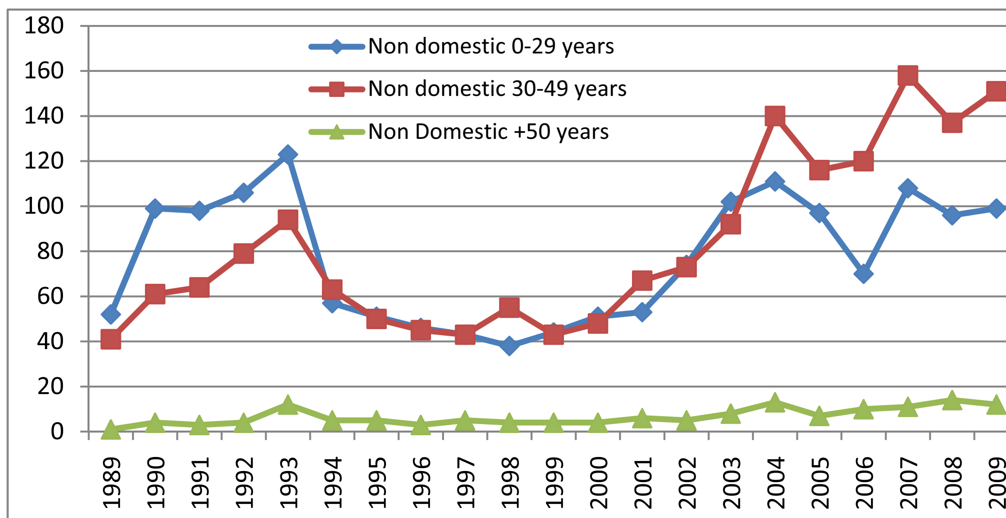
Figure 5b: Number of domestic people testing HIV positive per age strata, 1989–2009.



Source: SMI

In the group people infected prior to arrival the situation is similar, with the age group 30–49 being predominant but the age group 0–29 is more prominent here than among the domestic cases (Figure 6).

Figure 6: Number of people infected prior to arrival tested HIV positive per age strata, 1989–2009.



Source: SMI

National level

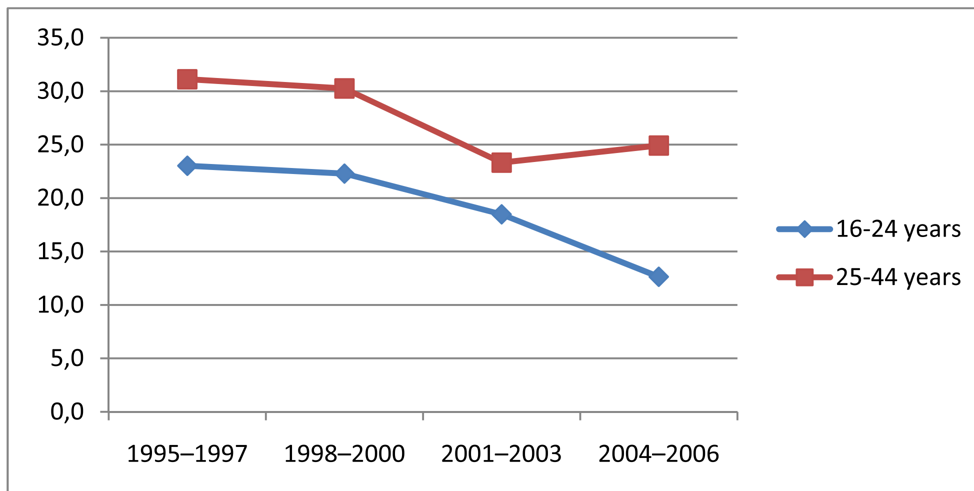
At the beginning of the HIV/AIDS epidemic, large communications interventions addressed to the general population were launched in Sweden. As early as 1989, 96% of the population were found to have considerable

knowledge. Today the Swedish strategy aims its prevention activities mainly at MARP and youth and young adults. This is primarily carried out via communication efforts in collaboration with NGOs and county councils in combination with VCT testing promotion. Preventive efforts concerning the general population lie in the long-term preventive interventions that target the MARP youth and young adults. Preventive efforts in this population target indistinct attitudes and behaviours that, if unchallenged, will age with the age group. The NBHW also sponsors the national and recurring study, HIV and Aids in Sweden [9], where general population trends are measured over time. This study was last conducted in 2007 and the next study will be conducted in 2010.

Knowledge, attitudes, practices and behaviour patterns in the general population

The General Population Report on both UNGASS and nationally adopted indicators. Most of the indicators are fixed until 2016, in line with the aims of the National Strategy, to monitor trends over time. However indicators are also developed to fulfil temporary needs. Results from the study HIV and AIDS in Sweden, 1987–2007 [9] indicate that HIV testing is declining over time for the age group 16–24 years (Figure 7).

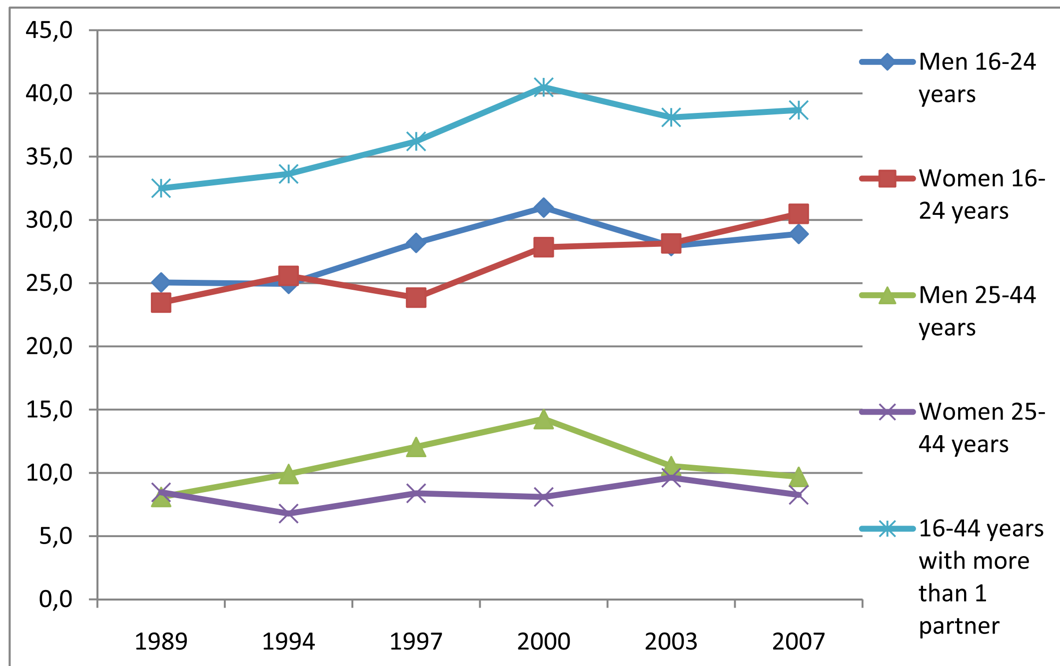
Figure 7: Percentage of 16–44 year olds who have taken an HIV test any time during the period 1995–1997, 1998–2000, 2001–2003 and 2004–2006 per age group.



Source: HIV/AIDS in Sweden, 1987–2007

The number of people who have more than one partner within a year is stabilising. The age group 16–24 years have a higher proportion of people who have several sex partners, primarily the women 16–24 years, overtaking men 16–24 years compared to 25–44 year olds, where a falling trend over time can be seen (Figure 8).

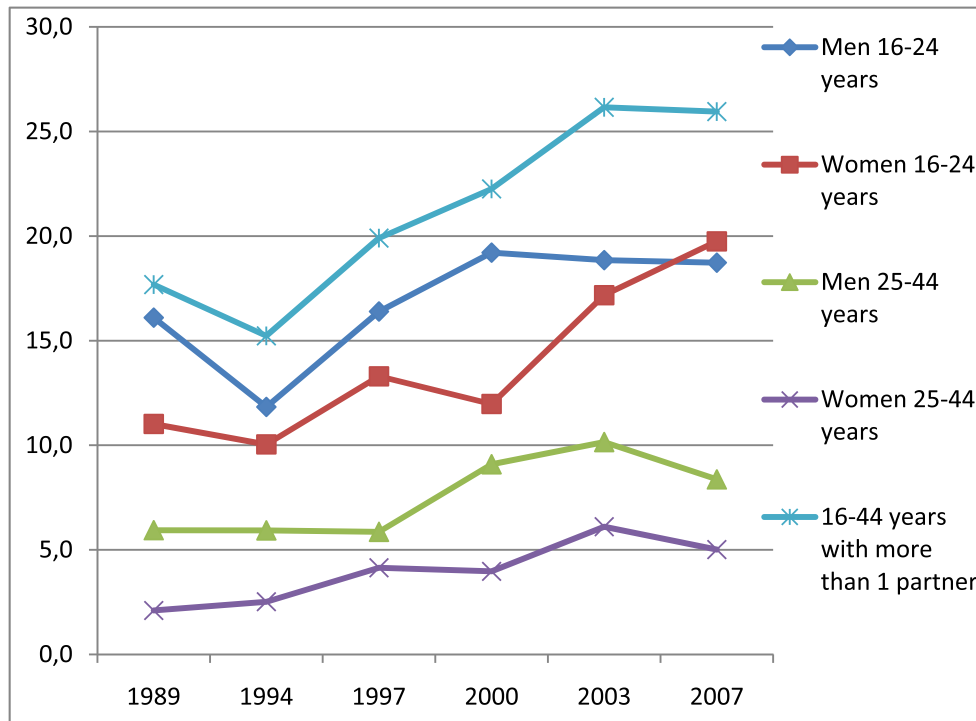
Figure 8: Percentage of respondents 16–44 years old who have had sexual intercourse with more than one partner during the last 12 months per sex and age group, 1989–2007.



Source: HIV/AIDS in Sweden, 1987–2007

Parallel to the increase in the number of people having multiple partners is the decrease in condom use. In the age group 16–44 years, the number of people who have sexual intercourse on a first date without using a condom is increasing. This increase is can partly be explained by the sharp increase in the number of women, 16–24 years who are having more unprotected sex, overtaking men, 16–24 years for the first time since the launch of the study series (Figure 9).

Figure 9: Percentages of respondents 16–44 years old who have had sexual intercourse on a first date without the use of a condom during the last 12 months, per sex and age group, 1989–2007.



Source: HIV/AIDS in Sweden, 1987–2007

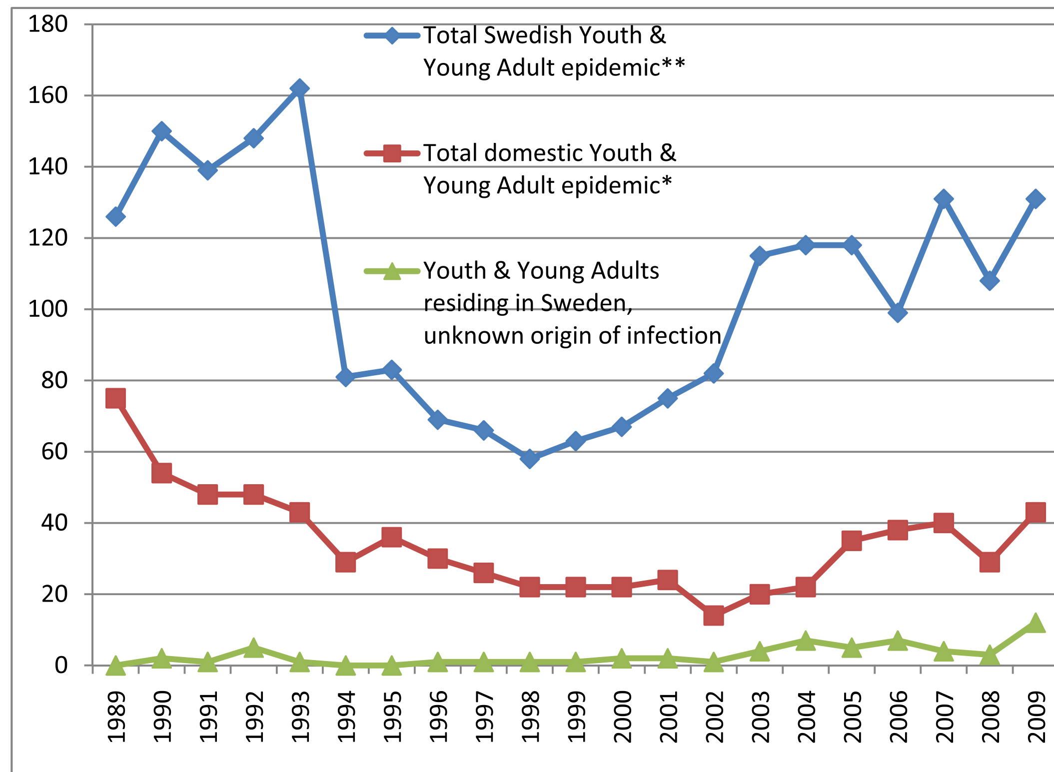
Youth and Young Adults

The National Strategy states that the School and Youth Clinics (YC) should be the cornerstone of preventive activities aimed at the youth and young adult population, complemented by efforts from NGOs. Special focus should be placed on youth and young adult men. Knowledge, attitude and practices concerning HIV/AIDS and STIs should also be strengthened and VCT improved and made more accessible. The National Strategy divides the youth population into three categories; 10–13 year olds, 14–19 year olds and 20–29 year olds. The HIV infection rate is low among the youth and young adults group. However risk factors are high which is reflected in the Chlamydia infection rate and in the number of unwanted pregnancies. Swedish youth and young adults are generally well informed about sexual matters. However, changes towards more high-risk sexual attitude and behaviour have been observed. Contributory factors to this include for example that sexual behaviour patterns are becoming more similar, love does not play quite as an important role as it used to do when it comes to having a sexual relationship [9]. It is increasingly considered OK to have sex just to satisfy sexual needs. A growing proportion has several or occasional partners, drink more alcohol [16] and travel more [17]. Internet also plays its part by dramatically providing new options in the sexual field by opening up new social networks [18].

Overall epidemiology 1990–2009

The number of people infected with HIV is low among the youth and young adult group in Sweden. Most youth and young adults who are HIV positive have been infected prior to arrival in Sweden. Since 1986, in the age group 15–29, a total of 879 men and 300 women have been found HIV positive (domestic). This is explained by the larger number of MSM that are found in the youth and young adult population. Since 2003 there has been an increasing trend in the domestic youth and young adult epidemic and after a temporary dip in 2008, preliminary numbers for 2009 indicate a return to the levels of 1993 (Figure 10). Of the 131 HIV positive cases detected in 2009, 88 were infected prior to arrival compared to 79 cases in 2008 (out of a total of 216). The 2009 figures are preliminary since the origin of infection for 12 cases at the time of reporting is unknown.

Figure 10: Number of Youth & Young Adults testing positive per origin of infection, 1989–2009.



* The total domestic epidemic includes HIV positive people residing in Sweden when infected.

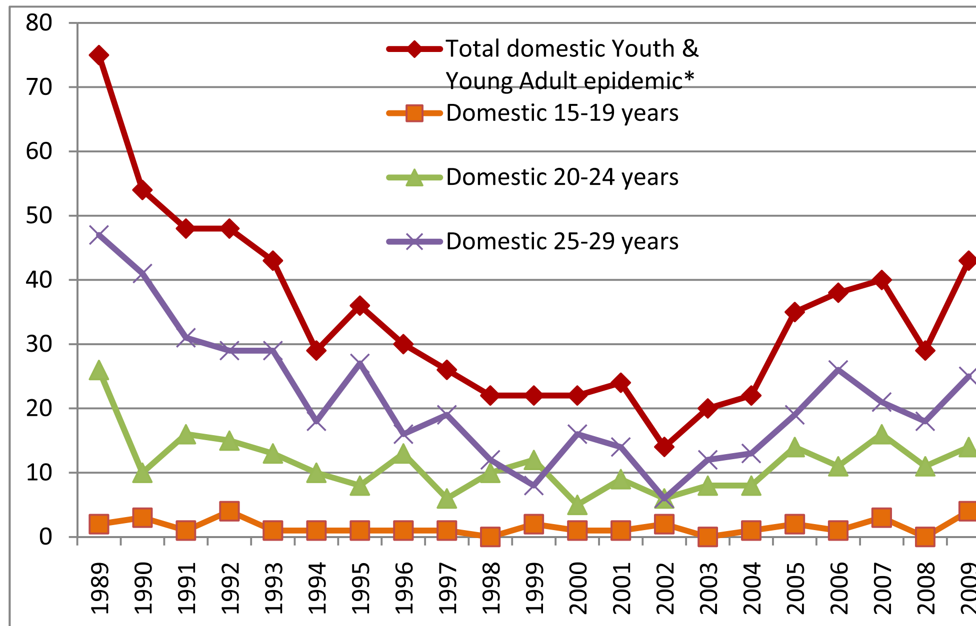
** Total Swedish epidemic includes all HIV positive people including people who are infected prior to arrival.

Source: SMI

When it comes to the different age groups within the youth and young adult population, more new cases are constantly found within the age group 25–29 (except for 1999 and 2002), compared to the 20–24 age group, coming in second place and the 15–19 age group, which has very few cases (below

five cases per year) coming in third place. All three age groups reported more new cases in 2009 compared to 2008. These youths and young adults have all been infected prior to arrival in Sweden (Figure 11).

Figure 11: Number of domestic Youth & Young Adults testing HIV positive per age strata, 1989–2009.



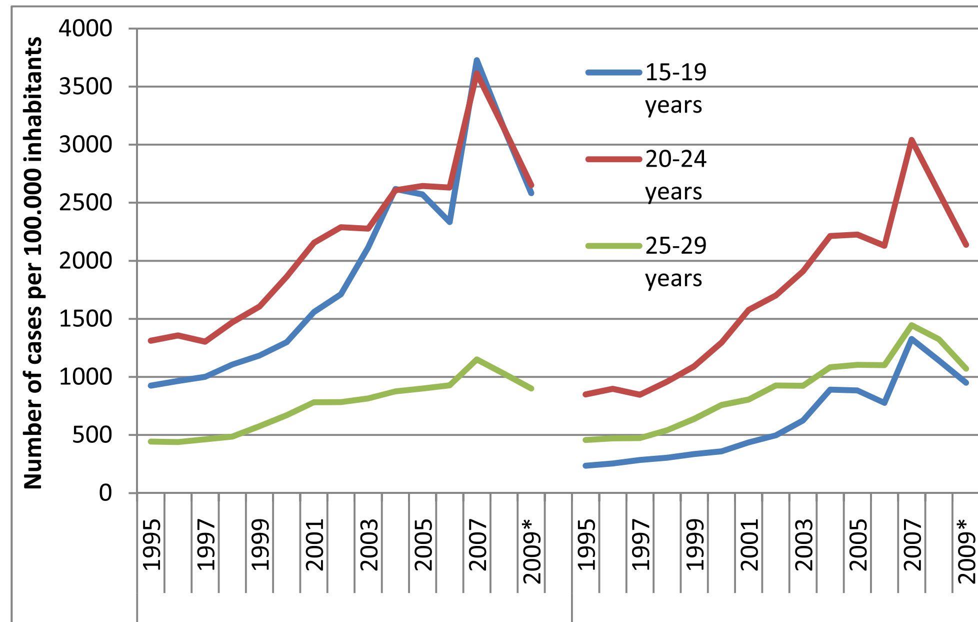
* The total domestic epidemic includes HIV positive people residing in Sweden when infected.

Source: SMI

Chlamydia infection

Chlamydia is the most commonly reported STI in Sweden. The number of people infected has increased continuously from 1997, peaking in 2007 (Figure 12). The principal route of infection is heterosexual sexual relations and most affected are 15–24 year old youths and young adults. In 2006, the number of new infections decreased, most probably due to a mutated variant which was discovered in late 2006. Existing test methods used in about half of the laboratories at the time, could not detect the new variant. After correction an all time high of reported cases in 2007. Better testing procedures have been introduced and in 2008–2009, the number of new cases reported decreased from 42 000 to 37 700. This decrease, however, only brings the epidemic back to its original rate of increase. Men are underrepresented in statistics of people who take a Chlamydia test [19].

Figure 12: Chlamydia incidence per sex and age group, 1995–2009.3



* 2009 Data are preliminary.
Source: SMI

National level response and general measures

The best arenas for long-term impact e.g. to enhance knowledge, influence attitudes and promote behaviour patterns are the schools, since they reach the entire youth and young adult population and this population contains all other MARPs in itself. There is also a good evidence base for the importance of sex education /HIV/AIDS education in school to make a difference to the target MARPs [15].

The second most important intervention in reaching the youth and young adult population is health care via youth-friendly services. Thirdly information campaigns, advocacy and outreach by NGOs are necessary especially to reach youth who feel and are marginalised from mainstream interventions.

Sweden possesses a good structure for health promotion and prevention for youth. Sex education is mandatory since 1956.The main goal of sex education, including HIV/AIDS carried out by schools, counselling services and NGOs is to increase youth and young adult people’s knowledge of their own anatomy and reproductive functions. Further to promote “safe sexuality and good reproductive health”, as stated in the national objectives for public health [20]. The principal of each school is specifically accountable for ensuring that interdisciplinary areas of knowledge are integrated into subject teaching. Goals are also set up for the promotion of gender equality, for example, as well as for supporting the development of pupil's self-esteem, empathy and other aspects of social competence that form a part of sex education.

There are roughly 273 YCs in Sweden today most often run in cooperation by regional medical services and local social services. This type of service was launched at the implementation of the Legal Abortion Act in

1975.[6] However it is not a compulsory type of service regulated by law. The YCs promote physical and mental health, reinforce youth and young adult peoples' identities so that they are able to manage their sexuality, and prevent unplanned pregnancies and STIs. The YCs function as low-threshold services (LTS). The upper age limit lies between 20 and 25 years old. Midwives, counsellors and/or psychologists, and physicians usually work at the YCs.

Studies carried out by the education authorities and the NBHW both conclude that the risks and challenges for youth and young adult people's sexual health have increased whilst neither the resources nor the capacity of schools and healthcare systems have been upgraded in proportion. Quality is very uneven and there is a lack of implementation of knowledge-based interventions.

The NBHW and the National HIV Council has embarked on addressing the above-mentioned shortcomings. In 2008–2009 the following coordinated interventions on the national level can be noted.

Because of unequal access to YCs for youth and young adult women and men, an online youth friendly clinic (UMO) [21] has been developed in 2008 where information about sex, health and relationships can be obtained. There are increasing opportunities for on-line Chlamydia testing through internet test-sites that have quality control and follow the Swedish Communicable Diseases and Prevention Act.[7] These testing sites have been found to reach youth and young adult men to a greater extent than YCs.

To focus, target and coordinate health promotion and prevention for youth and young adults, the NBHW conducted a research summary around youth and sexual health to guide the different actors [15]. In 2009 the NBHW also produced a national knowledge-based guide for youth-oriented preventive work in health care.

The Swedish National Agency for Education was recently tasked to educate teachers in this area using university courses. The Ministry of Education also suggests that sex education become a mandatory part of teacher training. A decision on this issue will be taken in 2010. The National Aids Grant is supporting an R&D study to develop evidence-based teacher training.

Supported by the NBWH, three NGOs developed and evaluated a sustainable approach for outreach work for youth at festivals and clubs.[8] NBHW also developed and launched a NAP for Chlamydia Prevention [22] in late 2009 together with the National HIV Council and all major stakeholders. The NAP has measurable indicators and defined intermediary targets. It is monitored by the UNGKAB study. The NAP is based on evidence and assists different actors to choose the most important improvements and coordinate their actions at regional and local levels. The NAP is currently being piloted and evaluated in one county council.

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[6] For more information see the Legal Framework for HIV/AIDS section.
[7] Ibid.
[8] For more information see the National Best practices section.

Regional level

The county councils and major cities are responsible for most preventive activities on regional level. During the period 2008–2009, 50% of these have made or updated Regional Action Plans (RAP) for HIV/STI prevention, including the prevention of unwanted pregnancies. Thus all counties and major cities run different preventive measures targeting youth and young adults.

The updates were made as a result of the New Swedish National Strategy from 2006 in order to implement many of the required strategic measures. The counties and cities cooperate with local branches of national NGOs and local NGOs for outreach work, and also support NGO activities in schools.

Counties are responsible for the around 270 YCs that function as youth-friendly advice centres. Many counties cooperate with municipalities and also provide training for teachers and other youth workers in sex education as well as special websites for youth, information campaigns and condom distribution.

As a result of RAPs, different interventions are planned based on local needs. Examples of targeted interventions during this period are outreach and information campaigns for youth and young adult seasonal workers in the ski-resorts and beach resort areas of Sweden.

A "Chlamydia Monday" has been held in more than half of Sweden's counties for several years. Chlamydia is highlighted in local information campaigns and testing sites prolong their opening hours. This has been evaluated and found to increase the awareness of the youth and young adult population about Chlamydia and open up testing to new social networks that had not before been found during contact tracing efforts. The evaluation also suggests that efforts must be sustained over some years before results can be measured and also that the efforts have to be properly targeted [23].

Results of intermediary measures

As described above there are three studies that monitor youth and young adults. Nearly two thirds of the respondents in HIV/AIDS in Sweden, 1987–2007 and UB are women. In UNGKAB, men and women are equally represented. Due to low response rates in traditional surveys, it is not possible to report truly representative data. The data presented are chosen from the study considered to be most suitable according to the indicator requested.

The results below reinforce the increasing challenges for health promotion and prevention and the need for upgraded, sustainable responses.

Knowledge levels

As can be seen from UNGASS indicator 13, knowledge levels about HIV have declined since the 1990s and are as low as 60% for some answers. However general knowledge on protective behaviour for STIs is higher, around 80% can answer such questions correctly. The need to upgrade knowledge to maintain suitable responses to HIV is evident. HIV testing- both UNGKAB and UB show that between 5 and 10% of youth (15–19) and

10–15% of young adults (20–24) have been tested for HIV during the last 12 month period (Table 2). Youth and young adult women have a tendency to test more than youth and young adult men. Compared to previously conducted studies the results indicate that testing rates among youth and young adults is declining over time [9].

Table 2: Percentage of respondents aged 15–24, who have been tested for HIV during the last 12 months.

Survey:	UNGKAB 2009		Youth Barometer 2009		*HIV/AIDS in Sweden, 1987–2007*
Age:	15–19	20–24	15–19	20–24	16–24
Percent	9	14	7	10	13

First intercourse

A number of studies indicate that the median age at first intercourse has remained between 16–17 years of age for more than 40 years [24]. Results from HIV/AIDS in Sweden and from UB show numbers aligned with these. Higher numbers in the younger age group are due to the fact that persons who have not yet experienced their sexual debut are excluded from the sample. More women than men debut before the age of 15 (Table 3).

Table 3: Percentage of young women and men aged 15–24, years who have experienced their first intercourse before the age of 15 years.

Survey:	Youth Barometer 2009	
Age:	15–19	20–24
Young women	20	12
Young men	12	8

Number of sexual partners

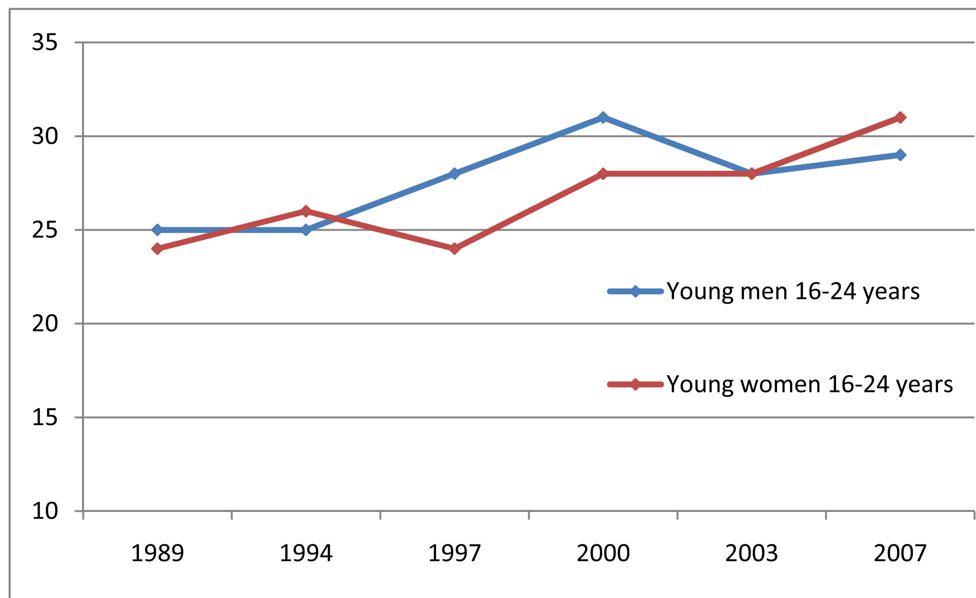
The number of young women and men aged 15–24 who have had sexual intercourse with more than one partner during the last 12 months varies between 30 and 52 % in the three studies (Table 4).

Table 4: Percentage of respondents aged 16–24, who have had sexual intercourse with more than one partner in the last 12 months.

Survey:	*HIV/AIDS in Sweden, 1987–2007*
Age:	16–24
Young women	31
Young men	28

Figure 13 shows the trend from 1989 to 2007 for young women and men aged 16–24 who have had sex with more than one partner during the last 12 months indicating a steady increase. The increase supports the idea that young people are becoming more open to having more occasional sex with more sexual partners. In 2007 the number of women reporting more than one partner exceeded that of men (16–24 years).

Figure 13. Percentage of young women and men aged 16–24, who have had sexual intercourse with more than one partner in the last 12 months, per sex 1989–2007.



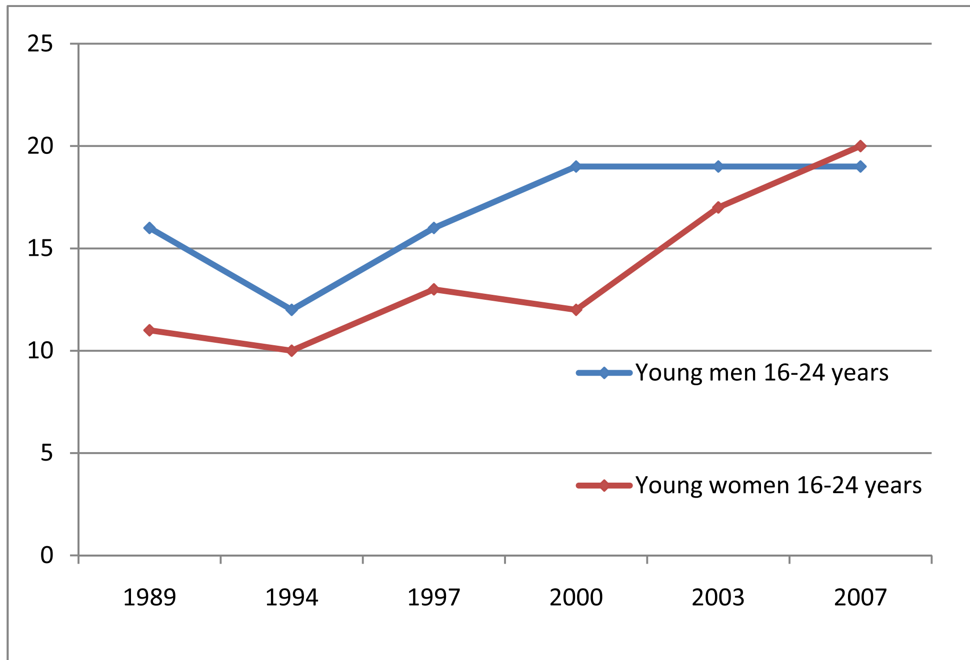
Source: HIV/AIDS in Sweden, 1987–2007

Condom use

Generally the use of condoms is higher among those aged 15–19 than among those aged 20–24. However, approximately two thirds of young women and men aged 15–24, who have had more than one sexual partner in the past 12 months, report that they did not use a condom the last time they had sex. As young women become increasingly sexually active they start using contraceptive pills. Studies show that unwanted pregnancies are regarded as a greater risk than HIV/STIs.

Condom use has been monitored in Sweden since 1989 (Figure14). The trend is that condom use among young women and men is decreasing over time. Monitoring is based on young women and men aged 16–24 who have had casual sex without condom.

Figure 14: Percentage of young women and men aged 16–24 who have had casual sex without using a condom during the last 12 month period.



Source: HIV/AIDS in Sweden, 1987–2007

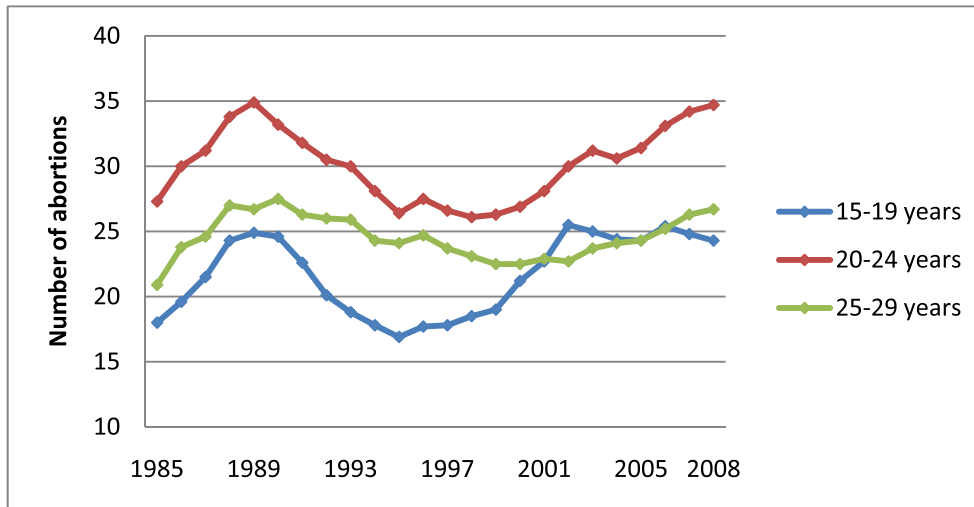
Condoms are available in Sweden through a broad distribution network and can be bought in shops, pharmacies and over the Internet. Condoms are also distributed free of charge to youth by many of the county councils.

Abortion

The current Swedish law on abortion was passed in 1975 (1974:595)[9]. The law permits abortion on the request of the pregnant women until the 18th week and after this only in cases of severe indications and after approval from the NBHW. Approximately 30 000 to 40 000 abortions are performed annually. Most abortions are performed on young women aged 20–24 (Figure 15). In 2008 the number among young women aged 15–19 was 24.4 per 1 000 women while the number among women aged 20–24 was 34.7. Abortion trends generally follow the trends exhibited by the birth rate. Almost 76% of induced abortions are performed before the end of the 9th week of pregnancy [25].

[9] For more information see the Legal Framework for HIV/AIDS section.

Figure 15: Number of abortions per 1 000 women per age group, 1985–2008.



Source: The NBHW [26]

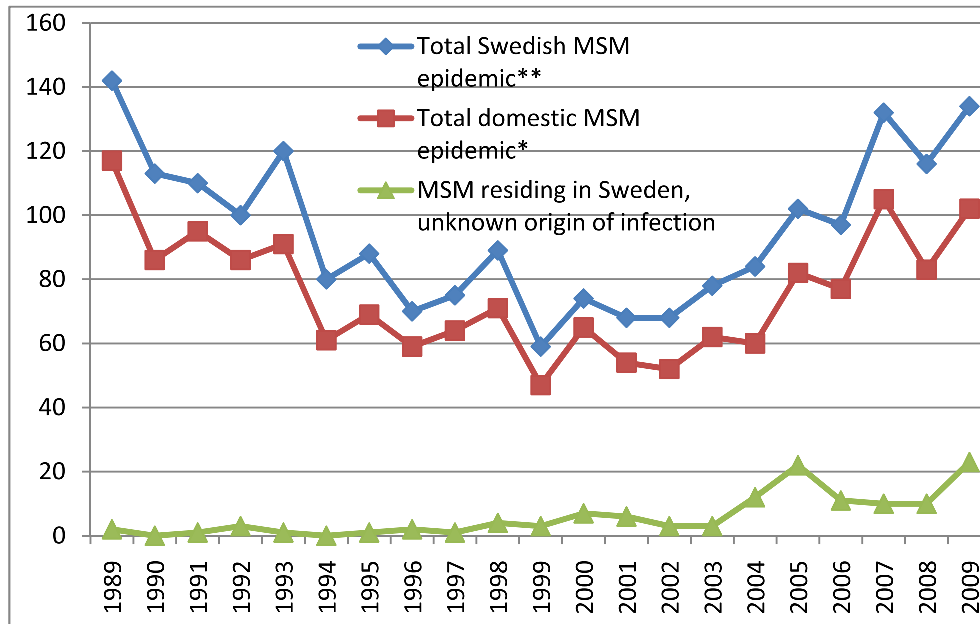
Men who have Sex with Men

The National Strategy states that the MSM population should be followed more closely in terms of epidemiological and behavioural monitoring, including promotion of regular VCT. The NGOs play an important role in reaching this population. It is difficult to estimate the actual size of the MSM population; however international research indicates that approximately 2.5% to 3.5% of the entire population belong to the MSM population. Based on a total population of 3 354 203 men between the ages 15 and 69 at the end of 2009, this would mean that approximately between 83 885 and 117 397 men were MSM active that year. The HIV prevalence among MSM is estimated at between 3–4% as opposed to 0.06% in the whole population.

Overall epidemiology 1989–2009

Since the beginning of 2000 there has been a slowly increasing trend for HIV infections from low numbers within the MSM population, indicating that risk taking is increasing. Of the 134 HIV positive cases detected in 2009, 32 were infected prior to arrival compared to 33 cases in 2008 (of a total of 116). The 2009 figures are preliminary since the origin of infection for 23 cases at the time of reporting is unknown (Figure 16).

Figure 16: Number of MSM testing positive per origin of transmission, 1989–2009.



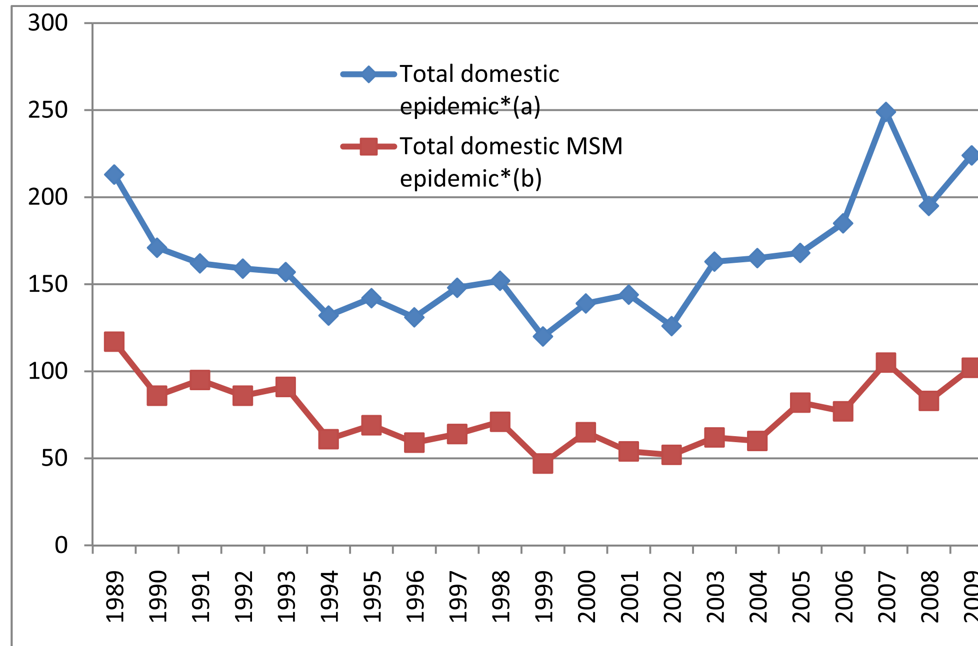
* The total domestic epidemic includes HIV positive people residing in Sweden when infected.

** Total Swedish epidemic includes all HIV positive people including people who are infected prior to arrival.

Source: SMI

The domestic MSM epidemic more or less sets the pattern for the total domestic epidemic, except for 2005–2006 when Sweden had an HIV outbreak within the IDU population and 2000–2001 when there was a small increase of HIV positive people within the heterosexual population (Figure 17).

Figure 17: Number of domestic MSM and General Public testing HIV positive, 1989–2009.



* (a) Total domestic epidemic includes HIV positive people residing in Sweden when infected.

* (b) Total domestic MSM epidemic includes HIV positive people residing in Sweden when infected.

Source: SMI

National level

The National Strategy argues that preventive measures aimed at MSM should be given high priority. The role of NGOs is emphasised as being particularly important. Regular HIV VCT should be offered to a greater extent to MSM, apart from the specialist clinics that specifically target the population today. The SGS has been reinforced for the population since 2006. Human and sexual rights for LGBT form the platform for an effective response. The following measures can be noted in the period 2008–2009.

- In February, 2008, the NBHW organised the first national conference with international speakers on HIV/STI prevention targeting MSM exclusively. The conference also attracted attention from other Scandinavian countries. The main theme was “How to develop new or adapt old methods to the changing societal and epidemical context, based on the needs of gay and bisexual men and other MSM”. The conference was based on results coming from the first Swedish “MSM Survey 2006” report. It was also based on a scientific review of evidence-based prevention for MSM [27]. The second survey, “MSM 2008” was launched in early 2008, making comparisons possible with the base-line data from the 2006 survey. The comparison shows no significant or major change in KAP from 2006 to 2008 and an extensive report will be published by the NBHW at the beginning of 2010.

- The 2008 MSM conference became the starting point for developing a NAP for HIV/STI prevention targeting homo and bisexual men and other MSM. The development process has involved participants from NGOs, health care institutions and various local and governmental agencies. Over the course of 2010 the plan will be subject to an extensive consensus remit for consideration by all organisations and agencies involved. The upcoming NAP will cover the period 2011–2016 in line with the aims of the National Strategy.
- RFSL is the main NGO working with MSM prevention on a national level through local branches. The NBHW has, through separate funding, supported the RFSL in the upgrade and systematisation of its own HIV prevention training manual. RFSL has also upgraded its communications strategy by conducting a special study for improvement.
- The NBHW supports an NGO consisting of actors from the commercial sector who run an information website, www.sentry.nu, for MSM connected to the largest gay internet and hard copy magazine in Sweden QX,
- The Stop HIV Intervention at the National Gay Pride festival every summer was evaluated in 2009 and found to be an effective intervention. It is a project where all the stakeholders come together and includes VCT and outreach [28].
- Swedish legislation has been changed to allow marriage between LGBT individuals during this period.

Regional level

Through the distribution of financial support and in cooperation with the county councils, the National Aids Grant indirectly supports various organisations' activities and interventions targeting MSM. The three major metropolitan areas have long-established programs targeting MSM. With close to two thirds of the MSM prevalence in these three metropolitan areas there are discrepancies in access to care and availability of interventions in the less populated areas of the country. During the period 2007–2009 RFSL has initiated a nationwide programme for LGBT certification of societal institutions such as youth STI clinics, thereby improving the MSM competence within the health care system. There is also a local NGO targeting youth and young adult LGBT people, which addresses HIV/STI prevention with many branches around the country.

Results of intermediary measures

The MSM population report on both UNGASS and nationally adopted indicators. Most of the indicators are fixed until 2016, in line with the aims of the National Strategy, to monitor trends over time. However indicators are also developed to fulfil temporary needs.

Testing

Results show that there are no significant changes in testing performance in the age groups 15–24 and 25–49. The older men (+50), though, show a significant decrease in their testing between 2006 and 2008. For both population and both studies, approximately 36–44% have taken an HIV test in the last 12 months. It should be noted that there are no cases where a person was tested and did not receive their results. It is extremely uncommon and is usually due to the patient not coming back for the results and not being reachable by e-mail or phone. Approximately 80% of MSM aged 15–24 know where they can take an HIV test and for the +25 more than 90% know where to get a test.

Knowledge

The level of knowledge about HIV and safer sex among MSM is considered to be very high compared to other MARP. In the 2006 and 2008 survey question regarding condom use, the question was divided in two parts concerning the active/penetrating partner or the passive/penetrated partner.

Condom use

The percentage of condom use for penetrator and penetrated is very similar, with a noticeable difference among the older men (+50), where the men being penetrated report a significantly lower use of condom (45% as opposed to 54% for those penetrating, in the 2008 study). The other two age groups report almost identical figures for both roles. Similarly, it is the older men that show differences in condom use over the period; whereas the other two age groups report increasing rates of condom use (up 5% in the middle age group and an increase of 10% for the youngest men) the men over 50 (being penetrated) report a decrease in condom use of 5%. In total for both studies and all three age groups, condom use the last time a person had penetrating/penetrated sex varies between 38–54% of the total study sample. Both studies show that there are few significant changes in knowledge level or behaviour pattern, most likely due to the short period of time in between the studies. The needs expressed in both studies remain the same.

Challenges

HIV incidence has risen slowly and gradually from the turn of the century to almost double the previous figures in 2009, indicating that the policies and/or actions taken to date have not been adequate. There is certain reluctance among some of the actors that implement knowledge-based methods tending to hold on to old practices. The work of the MSM NAP will focus on providing a current and coherent framework with up-to-date knowledge about how to work with prevention as concerns the MSM population. The MARP MSM whose ethnic background is not Swedish has also been prioritised by the NBHW; however the efforts to persuade the various MSM and/or ethnic organisations to cooperate have yet to be enhanced.

Migrants to Sweden

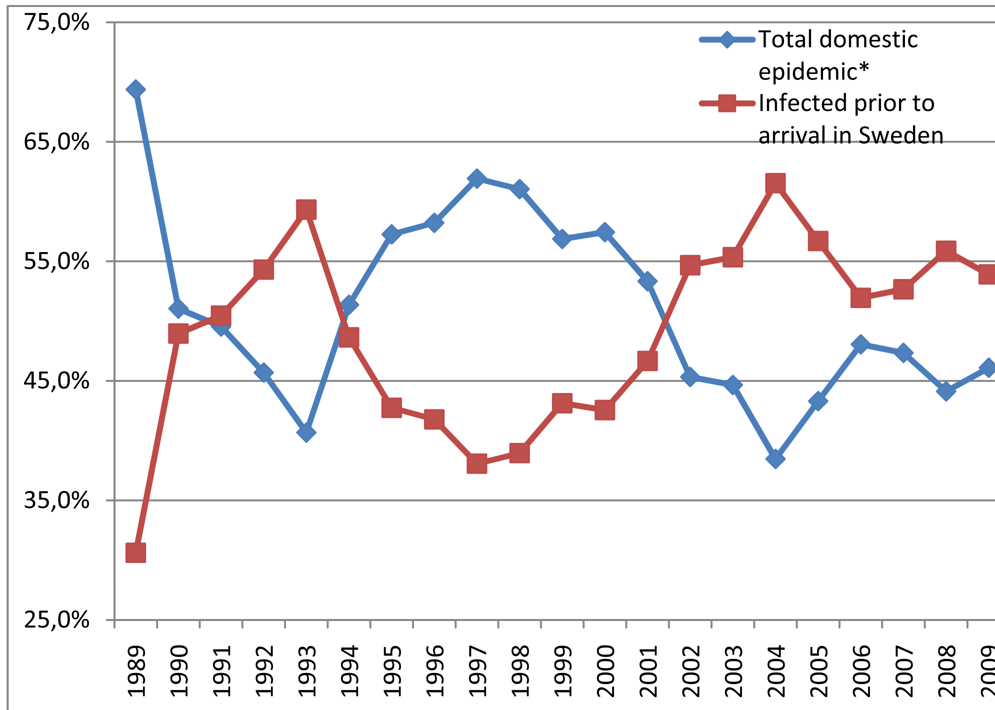
Sweden has 9 million inhabitants and approximately 1.2 million (12%) are born outside of Sweden. The Swedish National Strategy stresses the need to reach people who migrate to settle or stay long term, and who come from high endemic areas.[10] The NBHW foremost targets asylum seekers and immigrants arriving on the basis of family ties in its preventive efforts. In 2007, Sweden received more asylum seekers than any other country in Europe [29]. The same year a total of 526 new HIV cases were identified in Sweden out of which 53% were infected prior to arrival in Sweden. The number of asylum seekers depends on conflict situations in other areas of the world and numbers are currently declining, whilst immigrants arriving on the basis of family ties with Swedish citizens and former migrants, not least from Thailand and Somalia, are increasing.

Overall epidemiology 1989–2009

There are many migrants coming to Sweden and some become HIV infected after their arrival for various reasons. These persons cannot be easily identified in the epidemiological surveillance and are included in reports on the domestic population. There is little possibility of analysing their relative vulnerability although it may be assumed that some elements of the population are more vulnerable to infection. The group 'People infected prior to arrival in Sweden' refers to immigrants of various kinds, regardless of when they registered in Sweden who, certainly or most probably, were infected before they came to Sweden. The group people infected prior to arrival in Sweden fluctuates with immigration patterns. Between 1994 and 2001, more domestic HIV positive were found than non domestic. This changed however in 2001 and, to date, the majority of the new cases detected are people 'people infected prior to arrival' which changes the outlook and dynamics of the Swedish epidemic, calling for more tailored interventions (Figure 18).

[10] The English word migrant has no real translation in Swedish. Two words are used describing people migrating to or from Sweden. The connotation is long-term migration to settle. Otherwise people are considered to be travelling or temporary workers. In this text we will use the word migrants to Sweden meaning asylum seekers, refugees, people residing in Sweden who have immigrated during recent years, people from other countries working in Sweden long-term, but not settled long-term visitors or undocumented people.

Figure 18: Domestic HIV infection compared to the group of people infected with HIV prior to arrival to Sweden, percentage of all reported HIV cases 1989–2009.

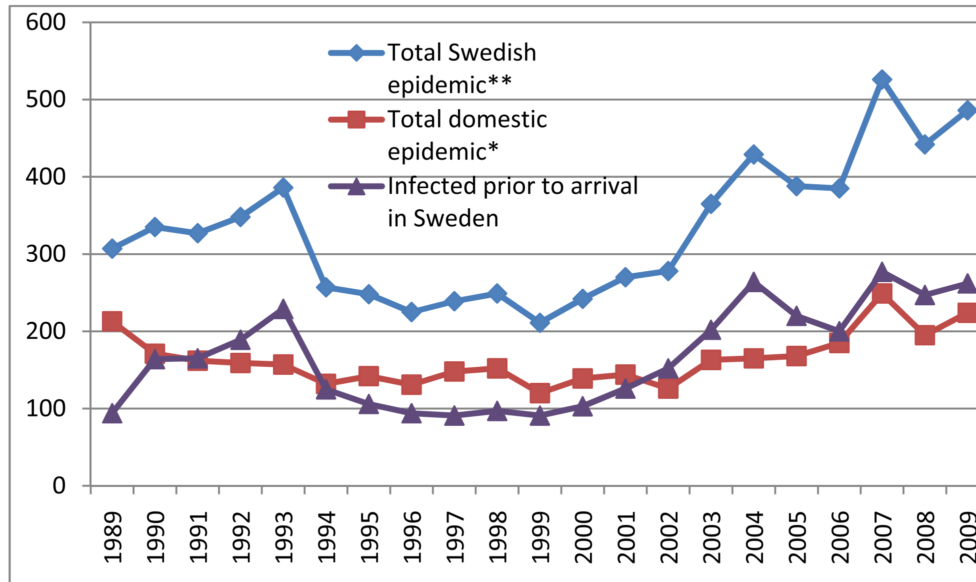


* Total domestic epidemic includes HIV positive people residing in Sweden when infected.

Source: SMI

The number of people detected as HIV positive in the group infected prior to arrival has increased since 1999 with a temporary dip between 2004 and 2006. Of the 486 HIV positive cases detected in 2009, 262 were infected prior to arrival compared to 247 cases in 2008 (of 442). The 2009 figures are preliminary since the origin of infection for 70 cases at the time of reporting is unknown (Figure 19).

Figure 19: Number of domestic and non-domestic people testing HIV positive, 1989–2009.



* The total domestic epidemic includes HIV positive people residing in Sweden when infected.

** Total Swedish epidemic includes all HIV positive people including people who are infected prior to arrival.

Source: SMI

National level

The National Strategy states that people seeking asylum or newly arrived due to family reunion immigration are to be offered a health check, including VCT, within two months of arrival. The National Strategy emphasises the systematic health check as a tool to access prevention, testing, treatment and support. The Health and Medical Service for Asylum Seekers and Some Others Act (SFS 2008:344)[11] states that county councils are to offer a health check to individuals newly arrived in Sweden who are covered by this law. This includes a health interview, laboratory tests including screening for HIV and other examinations when necessary. This is to be carried out as soon as possible after the person concerned has established residence in the county and has been registered at the Swedish Migration Board.

Measures 2008–2009

Asylum seekers are more systematically offered health checks than those who migrate for family reasons. In 2007 the number of asylum seekers offered testing was as low as 30%. It has now increased to 60% through various targeted efforts from many actors, including NGOs. It is, however, much more difficult to estimate the accessibility of health checks to other immigrants since these are not paid for by the Swedish Migration Board but

[11] For more information see the Legal Framework for HIV/AIDS section.

costs are integrated into ordinary health care budgets. The number is estimated to be below 10%.

The Swedish Migration Board has initiated a project to train their staff on how to meet needs of immigrants when it comes to health and HIV. Special attention needs to be given to the youth and young adult group with HIV coming from high endemic countries without their families.

In late 2009 collaboration was established with InfCare [30], a national quality register within the health care system for HIV care in Sweden. InfaCare was launched in 2004 and since 2008 all known HIV patients in Sweden are included in the system which also incorporates all HIV clinics. A more comprehensive system is under construction and will be operating fully in early 2010. This system will, among other things, be able to systematically collect treatment data which include newly infected people coming from foreign countries. It will be possible to establish if and when they received a health check on entry into Sweden.

The NBHW has conducted a literary review on the risk situations concerned with migration in order to better understand needs and activities that should be developed to address these.

On several occasions the NBHW has pointed out to the government the risky health and social situation in general for undocumented people living in Sweden.

The evaluation of NGO activities mentioned earlier demonstrated that many ethnic and other NGOs that are funded by the National Aids Grant contribute to the increase of understanding and the will to test among newly-arrived immigrants in Sweden. However these efforts are not reaching enough of the migrants coming from high endemic areas and are not disseminated evenly all over the country.

Regional level

There are considerable differences between various parts of the country with respect to the proportion of asylum seekers who undergo health checks. The conduct of the health interview and examination also differs throughout Sweden. The publication Health and Medical Services for Asylum Seekers and Refugees (1995:4)[12] published by the NBHW gives advice on how counselling and examination is to be carried out. Immigrants arriving on the basis of family ties, many of whom come from regions with high HIV prevalence, constitute a large portion of the relatively small amount of immigrants who are currently offered a health check. Within the framework of systematic monitoring of regional HIV/STI prevention activities, in 2008 and 2009, the NBHW has challenged the county councils, municipalities and regions to intensify health checks, including HIV screening, amongst asylum seekers and others newly arrived in Sweden. Lately, the NBHW has observed increasing efforts to actively reach out to the migrant community among these bodies.

[12] For more information see the Legal Framework for HIV/AIDS section.

A best practice example is demonstrated by the large Västra Götaland County Council who managed to reach over 80% of their newly-arrived asylum seekers and have documented their efforts for other county councils to duplicate.

Results of intermediary measures

Epidemiological surveillance for this MARP is difficult since appropriate mechanisms to monitor the number of voluntary health checks have not yet been fully established. Preliminary data obtained from the INFCARE quality register shows that approximately 9 out of 27 identified, diagnosed asylum seekers were diagnosed within 2 months of arrival. For immigrants arriving on the basis of family ties, approximately 15 out of 40 identified and diagnosed were diagnosed within 2 months of arrival. The data comes from the major infectious diseases clinic in Stockholm at the Karolinska University Hospital (KS) where approximately 33% of Sweden's HIV positive patients are registered. In 2009, KS received 118 newly-diagnosed patients. The data does not capture people immigrating for reasons of work, or people with an EU residence permit. The data is not representative

People Travelling Abroad

The National Strategy identifies the vulnerable situation of people travelling to and from high endemic areas. The MARP however is complex, covering a variety of people such as tourists, people working or studying abroad for shorter or longer periods of time and (foremost previous immigrants) travelling back to their home country. Consequently the MARPs People travelling abroad and People migrating to Sweden overlap each other. In addition, all the other MARP can also be found here. For instance around 10% of infected MSM were infected whilst travelling to another country in 2008 at least 15% in 2009. Many were infected in major European cities.

The National Strategy identifies that epidemiological and behavioural surveillance needs to be strengthened. Health promotion including VCT for the people travelling to high endemic areas also needs strengthening within the health care system. The National Strategy has the objective that a person travelling abroad and who stays in a high endemic country, should be offered VCT for HIV infection no later than 6 months after returning to Sweden. The reality is that the time between arrival in Sweden and VCT often is much longer.

Injecting Drug Use

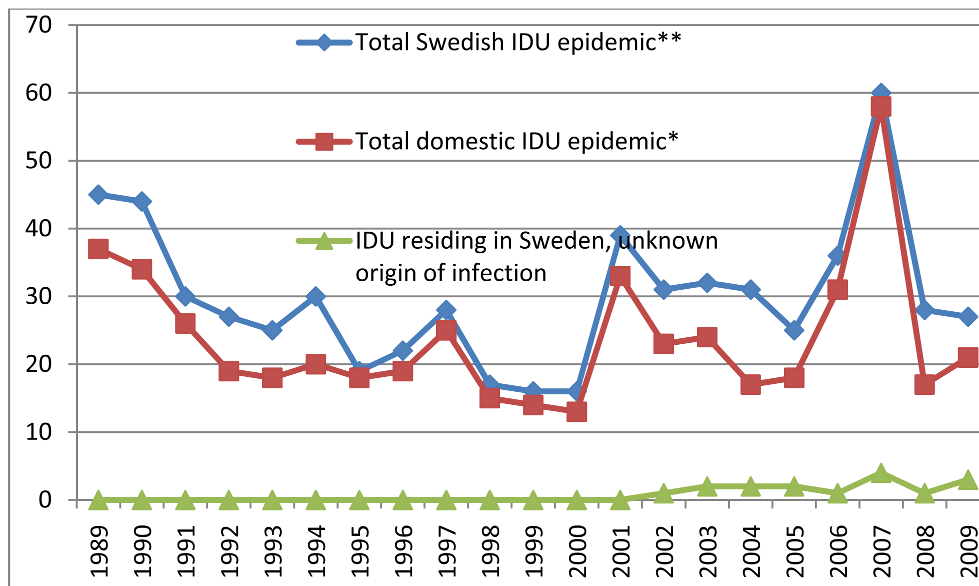
The National Strategy states that efforts should be made concerning epidemiological and behavioural surveillance, including VCT for the IDU MARP, especially the female IDU. Hepatitis B and C should also be taken into consideration. In addition, the profession handling the IDU population also needs to strengthen its knowledge around HIV/AIDS and attitudes towards the IDU population. The National Strategy underscores the impor-

tance of offering comprehensive drug abuse treatment to those in need, since drug abuse is the major contributor to increased high-risk behaviour patterns in the form of the use of non-sterile injecting equiptment and/or unprotected sex.

Overall epidemiology 1989–2009

By the end of 2009, a total of approximately 967 cases of HIV positive IDU had ever been detected in Sweden. Of the 27 HIV positive cases detected in 2009, six were infected prior to arrival compared to 11 cases in 2008 (of a total of 28). The 2009 figures are preliminary since the origin of infection of three cases at the time of reporting is unknown (Figure 20).

Figure 20: Number of IDU testing positive per origin of transmission, 1989–2009.



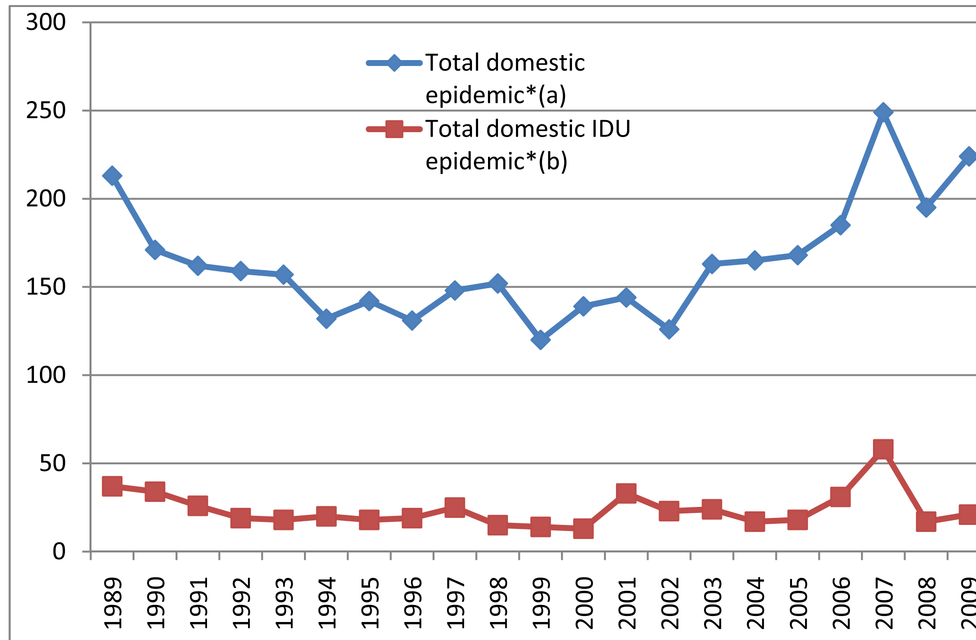
* The total domestic epidemic includes HIV positive people residing in Sweden when infected.

** Total Swedish epidemic includes all HIV positive people including people who are infected prior to arrival.

Source: SMI

In 2006 an HIV outbreak occurred in the domestic IDU population in Stockholm. As a response, intensified testing and other activities resulted in more HIV infected IDUs being detected in 2007. In 2008, the epidemic was reversed (Figure 21).

Figure 21: Number of domestic IDU and General Public testing HIV positive, 1989–2009.



* (a) Total domestic epidemic includes HIV positive people residing in Sweden when infected.

* (b) Total domestic IDU epidemic includes HIV positive people residing in Sweden when infected.

Source: SMI

National level

Needle and syringe exchange program (NSEP)

The first NSEPs were initiated in Lund and Malmö in the mid 1980s and run on a pilot basis by the Skåne County Council. NSEP was regularized in 2006, when a new Injection Needle Exchange Act (2006:323) entered into force, allowing county councils across the country to run NSEPs after authorization by the National Board of Health and Welfare. The NSEP shall offer free HIV, Hepatitis B and C testing and be organized in such a way that the individual who takes part in the program can be motivated to addiction treatment and care. Only individuals 20 years or older can participate. Normally, clean needles and syringes can be distributed only in exchange of used ones.

Sentinel surveillance

Parallel to the NSEP efforts, the NBHW is developing a complementary SGS sentinel system for the IDU population and, indirectly, the SW MARP. An evaluation performed on the Socio-Medical Remand Project running in the remand prisons in late 2008 concluded that the project was successful in its realisation and suggested that it be integrated into regular activities. The project offers VCT, hepatitis B immunisation and monitors HIV prevalence,

incidence and behavioural risk factors for sexual and IV transmission of HIV and hepatitis among IDUs. A very positive aspect of the project was the IDUs themselves who found the VCT sessions that were offered to be an opportunity for reflection. The project, now re-named The Swedish Prison Programme (SHP) is a joint collaboration between the county councils, the Prison and Probation Service, Karolinska Institutet and NBHW. In 2009, a total of 259 IDU participated in the program.

Problem Drug Use (PDU)

Studies on prevalence regarding problem drug use (PDU) have been undertaken sporadically in Sweden. The latest case-finding study dates back to 1998, and resulted in an estimated population of 26 000 PDU, of which 89% were described as IDU (has injected on some occasion during the last 12 months). With the use of the national registry on in-patient discharges, combined with discharges from the correctional system, an alternative method of estimating has provided new data.[13]

The results from the latest estimate from 2007 suggested a slight increase of the PDU population, as compared to the 1998 figure of 26 000 PDU. The estimate for 2007 was 29 500 PDU. The PDU rate for 1998 was estimated at 2.9 per 1000 inhabitants compared to the rate for 2007 of 3.2 per 1000 inhabitants.

The three major county councils Stockholm, Skåne and Västra Götaland ranked above average in the spectrum, although not at the high end. Since the regions also included more densely populated municipalities, the figures may be misleading e.g. the Västra Götaland County Council which contains 49 municipalities, one of which being the city of Gothenburg where approximately one third of the region's population live (Table 5). Different studies suggest that the proportion of IDU falls between 70–90% within the PDU population.

[13] Truncated poisson model with a focus on the frequency distribution of individuals appearing in the treatment and correctional systems.

Table 5: Estimated number of PDU per 1000 inhabitants and county council, 2007.

2007	Estimated no of PDUs	Estimated no of PDUs per 1000 inhabitants
Stockholm	6 408	3.3
Skåne	4 469	3.7
Västra Götaland	5 328	3.4
The whole of Sweden	29 513	3.2

Source: NBHW

Second generation surveillance (SGS)

In line with the development of the SGS for the IDU population, in 2008–2010 the NBHW has worked closely with EMCDDA [32] and the Finnish national HIV/AIDS team. Both of whom have contributed greatly to the advancement of the surveillance and prevention of IDUs in Sweden.

Regional level

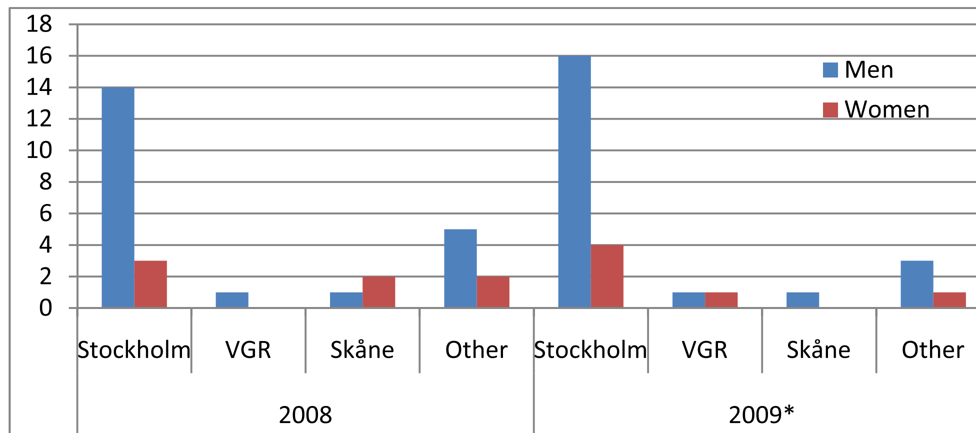
Stockholm County Council

Between 2007 and 2008, a regional study was conducted in Stockholm [33]. The aim was to interview, test and vaccinate IDUs and a total of 1 145 IDUs were identified. Of the 1 145 IDUs, 720 had injected sometime during the preceding 12 months. The mean age of the 720 IDUs was 40 years and 73% of them were men. Approximately two thirds had been to prison. The majority made their narcotics debut at 15 years of age and their intravenous debut at the age of 19. 75% used amphetamine as their first intravenous drug. Risk behaviour patterns were widespread within the population. 51, or 7.1%, of the 720 IDUs tested HIV positive of which approximately one third were new cases detected. 82% were HCV positive.

Skåne County Council

In 2009, the Malmö NSEP tested 749 active IDU participants (100%) out of which no new HIV infections were found. In 2008, the program tested 800 active IDU participants (100%) out of which no new infections were found. In 2009, 143 cases (114 in 2008) were registered in the program, however within the three month period before the obligatory HIV re-test was scheduled, the participants dropped out of the program i.e. went into substitution therapy, went to jail, moved, died or quit their abuse etc. The NSEP and its preventive efforts has had a positive effect on preventing new HIV cases whereas Stockholm, without a NSEP, continues to have higher numbers of new HIV infections (Figure 22).

Figure 22: Number of IDU cases testing positive per major county council, 2008–2009.



Comment: Data reported comes from the three major county councils (regions) in Sweden. 'Other' refers to the rest of the country. Cases are reported by county council of detection, which for some cases might differ from county council of infection. *Data for 2009 are preliminary.

Source: SMI

In 2009, the program also tested a total of 910 out of 914 (99.6%) IDU participants for HBV and HCV and in 2008, only one of all 891 participants declined an HBV/HCV test. In 2009, 84 new IDU entered the program-a few more than in 2008 when 79 new IDU entered. The mean age for the IDUs enrolled in the Malmö program varies from 38–41 years; however, in 2007 and of the 95 new IDUs who entered the program, the mean age was 26 years old, suggesting a breakthrough in reaching a younger and harder-to-reach population within the IDU community.

Results of intermediary measures

The IDU population report on both UNGASS and nationally adopted indicators. Most of the indicators are fixed until 2016, in line with the aims of the National Strategy, in order to monitor trends over time. However indicators are also developed to fulfil temporary needs.

Preliminary data from the SHP for 2009 show that 82% of the IDU identified in the program have taken an HIV test. 80% know where to go if they want to have an HIV test. 27% have been given condoms by a preventive measure such as outreach activities, or via a health centre. 24% of the IDU have been given sterile needles and syringes. Note that the SHP is not active in the Skåne County Council, where the current and only NSEP is in operation in Sweden, suggesting that the IDU responding to the questions have been given clean needles via informal NSEP. 9.3% of the IDU tested were HIV positive.

Correctional facilities

The prison system in Sweden has no delegated obligation to provide inmates with health care. According to the Principe of Normality [34] people in

prison or in remand prison have the same right to health care as all the other inhabitants in Sweden and this should be provided by the county councils. However, due to security issues and for practical reasons, the Swedish Prison and Probation Service (KV) provides for such health care services. The health care in the prison system is, as all other health care in Sweden, under the supervision of the NBHW. Most of the health care in prisons is provided by nurses specially trained in prison medicine, i.e. a specialisation for nurses designed according to the special needs of the inmates. A part of this service is prevention of blood borne infections, for example HIV testing, hepatitis vaccination and special counselling. Everyone in Swedish remand prisons are offered VCT. In addition to regular VCT, the KV and the NBHW together with the county councils and the Karolinska Institutet (KI), collaborate on the SHP program, intended as a sentinel surveillance system designed to offer VCT and vaccination to all IDU identified within the prison structure.

During the period of imprisonment, additional disinfectants and condoms can be obtained from the prison health care service. However injection equipment exchange services are not available within the correctional facilities. Addiction and detoxification health services are available in the remand prisons system. Opiate maintenance or substitution therapy is available in certain prisons when the inmate has at least a 3-month sentence.

Persons Buying and Selling Sex

The Swedish term for sex worker is people who are victims of prostitution; however in this text the international terminology is used. The term commercial sex is not applicable in Sweden since the purchase of sexual services is illegal (but not selling sexual services). The National Strategy states that the link between men’s exploitation of SW and the spread of HIV and STIs must be exposed since those who sell and those who buy sex run a higher risk of infection by HIV and STIs and that it is the behaviour of the buyers, most often men, that constitutes the defined problem. The NBHW has not yet analysed the risk factors for HIV and STIs nor estimated the prevalence of the population. It is clear, however, that some IDU, MSM and certain youth and young adults, foremost youths and young adults within institutional care, buy and sell sex. Another target group is the group of people travelling abroad, primarily going to countries with a generalised epidemic which exhibit an easier attitude towards the sex worker phenomenon. Estimates of the number of people involved in commercial sex in Sweden vary widely and are very hard to estimate since it is mostly hidden and initiated primarily through the Internet or telephone. Although street prostitution does occur it is assumed to be only a fraction of total prostitution.

Legislation

Purchasing, or attempting to purchase, sexual services became criminal acts in Sweden in 1999 when the law prohibiting the purchase of sexual services (The Penal Code, Chapter 6, and Section 11) took effect. The law expresses,

in a practical form, a will for gender equality on the premise that men are normally buyers of sex and women sellers. This shift has made a renewal of the conceptual apparatus necessary. The legislation, however, is gender-neutral and based on the premise that both women and men can both buy and sell sex. However it is the seller who is regarded as the vulnerable party. The terms of punishment include fines or a maximum of six months' imprisonment. The selling party never runs the risk of any judicial consequences.

Overall epidemiology

At the moment, the only data which exists in regards to prostitution is linked to the work of three Prostitution Groups run in the three major metropolitan areas and a few research projects. The common problem is that prostitution is hidden for the most part. The IDU sentinel surveillance within the remand prison structure is also designed to cover people selling and buying of sexual services and of 952 people asked in the SHP during 2006–2007, 46 (5%) have paid for sexual services.

National level

In order to address the knowledge gap around prostitution, the Swedish Government adopted an NAP in July 2008 aimed at combating prostitution in Sweden and human trafficking for sexual purposes [35]. Altogether, SEK 203 million will be invested in 36 measures up to 2010. The Government Action Plan covers five priority areas:

1. Greater protection and support for those at risk.
2. More emphasis on preventive work.
3. Higher standards and greater efficiency in the justice system.
4. Increased national and international cooperation.
5. Greater knowledge and awareness.

All major government actors will contribute to this work and a national epidemiological study of people buying and selling sex is planned for early 2010.

Regional level

Stockholm County Council in is running the Spiral Project, directed at women who sell sex. The project started in 1978 and has since become a permanent operation. The Spiral Project offers a physician's clinic with gynaecologist, psychologist and counsellor, free of charge. The project also has outreach activities. Malmö and Gothenburg municipalities also have Prostitution Groups offering counselling programmes under the auspices of the Social Services Administration for people selling sex.

There are programs for people with experience of selling sex and they work on a broad front with therapy, counselling, prevention and care. Outreach takes place both as field-work in the streets and on the Internet. Malmö also offers “Navet”, an outpatient treatment and counselling program for women who are former injecting drug users with experience of

selling sex. “FAST" (the sale of sexual services) is another Malmö programme specifically targeted to people selling sexual services outside the street environment. The cities also have programs called “KAST” (the purchase of sexual services) directed towards people who buy sex. Certain police officers in the three cities work specifically with street-based sex work. This cooperation between the authorities in the field of infectious disease prevention, the police and the social services is of importance at both the national and the regional levels.

Results of intermediary measures

A proper surveillance system has not been established for the SW group and no clear overall understanding exists in regards to risk taking and HIV prevalence data. The SW group report both on UNGASS and nationally adopted indicators. The national indicators cover the period 2006–2016 in order to monitor trends over time.

Mother-to-Child-Transmission

A total of 140 cases of HIV infection transmitted from mother to child in connection with pregnancy and childbirth have been reported in Sweden since the data HIV surveillance system commenced. Of these, 83% were infected prior to arrival in Sweden. Since 2000, only four cases of mother to child transmission that occurred in Sweden have been registered and of these, two cases were notified in 2009.

Maternity welfare

Since 1987, when the maternity welfare and abortion screening system was introduced in Sweden, a total of 303 women have been detected as HIV positive. Approximately 50% of the cases have been detected in the group infected prior to arrival in Sweden, with most of the cases coming from countries with a generalised epidemic in Sub-Saharan Africa (56%) and Asia (20%). 269 cases originate from the heterosexual route of transmission and four from the IDU route of transmission. In the last 10-year period, approximately 15 women have been detected annually.

Nosocomial Transmission

Nosocomial HIV transmission includes patients infected within the health care system as well as staff members infected in the line of duty. So far there have been no cases of nosocomial HIV transmission in the Swedish health care system. In order to prevent nosocomial transmission between patients, from patients or samples to medical staff and from medical staff to patients respectively, several measures are recommended by the NBHW;

- Adherence to basic hygiene rules.
- Working in ways that prevent injuries from cuts and piercings.

- Not using the same syringe to administer drugs to different patients.
- Not re-using a syringe for drawing medicine even for the same patient.
- Using personal protective equipment to protect the mucous membranes of the mouth and eyes during work when there is a risk for splashes of blood or other bodily fluids.
- Having written routines for measures to be taken after an event.
- Using recommended disinfectant for point disinfectant after spills.
- Proper disinfecting of equipment that is reused.
- Handling bloody laundry and waste as dangerous/contagious.
- Choosing equipment that does not have sharp edges during surgery, when possible.
- Avoiding double-ended instruments.
- Using two pairs of gloves during procedures with a high risk of glove perforation.
- Using reinforced protective clothing during operations, when larger amounts of blood are to be expected.

The Swedish Work Environment Authority [36] has published provisions on microbiological work environment risks-Infection, Toxigenic Effect, Hypersensitivity, together with general recommendations on the implementation of the provisions. These provisions apply to both employers and staff and aim to protect staff from e.g. blood-borne pathogens. There are also general provisions on protection against blood-borne illnesses [37].

Blood donation and blood product mediated transmission

About 180 people were traced and found to have been HIV infected by blood transfusion or blood products in Sweden when it became possible to start doing HIV tests in 1985. Since 1986 there have been no new cases of HIV transmission occurring in Sweden through this route of transmission. In order to prevent transmission of HIV through blood transfusion or blood products, persons known to be infected with HIV are excluded from donating blood, organs, tissues and cells. Assisted reproduction for a couple is only performed if the probability of transference of the disease is considered unlikely. In practice, persons infected with HIV are excluded. When the donator of germ cells is not a partner, a negative HIV test is mandatory. Screening for antibodies against HIV-1 and HIV-2 is mandatory following blood donation as well as preceding donation of organs, tissues or cells (including germ cells). From April 1st 2010 the blood banks are required to test against HIV using the combined antigen-antibody test. (The same requirement is not applied regarding donors of organs, tissues or cells. Following April 1st using serology only is still acceptable).

By the end of 2008, a total of 415 801, or approximately 44.9 per 1000 inhabitants were registered as blood donors in Sweden. These donors had access to a total of 107 fixed and mobile sites, spread over six regions [38].

Treatment and Care

As stated earlier in this report any person who is legally present in Sweden and needs ART has access to treatment. Around 98% of the relevant patients receive therapy and the remaining 2% are persons who live with drug addiction and are unable to maintain adherence to ART. The cost of the full treatment, i.e. consultation, drugs and so on, is covered by the national health insurance scheme and cannot be easily estimated.

In 2008, 3615 (2 310 men and 1 305 women, 15 years and older) were receiving ART [30]. The number receiving treatment in 2009 was 4 185 (2 631 men and 1 497 women 15 years and older, and 57 children 14 years or younger), approximately 80% of all the people living with a known HIV infection in Sweden.

According to recommendations in Sweden, treatment for an asymptomatic adult infected with HIV is started before their CD4 cell count falls below 350. The numbers presented above have been calculated based on the WHO guidelines, which define advanced HIV infection as when the CD4 cell count is below 350. All pregnant women with an HIV infection are offered ART and treated. All patients discovered to have both TB and HIV are given both TB treatment and ART. ART starts 1–3 weeks after TB treatment.

Studies done by the NBHW in 2007 revealed uneven quality of care and support throughout the country for children and youth living with HIV [39]. In many places there is only one or a few cases and staff need training in how to handle the children. In 2008 a special national knowledge centre for children infected and affected was established at the largest infectious diseases clinic at Karolinska University Hospital in Stockholm. The aim is to support staff throughout the country who encounter, treat and support children and youth living with HIV. Supervision can be offered via phone or visits.

Support

The Swedish Communicable Diseases and Prevention Act (2004:168) give the health care and especially the treating physician a big role in supporting persons living with HIV and Aids. The psychosocial support offered should ensure the patients and next of kin possibilities to live as normally with the infection as possible. It should also help the persons to be able to disclose their status to sexual partners or to avoid sharing needles. This is a tremendous challenge. Supervision of the support given within the health care from the NBHW has demonstrated that there are real efforts to meet these challenges from the health care staff. Bearing in mind that over half of new cases are migrants newly arrived to Sweden from high endemic areas it should come as no surprise that there are tremendous cultural barriers meeting these efforts.

The NBHW allocates around 50% of NGO funding to NGOs that work with psychosocial support and Human Rights for PLWHA. These NGOs support self help groups, educate staff and also give legal advice concerning

the rights of PLWHA. The HIV Sweden organisation is an umbrella organisation for PLWHA.

Overall social welfare and social support and care are services run by the municipalities. As PLWHA are aging the social services in major metropolitan areas have started to face the need of educating staff to care for ageing and ill PLWHA.

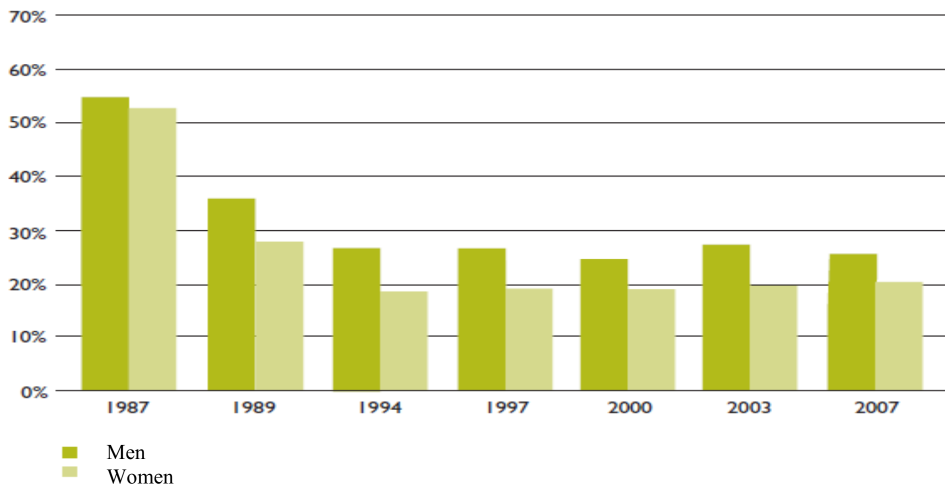
Stigma and Discrimination

The National Strategy emphasises the importance of reducing causes of stigma and discrimination of PLWHA and other groups affected and that measures to counteract this are essential for the success of the preventive activities. One of the interim objectives in the Swedish HIV strategy states that 'Knowledge about HIV/AIDS and conditions when living with the disease must be improved in the public sector, in working life and society as a whole'.

Sweden has a fundament of anti-discriminatory laws and regulations in the Discrimination Act[14] that prohibits discrimination of people on grounds of sex, transgender identity or expression, ethnicity, religion or other beliefs, disability, sexual orientation or age. A person that considers him or herself to be discriminated against may report this to the Equality Ombudsman [40], a government agency responsible for investigating discrimination complaints. Few cases of discrimination connected to HIV have been officially reported. One case of discrimination on the grounds of HIV infection was taken to court in 2008 with a guilty verdict. Self-stigma and isolation among PLWHA are feelings reported in a study conducted by NordPol [41] in 2007, a cooperative body of Nordic umbrella organisations for PLWHA. The longitudinal survey HIV and AIDS in Sweden [9] has followed knowledge, attitudes and behaviour in the general population. The study shows that knowledge about HIV/AIDS and the transmission routes continues to be at a high level and that negative attitudes towards PLWHA have decreased considerably since the surveys began in 1987 (Figure 23).

[14] For more information see the Legal Framework for HIV/AIDS section.

Figure 23. Percentage of women and men, 16–44 years who answered 'yes, surely' or 'yes, probably' to the question of whether they would avoid close contact with a friend at work or in school after learning that this person was HIV positive.



Source: HIV/AIDS in Sweden, 1987–2007

Intermediate measures

To combat stigma and discrimination the NBHW has undertaken the following measures in 2008–2009:

- Participation of PLWHA in the National Council.
- Co-operation with PLWH in strategic preventive work.
- National funding of organisations for PLWH.
- National surveys on knowledge concerning HIV and attitudes in the general population.
- A National Conference on Children Infected with or Affected by HIV/AIDS and a conference report summarising current knowledge on problems and practices.
- Support to a network for HIV counsellors in health care settings.
- National WAD campaigns focused on issues of stigma and discrimination.

A National Resource Centre for children living with, or affected by, HIV was established in Stockholm in 2008 with support from the National Aids Grant.

In cooperation with HIV Sweden, a study on methods and best practices to follow the prevalence of perceived stigma and discrimination among PLWHA over time was initiated in 2009. The first report will be published at the end of 2010. On the basis of this study, a strategy for measures to improve knowledge on the prevalence of discrimination and stigma will be developed.

World Aids Day (WAD)

For the 2009 WAD, the NBHW together with the National HIV Council, the county councils and relevant NGOs, launched the campaign “HIV exist in Sweden”. The purpose of the campaign was to focus on discrimination and stigma and to re-engage the media in the HIV debate. The specific targets of the campaign were;

- To increase knowledge on HIV among the general public.
- To encourage people who are infected with HIV to regard themselves as any other member of Swedish society.
- To prevent discrimination of people infected with HIV.
- To declare to the general public that HIV exists in Sweden and that it concerns us all.

The campaign was based on posters displaying the message “I live with HIV and your prejudices” depicting individuals in environments where discrimination is prohibited, i.e. working life and education, goods, services and housing etc., and health and medical care and social services. This campaign engendered positive responses on both national and regional levels. The posters were used by all major Swedish stakeholders and put up all over the country as posters or as advertisements in large daily papers, on buses etc.

National Communications Strategy

One success factor in preventive activities with HIV/AIDS and STIs is that the awareness of the general public remains high. In order to maintain such an initiative and render it effective, a coherent and well-grounded communications strategy that is able to reach the target MARPs is required.

Health promotion and prevention of HIV/AIDS depend largely on the ability to handle different types of communication:

- Interpersonal communication for behaviour change in individuals at risk of infection or infected.
- One-way communication or information to attract attention to the issue or to disseminate information in order to maintain the awareness of the MARP and the general public at a high level or just to remind them of what they know and their intentions to protect themselves.
- The public dialogue - a combination of meetings, information and activities in the media to make these issues important so that the debate around them continues to be present on society's agenda.

In 2008, the NBHW developed a national communications strategy (NCS) for overall communications [42], which will be in effect until 2016. The purpose of this strategy is to clarify the different types of communication needed, as well as the roles and responsibilities of different actors, and also to define the different target groups for whom the communication is intended.

The NCS recognises that one major obstacle to Swedish HIV/AIDS prevention has been the frequent change of location for national coordination and the consequent change of logo and messages. The NCS have made an effort to launch a neutral logo to follow the work irrespective of formal ownership. All members of the National HIV Council may use this logo in combination with their own.

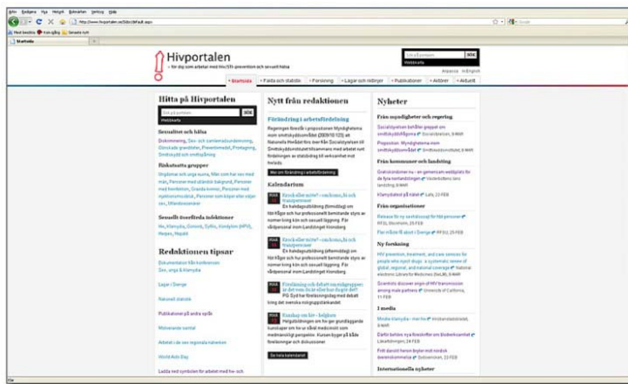
The NCS provides a framework for how communication developed for a specific MARP should be coordinated amongst actors on national and regional level to ensure that information is explicit, coherent and focused. The NCS also covers other areas such as research and a variety of meeting forums.

Research show that youth and young adults' perception of the risk of infection and their knowledge about the condom and its protective qualities, does not correspond with their own attitude towards condom usage [9]. In 2009 the government also commissioned the NBHW to develop a communications framework that allows for attitude and behavioural change towards improvements in condom use in the MARP youth and young adults. The targeted information intervention will commence in early 2010 in collaboration with the county councils and the NGO community.

The HIV portal

An important part of the National Communication Strategy is the coordination and dissemination of information and communication support to actors in different sectors.

The HIV Portal [43] was launched in September 2009. This is a coordinating web portal for all actors on all levels working with HIV/AIDS and STI prevention and SRHR in Sweden. It has been developed by the National HIV council together with the NBHW. The HIV Portal plays an important role in national preventive activities and its purpose is to scrutinise older information and provide up-to-date and data on HIV/AIDS and STIs such as reports, best practices, news, and research among other things. An Editorial committee from the National HIV Council reviews what is published on the portal.



Source: www.hivportalen.se

Legal and Policy Framework for HIV/AIDS

HIV and STIs

- **National Strategy to Combat HIV/AIDS and Certain Other Communicable Diseases (Govt. Bill 2005/06:60).** This government bill provides an overall strategy for societal inputs as concerns the prevention of spread, and alleviation of impact, of HIV infection and other sexually transmittable and blood-borne infections.
- **Society's Efforts on HIV/STI: embracing change (SOU 2004:13).** The major part of this commission of inquiry's proposals are summarised in the form of a proposed National Action Plan for measures concerning HIV/STIs. The report states that the greatest weaknesses as concerns society's activities to combat HIV/STIs lie in structural issues and this Action Plan is an attempt to achieve improved mobilisation of total social resources by creating an effective state structure for planning, follow-up and implementation of the necessary inputs.
- **The UN Convention on the Rights of the Child.** A convention on children's rights has been adopted by the UN and covers all children under the age of 18. Sweden ratified this Convention on 21 June 1990. In Arti-

cle 24 of the Convention a general approach to health is stated in order to secure the right to preventative measures as well as health and medical care. In Govt. Bill 1997/98:182 a strategy for the realisation of the UN Convention on the Rights of the Child in Sweden is stated. This includes the stipulation that municipalities and county councils should establish a system to monitor how the best interests of children are fulfilled within municipal operations.

- **Human Rights Convention.** In 1994 the Swedish Parliament took a decision to adopt the European Convention on Human Rights into law in Sweden - the European Convention for the Protection of Human Rights and Fundamental Freedoms Act (1994:1219). Consequently individuals were able, from 1 January 1995, to take violations of human rights as defined by the European Convention to Swedish courts to seek justice. Human rights in Sweden are primarily guaranteed via the Constitution/fundamental law.

Health and medical care and social services

- **Goals for Public Health (Govt. Bill 2002/03:35).** The overall goal is proposed as the creation of social preconditions for good health on the same conditions for the entire population. It is especially important that the public health is improved for population groups who are most exposed to ill health.
- **The Health and Medical Service Act (1982:763).** The Health and Medical Service Act (HSL) contains the fundamental regulations for all health and medical care. This Act regulates measures to medically prevent, examine and treat illnesses and injuries. It states the goals of health and medical care and the requirements concerning good levels of care. In addition it includes regulations that clarify the responsibilities of the county councils and municipalities for the different components of health and medical care provision.
- **Patient Data Act (2008:355).** This Act is applied to the management of personal data by health and medical care providers. The Act also contains regulations concerning the obligation to keep patient records.
- **The Patient Injury Act (1996:799).** The content of this Act consists of regulations concerning patients' rights to damages and of the obligation of the care provider to maintain insurance that covers such financial compensation (patient insurance).
- **The Social Services Act (2001:453).** The Social Services Act regulates the goals of the social services. Social services are to promote the financial and social security of individuals, equality of living conditions and active participation in society.
- **Establishment of Common Committee within Care and Treatment Act (2003:192).** This Act regulates collaboration between municipalities and county councils.

- **Public Access to Information and Secrecy Act (Govt. Bill 2008/09:150).** The Public Access to Information and Secrecy Act (2009:400) and the Public Access to Information and Secrecy Ordinance (2009:641) is a reworking of the Secrecy Act. This Act brings no amendments to the subject contents of the Act but is instead aimed at making it more accessible and easier to understand. In order to facilitate the comparison of the new Act with the previous Secrecy Act, two comparative tables have en been attached to the Govt. Bill 2008/09:150 which may assist when searching for the position of the Secrecy Act's regulations in the new Act.
- **Public Access to Information and Secrecy Act (2009:400).**
- **Public Access to Information and Secrecy Ordinance (2009:641).**

Anonymous HIV testing

- **Testing for HIV Infection Ordinance (2008:363).** This Ordinance regulates the right to anonymous HIV testing and anonymous record keeping until it has been proved that the individual in question is infected with HIV. When this condition is proved, the identity of the patient must be revealed.

Communicable disease control

- **The Swedish Communicable Diseases and Prevention Act (2004:168).** Society's communicable disease control must fulfil the needs of the population for protection against the spread of communicable diseases. The Act regulates the division of responsibilities and the measures to be taken, obligations and rights etc. Around 60 different diseases are encompassed by the regulations of this Act including HIV infection, Chlamydia infection, Gonorrhoea, Syphilis and Hepatitis A-E.
- **The Communicable Diseases and Prevention Ordinance (2004:255).** This Ordinance provides additional regulations to the Communicable Diseases and Prevention Act concerning issues such as the obligations of medical care providers to de-identify and code case reports of HIV infection and other STIs covered by the Communicable Diseases and Prevention Act.
- The National Board of Health and Welfare Case Definitions when Reporting in Accordance with the Communicable Diseases and Prevention Act provides instructions on the criteria to be applied as concerns reporting suspected or confirmed cases of diseases encompassed by the Communicable Diseases and Prevention Act.

Contact tracing

- The Swedish Communicable Diseases and Prevention Act (2004:168) regulate the diseases that entail contact tracing and also the preconditions for this contact tracing. In the National Board of Health and Welfare's

National Routines for Reporting in Accordance with the Communicable Diseases and Prevention Act (SOSFS 2004:5) additional diseases are stated for which contact tracing is to be carried out.

- The National Board of Health and Welfare's **Regulations and Guidelines on Contact Tracing (SOSFS 2005:23).** This provides additional regulations and advice on contact tracing. More detailed instructions and examples can be found in the National Board of Health and Welfare's Regulation Manual Contact tracing of sexually transmitted infections in Swedish.

Screening of pregnant women

- The National Board of Health and Welfare's **Regulations (SOSFS 2004:13) on the Infection Screening of Pregnant Women** that regulates the medical care provider's obligation to offer all pregnant women testing for HIV infection, Hepatitis B and Syphilis.

Work Environment

- **The Work Environment Act (1977:1160).**The Work Environment Act is intended to prevent ill health and accidents at work, as well as otherwise achieving a good working environment. The Act also applies to individuals who are participating in educational/training inputs.

Discrimination

- **Discrimination Act (2008:567).** The European Convention contains a ban on discrimination in its Article 14. All individuals, irrespective of origin, are guaranteed absolute entitlement to all possible human rights. An additional Protocol 12 to the Convention that contains a general ban on discrimination has recently been adopted. EC law, for example Article 13 of the EC Treaty and Article 21 of the EU Statute, contain regulations through which discrimination is prohibited. In Sweden, the Discrimination Act (2008:567) stipulates the equivalent prohibition on discrimination. More information is available at www.do.se.

Abortion

- **The Abortion Act (1974:595).** The Abortion Act stipulates that a woman is able to undergo an abortion at her own request before the end of the 18th week of pregnancy. Permission is necessary from the National Board of Health and Welfare if the abortion is to be carried out later in the pregnancy.
- **Abortion in Sweden (SOU 2005:90).** According to the Swedish Abortion Act, an abortion may only be carried out if the woman is a Swedish citizen or if the National Board of Health and Welfare, due to special circumstances, grants permission for such a procedure. This report proposed that the Abortion Act should be amended so that non-Swedish women

would be able to undergo an abortion in Sweden without the prerequisite of special circumstances and in accordance with the same regulations as Swedish women.

- **Abortion for Non-Swedish Women and the Prevention of Unwanted Pregnancies Act (Govt. Bill 2006/07:124).** In accordance with what is applicable concerning other health and medical care provided for non-Swedish people, county councils' costs for medical care will be reimbursed either by the woman's medical care insurance in her home country or by the woman herself, depending on the regulations applying to each individual case.

Sterilisation

- **The Sterilisation Act (1975:580).** Regulates stipulations concerning sterilisation.
- Financial compensation for certain birth control activities etc. Act. This page contains information concerning the amendments made to this Act.

Drug abuse (injection)

- **The Care of Alcoholics and Drug abusers Act in Certain Cases (LVM, 1988:870).** This Act regulates the opportunities to, under certain conditions, admit an adult drug abuser into a medical care facility against his/her will. The aim of this compulsory care is to motivate drug abusers to voluntarily participate in continued treatment and to support them in their efforts to leave their drug abuse.
- **The Injection Needle Exchange Act (2006:323).** On 1 July 2006, an Act entered into force which regulates needle exchange operations. The aim is to prevent the spread of HIV infection and other blood-borne infections among syringe-using drug abusers. Please also refer to the Government Bill entitled National Strategy to Combat HIV/Aids and Certain Other Communicable Diseases (Govt. Bill 2005/06:60).
- Additional regulations for needle exchange operations can be found in the National Board of Health and Welfare's **Regulations (2007:2) on the exchange of needles and syringes for individuals who abuse narcotic drugs**.

Prostitution

- **Action Plan against Prostitution and Human Trafficking for Sexual Purposes (Written Communication 2007/08:167).** This Written Communication includes a description of how prostitution and human trafficking for sexual purposes are to be combated and how individuals who are victims of this abuse are to be provided with improved protection and support.
- **Sex Crimes Act (SOU 2004/05:45).** This Report presents proposals for reformed sex crime legislation. These proposals aim at improving protec-

tion against sexual violations and at further strengthening individuals' sexual integrity and right to make decisions concerning their own bodies.

Asylum seekers/family reunification

- **The Health and Medical Care for Asylum Seekers and Others Act (SFS 2008:344).** This Act contains regulations concerning the obligation of the county councils to, in addition to the provisions of the Health and Medical Service Act (1982:763) and the National Dental Service Act (1985:125), offer health and medical care plus dental care to asylum seekers and certain other foreigners.

- **The Health and Medical Care for Asylum Seekers and Others Ordinance (2008:347).** This ordinance contains regulations concerning health and medical care for asylum seekers and others.
- **State Compensation (Refugee Reception etc.) Ordinance (1996:1357).** This ordinance contains regulations concerning state financial compensation to county councils, municipalities and pharmacies for costs for health and medical care and for dental care and prescribed medication for certain foreigners.
- **Care charges etc. for Certain Foreigners Ordinance (1994:362).** This ordinance includes stipulations on state reimbursement of health and medical care charges etc.
- **National approach as concerns health care in the first period in Sweden.** According to the State Compensation for Refugees and Others Ordinance (1990:927), the Swedish Integration Board is responsible for costs for health examinations of certain foreigners after they have been received by a municipality for the first time. These are foreigners who have been transferred to Sweden based on a Government decision (resettled refugees), those in need of protection in certain cases or for humanitarian reasons and foreigners who have been granted residence permits due to their connection to another foreigner who is covered by the categories above (next-of-kin cases) and have applied for residence permit within two years of the person that he/she is next of kin to first being received by a municipality.

Donating blood, organs, tissue and cells including germ cells

- The National Board of Health and Welfare **Regulations on Operations Involving Blood (SOSFS 2009:28)**.
- The National Board of Health and Welfare **Regulations on Donation and Management of Tissue and Cells (SOSFS 2008:22)**.
- The National Board of Health and Welfare **Regulations and Guidelines; measures against the transmission of infection in transplantation of organs and tissue (SOSFS 1994:4)**.

Criminal offences

- **The Criminal Code.** Any individual who intentionally, or through carelessness or neglect, exposes another person to risk of infection may be convicted of a crime according to the Criminal Code. The crimes which may be applicable in connection with spread of infection may include criminal assault according to Chapter 3, sections 5 or 6 of the Code. If anyone, due to carelessness, is exposed to risk of infection and this individual becomes ill then the crime may be classed as causing bodily harm or illness in accordance with Chapter 3, Section 8 of the Code. Anyone who, due to gross negligence, exposes another person to risk of a serious illness may be prosecuted for causing danger to another in accordance with Chapter 3, Section 9 of the Code. Furthermore, in Chapter 13, Section 9 of the code there is a proscription concerning causing danger to life or health through transfer of infection or serious illness. In this case a wider circle of individuals must have been exposed to the risk of infection.
- Survey concerning HIV infection in criminal cases. In the **Act Concerning Examination for HIV Infection in Criminal Proceedings (1988:1473 amended 2004:179)** and in the **Ordinance on Examination for HIV Infections in Criminal Proceedings (2004:260)**, opportunities to compel examination for this infection, if requested by the injured party, are regulated. The defendant will be examined if he/she is suspected of a sexual crime or some other crime that, due to circumstances, may give rise to fears that the HIV infection could have been transferred to the injured party due to the crime in question.

NATIONAL BEST PRACTISES

Among all the ongoing initiatives in Sweden at the moment, there are several activities that may possibly develop into best practises. However, most of these activities are now entering into their third and final year of operation.[15] After this, evaluations will show which of the activities have the potential to develop further and which should be integrated into normal activities. For the period of 2007–2009 two successful projects have been undertaken:

The Prevention Resources Allocation Index Model – 'Fördelningsindex'

Background

Since 1986, national resources in Sweden have been set aside for HIV prevention activities. A significant part has been distributed to regional health authorities (county councils). Half of this sum has been reserved for the three major metropolitan regions and has been allocated according to guidelines established in 1987 which have never been transparent. Hence there was a need for a transparent method of distribution that would be possible to adjust according to new needs.

Aim

The aim was to develop an index model based on reliable and valid data that could compare the needs of three regions as concerns prevention interventions. A study was conducted in order to develop such an allocation index. It reviewed literature, interviewed key informants and analysed epidemiological data including key variables. Each of the variables was assessed for the availability of reliable data at regional level. Variables that did not possess such data were excluded. Based on the UNGASS agreement of 2001 [11], the burden of prevention for vulnerable MARP was considered important. The following potential index variables were identified:

- Population – general and target age groups.
- Distribution of population with regard to densely populated areas.
- Pregnant women.
- Teenage abortions (marker for unsafe sex among teenagers).

[15] The majority of the activities supported by the NBHW work on three year project cycles, i.e. one year for build-up, one year for operation and one year for evaluation and (if successful) integration into regular activities.

- Foreign-born from countries with an HIV prevalence >1 (high-endemic countries).
- Immigrants from high-endemic countries.
- Asylum seekers from high-endemic countries.
- Travellers to high-endemic countries.
- Number of IDU.
- Number of MSM.
- Number of SW.
- HIV incidence.
- HIV prevalence.
- Chlamydia incidence (as Chlamydia is the leading STI in Sweden).

The variables number of IDU, MSM and SW were discarded due to lack of valid population data, either generally or at regional level. The information on travellers to high-endemic countries also proved to be of limited use because of the inadequate size of the sample that the information was based on. Some other variables, when tested, were found not to provide any added value to the index. The index was eventually based on;

- Population 15–54.
- Distribution of population.
- HIV incidence (incidence data based on a five-year period divided into heterosexual and MSM transmission routes respectively).
- HIV prevalence.
- Chlamydia incidence.
- Teenage abortions.
- First generation migrants and asylum seekers from high-endemic countries.
- Reported deaths due to narcotics.
- Number of patients in hospitals with a diagnose of drug abuse.

Research shows that youth and young adults' perception of their risk of infection and their knowledge about the condom and its protective qualities does not correspond with their own attitude towards condom usage [9].

The study shows that it is possible to develop a rational index for allocation of resources to HIV/STI prevention based on relevant variables. However, it also shows that, even in a country with ample supply of information, data on some key MARP may be missing. Proxy variables may be used to substitute for the absence of the variables related to the relevant MARP. A process of participation for the stakeholders was also introduced into the project. The process of developing the index and eventually deciding on actual allocation of resources based on it leads to involvement in, and increased transparency of, the decision making process. Consequently, an index model for allocation of resources for HIV/STI prevention can be developed even in the absence of complete information on risk variables. The application will most likely also lead to increased transparency. The NBHW

introduced the new index model in the 2010 HIV funding process to the metropolitan regions. This index will be updated after three years of application and if more reliable data is available at that time, this can be included in the model.

Colour of Love – An Annual Outreach Campaign

Since 2008, after an evaluation of previous outreach campaign efforts in Sweden, three major NGOs with funding from the NBHW are now collaborating in a joint campaign venture targeting youth and young adults. The joint venture is based on a campaign called Colour of Love where the objectives are:

- To educate and train campaign coordinators within the NGOs' own organisations so that they will become more capable of organising local outreach efforts.
- To build a sustainable education and training for outreach workers that is also possible to adapt to different settings and to upgrade.
- To support outreach on 10 sites of national importance.

The education and training of outreach workers has been evaluated and found to produce project managers for outreach work who can organise and deliver good outreach in a variety of environments. The materials used have also been evaluated.

Together with a number of trainers and experienced outreach-workers, local volunteers will work at a number of selected sites in Sweden, e.g. the annual Pride Festival in Stockholm and the Arvika Music Festival. They will also be provided with theoretical training. The volunteers from the three cooperating organisations apply and are selected according to established criteria. The three organisations that have come together are RFSL, RFSL Ungdom and RFSU, whose local branches together can cover the major part of the country. The project managers trained can then cooperate with the local county coordinator to cover important outreach locations.

In addition to educating and training project managers for outreach work, the NGOs offer project management and tutorial support to the county councils where there is a lack of local volunteers or knowledge or there may be a special need to increase outreach activities beyond the capabilities of the local NGOs. This is offered in a purchased (but subsidised) package. In 2009, ten additional local sites joined the campaign and used its concept and material.

The sites for these national outreach efforts are identified annually and areas of method development suggested by the NGOs. Altogether, the Colour of Love campaign was used at twenty sites in Sweden, mainly during summer.

One aim for the future is to disseminate campaign activities over the entire year. These recurrent, coordinated and quality controlled outreach campaigns can be used within the county councils' own prevention work are,

and may be, integrated into national and regional actions plans. On a long term level, this cooperation between several organisations on different levels contributes to maintaining and developing the knowledgebase around outreach activities. It also provides the NGOs a clear role as equal partners in health promotion and disease prevention.

OVERALL CHALLENGES

Given that Sweden's last UNGASS report was written at the same time as the HIV function at the NBHW was under construction, it was not able to successfully incorporate all the ongoing activities in Sweden. This year, more resources have been invested in the report as well as in the national coordinating function, which have helped in tightening up the overall national preventive work.

Progress made on Key Challenges Reported in the Previous UNGASS Report

The previous UNGASS report from 2008 covering the period 2006–2007 emphasises the challenge in implementing the new National Strategy in Sweden. The necessity of systematic, coordinated and monitored action was highlighted, as well as the need to speed up preventive activities after a period of review and reallocation.

- Since 2007 a reasonably efficient system of planning, coordination and monitoring has been put in place.
- The National HIV Council [6] has been established as a mechanism of coordination for key stakeholders and to act as an advisory board on the policy level. It also has an important role to play in information efforts.
- A systematic process of planning, coordination and monitoring is currently under implementation including a system of SGS [5]
- National action plans with clearly-stated targets have been put in place and are now under implementation on several levels of society [22, 35, 42].
- Counties have systematised their work and about 50% have renewed their policy applying the logical framework approach (LFA) [44]. Counties and NGOs have improved the coordination of their activities.
- Pilot projects for IDU are being integrated in the regular activities of the prison and remand prison systems (SHP).
- A national centre to support work with children infected and affected by HIV has been developed.
- Several measures aimed at renewing teacher training for sex education have been taken.
- The amount of preventive efforts has clearly been augmented and are also more targeted as can be seen in the evaluation of the work of national NGOs.

Another challenge was the need to increase access to VCT for newly-arrived migrants. *Clear progress has been made concerning refugees and asylum seekers as access has doubled during the period.* The challenge of reaching persons who migrate to join their families with preventive measures still remains.

Challenges Faced Throughout the Reporting Period 2008–2009

Some of the challenges of the period have been:

- The reformation of a 15-year-old method of working by the main stakeholders including reallocation of grants and new targeted approaches, all implemented in a very decentralised system.
- Finding ways to improve outreach to vulnerable migrant MARPs and to make them partners in prevention and support work.
- The development of a new national prevention unit within the NBHW.
- The establishment of a research-based SGS system within a short period of time. Some MARP are still missing from this system so the challenge remains.
- The ongoing and slowly increasing HIV endemic within the MSM population.
- The lack of systematic prevention efforts for the IDU population.
- Establishing alternative monitoring systems, such as sentinel surveillance within an otherwise robust monitoring system.
- Economic recession 2008/2009.

Concrete Remedial Actions Planned to Ensure Achievement of Agreed UNGASS Targets

The following activity areas are planned for the next period 2010–2011:

- Improved monitoring of stigma and discrimination and improved activities aimed at minimising such conditions for PLWHA.
- Improved action to increase access to health checks for family reunification migrants.
- Development of NAP for MSM and vulnerable migrant MARPs in Sweden.
- Close monitoring of actions to improve condom use and reduce risk behaviour patterns among youth and young adults i.e. the implementation of the Chlamydia NAP.
- Continuous and consistent information interventions.
- Continuous development of monitoring mechanisms for e.g. IDUs.
- Continuous efforts to promote knowledge development and evidence-based interventions.

The outcome of the first three-year period clearly indicates the success of a more systematic way of working. The challenge is to keep this up with new reorganisations/reallocations as concerns the National Unit for HIV Prevention.

SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS

Not applicable. Sweden is a bilateral, regional and multilateral donor.

REGERINGSKANSLIET
Government Offices of Sweden

SUPPORT FOR GLOBAL COMMITMENTS

HIV/AIDS constitutes a key priority in Sweden´s international efforts. The decision to make HIV a priority is based on the fact that the HIV pandemic is a large-scale international development challenge, rather than an isolated health issue. The Ministry for Foreign Affairs, which is responsible for coordinating the Swedish foreign policy, also coordinates Sweden's international work with HIV/AIDS, together with the Swedish International Development Cooperation Agency (Sida).

International Development Policy

With the aim of creating a platform for Sweden's international action in the field of HIV/AIDS, the Swedish Government in November 2008 adopted a new policy for Sweden´s international HIV/AIDS work. The objective of the policy is to reduce vulnerability to HIV/AIDS and increase opportunities for enjoying the best possible conditions of life for the groups primarily affected.

The focus of the work lies on the prevention and alleviation of the long-term effects of HIV/AIDS. The policy also states that Sweden will take action to strengthen research on HIV prevention as well as on the long-term effects of the disease. The policy is based on a human rights perspective. Consequently Sweden's international efforts in the field of HIV/AIDS are to be characterised by the demand for strengthened respect for human rights and increased efforts for gender equality. Focus is placed on the individual.

The policy emphasises the links between HIV/AIDS and SRHR and stresses that these rights, with relevant services, must be guaranteed to all women and men, girls and boys. Women and men, children and youth and young adult people, regardless of HIV status, sexual orientation or gender identity, must have access to information and knowledge about HIV and SRHR. From this point of departure, the policy draws attention to the need for greater visibility of youth and young adults and key MARP and opportunities for them to influence their conditions of life. Stigmatisation and discrimination must be reduced and openness be promoted at all levels of society.

The policy emphasises that an effective response to HIV and AIDS must be undertaken on the basis of the scale, spread and nature of the epidemics, which vary in different parts of the world. Measures must therefore be adapted to the local context and to the needs of the specific target groups. The concept of “knowing your epidemic” is crucial.

International Cooperation Policy

The policy is to be implemented in strategies for cooperation with countries, regions and organisations, but is also to serve as a framework for Sweden's efforts in international policy development and standard-setting activities. The implementation of the policy requires the active commitment of a large number of actors – state and non-state – in Sweden and internationally. In order to be able to act in a coherent manner, concordance is necessary when taking action and initiatives must serve to support the countries' own priorities, plans and programmes.

The importance of responsible leadership is another critical aspect highlighted in the policy, leadership both at the political level and within civil society organisations. Experience shows that such leadership is necessary for successful responses to fight HIV/AIDS.

In 2008, Sida disbursed in total SEK 652 million to HIV/AIDS programs around the world; in 2009 the figure amounted to SEK 675 million. The majority of Sida's funding goes to Sub-Saharan Africa which is the region worst affected by the epidemic, but is also channelled to other regions. In line with the Swedish policy, prevention of HIV and impact mitigation are the key priorities for Sida's development cooperation on HIV/AIDS. Sida also supports research programmes in the field of HIV vaccines and microbicides. As a means of scaling up their response to HIV/AIDS in Sub-Saharan Africa Sida, together with Norway, has set up a regional HIV/AIDS Team located in Lusaka, Zambia. The Swedish-Norwegian Regional HIV/AIDS Team supports a variety of actors ranging from civil society organisations to regional economic organisations with the aim of scaling up their work on HIV/AIDS. Apart from allocating financial resources, Sida also plays an active role as a dialogue partner where HIV prevention, the need to better integrate prevention and SRHR and comprehensive sex education have been assigned high priority.

Global Fund

Financially, Sweden allocates about SEK 1.5 billion per year for international HIV and AIDS initiatives. The majority of these funds are channelled through multilateral organisations and mechanisms, in particular the Global Fund against AIDS, TB and Malaria (GFATM), and UNAIDS. Sweden allocated SEK 1.83 billion for the GFATM for the three year period 2008–2010 while its contribution to UNAIDS for 2008 amounted to SEK 242 million and SEK 290 million for 2009.

Regional Activities

The NBHW takes part in a multitude of collaboration networks both European and regional. Over the two-year period the NBHW and its HIV function have participated in, among other things, the EU Think-Tank Collaboration, the ECDC Dublin Declaration Development, the ECDC Behavioural Surveillance Development, the Nordic Dimension Project, Health Coopera-

tion in the Barents Region and the EMCDDA collaboration as well as in the Network for Quality Assurance of HIV Prevention led by Germany. Activities aimed to promote better cooperation and common use of research resources are currently under discussion by Norway and Sweden (and possibly Denmark and Finland) where it is possible to exchange services without translation.

MONITORING AND EVALUATION ENVIRONMENT

An M&E system plays an important role in ensuring that preventive efforts reach their designated targets. The NBHW have dedicated resources to continuously develop its M&E function, whose long-term purpose is to coordinate all national actors working with M&E in Sweden.

The M&E system in Sweden is primarily based on UNGASS, the Dublin Declaration and national indicators developed according to targets set in the National Strategy and NAP produced by the NBHW. In the majority of the cases, the indicators are developed using the LFA method.

In addition to the monitoring system, the NBHW continuously conducts evaluations. This has been running successfully for the last three years during which period several evaluations have been conducted. Both the monitoring and evaluation together play an important part in understanding whether designated targets are reached, and the effects that surround this achievement.

Overview of the Current Monitoring and Evaluation (M&E) System

Monitoring

The current monitoring system in Sweden is extensive and dispersed amongst a large number of actors, government bodies, research institutions and NGOs, the majority of them listed above. Given Sweden's previous history with a strong culture of collecting statistics [45], the existing systems are robust and not that flexible to change due to new requirements for indicator data.

Steady epidemiological data are collected by SMI and InfCare and, to complement this, the NBHW has initiated a number of initiatives in order to be able to monitor both epidemiological and behavioural aspects of the HIV/AIDS and STI epidemic. The NBHW supports a number of large national surveys, described earlier in this report, whose purpose is to collect data for research as well as to monitor trends over time via various specific, measurable, attainable, realistic and timely indicators, i.e. SMART indicators.

Parallel to this, for MARPs that are hard to reach such as SW, IDU and people travelling abroad, different types monitoring mechanisms are currently under development such as sentinel surveillance. For specific indicators that need to be measured on a specific occasion, research is conducted,

or data is collected, via local or temporary initiatives e.g. by NGOs or specific county councils.

Evaluation

The National Strategy emphasises the need to evaluate preventive work with HIV and STIs. The NBHW utilises two types of evaluations:

- Evaluations focusing on total activities performed by the NGOs, the county councils and municipalities.
- Evaluations of specific national prevention efforts, or efforts that are of national interest.

In 2007–2009, the NBHW has evaluated all NGOs and their activities mentioned above. In 2007 the Colour of Love campaign was evaluated and the results from this evaluation changed the way outreach campaigns work today. Another evaluation that has had a positive result is the evaluation of the SHP were it was shown that the projects fulfilled their purpose, at the time running as local projects in the cities of Gothenburg and Stockholm. The outcome of the evaluation has meant that the project has now been absorbed and integrated into the ordinary activities of the Swedish Prison and Probation service.

These examples show how the NBHW successfully uses the evaluation method to develop national HIV and STI prevention. However, each evaluation demands time and resources. In addition, a structure that is able act on the results, whatever they may be, needs to be in place before the evaluation can be realised. The NBHW also uses evaluations on its own in-house activities.

Counties, major cities and NGOs are also encouraged to monitor their work through simple indicators and also sometimes to evaluate measures, in which case extra funding is sometimes added. This is a way to develop best practices and to deepen the understanding of health promotion and prevention of HIV and STIs. In this report several of these evaluations are mentioned.

Challenges faced in the Implementation of a Comprehensive M&E System

The national coordinating HIV/AIDS function at the NBHW may change its organisational location for another government body in the future. Such a change would hinder the function from running as it does today.

Further, a comprehensive M&E NAP is missing and needs to be developed since it is currently difficult to adapt to international demands for surveillance information, e.g. number of HIV tests and so forth. An M&E NAP will clarify the roles of all the actors collecting information, as well as what is possible to collect or not at the moment. Another challenge lies in the parallel reporting systems described above, i.e. that both a doctor who detects a case and a laboratory might report it, creating duplicated data.

Remedial Actions Planned to Overcome the Challenges

An M&E NAP will be developed in collaboration with key actors in 2010. In line with this NAP, a SGS group will be created, a group whose primary function will be to analyse trends and results in depth from the national MARP surveys. The SGS group will have an academic advisory function to the NBHW and its HIV/AIDS coordinating function.

The Need for M&E Technical Assistance and Capacity Building

The most imminent need for the Swedish M&E system is to enhance its coordinating function. In addition, contextually adapted sentinel surveillance structures need to be developed for MARPs that are hard to reach.

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A. UNGASS INDICATORS

Commitment and action

Indicator 1: Domestic and international AIDS spending by categories and financing sources.

	Recipient	2008	2009
Sida	STI control including HIV/AIDS	422 469 520	386 103 173
Sida	Social mitigation of HIV/AIDS	152 295 261	214 149 164
Swedish MFA	Global fund	660 000 000	670 000 000
Swedish MFA	UNAIDS	242 000 000	290 000 000
Sida	Domestic / International research	77 500 000	75 000 000
Comment: The main focus of Sida's HIV/AIDS support is on prevention, where gender, human rights and youth are prioritised. Almost 80% of Sida's HIV/AIDS funding goes to Sub-Saharan Africa, the worst affected region. Unfortunately there has been no opportunity to estimate total national spending.			

Source: Swedish MFA/Sida

Indicator 2: National Composite Policy Index.

See annex below (Annex B)

National Programs

Indicator 3: Numbers of donated blood units screened for HIV in a quality-assured manner

		2008	2009	**Total**
Numerator:	Number of donated blood units screened for HIV in a quality-assured manner.	576 656	n/a	**n/a**
Denominator:	Total number of blood units donated.	576 656	n/a	**n/a**
Comment: Data are representative for the whole country.				

Source: Svensk Förening för Transfusionmedicin. Blodverksamhet i Sverige 2008.

Indicator 4: Number of adults and children with advanced HIV infection receiving antiretroviral therapy.

		Sex	2008			2009		
			0–14 years	+15 years	**Total**	0–14 years	+15 years	**Total**
Numerator:	Number of adults and children with advanced HIV infection who are currently receiving ARV in accordance with the nationally approved treatment protocol at the end of the reporting period	M	n/a	2310	**2310**	27	2631	**2658**
		F	n/a	1305	**1305**	30	1497	**1527**
		Total		**3615**	**3615**	**57**	**4128**	**4185**
Denominator:	Estimated number of adults and children with advanced HIV infection	M	n/a	2356	**2356**	27	2683	**2710**
		F	n/a	1331	**1331**	30	1527	**1557**
		Total		**3687**	**3687**	**57**	**4210**	**4267**
Comment: The proportion of patients not receiving ART despite advanced infection is, on an annual basis, 2%. The reason for this is that some patients have been diagnosed recently and ART has not been initiated due to the importance of preparing patients before ART initiation. Secondly, some very advanced drug addicts have not been treated due to their inability to take ART. The figures for children in 2008 are not firmly documented but are most likely to be very close to those of 2009. Data are not representative for the whole country.								

Source: InfCare

Indicator 5: Number of HIV infected pregnant women who received antiretroviral to reduce the risk of mother-to-child transmission.

		2008	2009	**Total**
Numerator:	Number of HIV infected pregnant women who received antiretroviral medicines to reduce the risk of mother-to-child transmission during 2008 and 2009	40	43	**83**
Denominator:	Estimated number of HIV infected pregnant women in 2008 and 2009	40	43	**83**
Comment: Reported figures are for Stockholm area only, corresponding to around 50% of all HIV infected patients in Sweden. In this table only women who completed their pregnancies are included. Women with active or spontaneous abortion are excluded. An extrapolation from the figures in Stockholm (25 and 27) suggests that there were 40 and 43 pregnant women in Sweden in 2008 and 2009. In Sweden, all pregnant women are offered ART and are treated. Data are not representative for the whole country.				

Source: InfCare

Indicator 6: Number of estimated HIV positive incident TB cases that received treatment for TB and HIV.

		Sex	2008			2009		
			0–14 years	+15 years	**Total**	0–14 years	+15 years	**Total**
Numerator:	Number of adults with advanced HIV infection who received antiretroviral combination therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) and who were started on TB treatment (in accordance with national TB programme guidelines), within the reporting year	M	n/a	19	**n/a**	1	21	**22**
		F	n/a	31	**n/a**	2	33	**35**
		Total		**50**		**3**	**54**	**57**
Denominator:	Estimated number of incident TB cases in people living with HIV	M	n/a	19	**n/a**	1	21	**22**
		F	n/a	31	**n/a**	2	33	**35**
		Total		**50**		**3**	**54**	**57**
Comment: Figures for 2008 are extrapolated to the whole country from figures received from the Karolinska University Hospital. It is unclear to which extent the diagnosis of pulmonary tuberculosis is introduced into the InfCare HIV database. All patients discovered with TB and HIV are given both TB treatment and ART in Sweden. Usually ART starts between 1–3 weeks after TB-treatment. Patients with latent TB are not included since we do not regularly diagnose latent TB.								

Source: InfCare

Indicator 7: HIV Testing in the General Population.

		Sex	16–19 years	20–24 years	25–44 years	**Total**
Numerator:	Number of respondents aged 16–44 who have been tested for HIV during the last 12 months and who know their results	M	19	34	103	**156**
		F	55	92	230	**377**
		Total	**74**	**126**	**333**	**533**
Denominator:	Number of all respondents aged 16–44	M	466	269	528	**1263**
		F	641	371	736	**1748**
		Total	**1107**	**640**	**1264**	**3011**
The national survey for the general population only covers the age strata 16–19, 20–24, and 25–44. This will be changed in the upcoming study planned for 2011. Reported data are from the 2007 study. Data are representative for the whole country.						

Source: HIV/AIDS in Sweden, 1987–2007

		Sex	15–19 years	20–24 years	25–44 years	Total
Numerator:	Number of respondents aged 15–49 who have been tested for HIV during the last 12 months and who know their results	M	105	206	n/a	**311**
		F	177	323	n/a	**500**
		Total	**282**	**529**		**811**
Denominator:	Number of all respondents aged 15–49	M	1397	1740	n/a	**3137**
		F	1555	1795	n/a	**3350**
		Total	**2952**	**3535**		**6487**
The UNGKAB survey, targets youth and young adults and does not cover the 25–49 age group. Data are from the 2009 survey and are more up to date for the age groups 15–19 and 20–24 compared to the national survey for the general population (2007). Data are not representative for the whole country.						

Source: UNGKAB, 2009. Göteborgs universitet

Indicator 8 MSM: Number of most-at-risk populations that have received an HIV test in the last 12 months and who know the results.

		Study 2006				Study 2008			
		0–24 years	25–49 years	+ 50 years	**Total**	0–24 years	25–49 years	+ 50 years	**Total**
Numerator:	Number of MSM respondents who have been tested for HIV during the last 12 months and who know the results	236	672	72	**980**	340	973	181	**1494**
Denominator:	Number MSM respondents population included in the sample	632	1538	210	**2380**	931	2350	545	**3826**
Comment: In 2006 the question read "When was the last time you were tested? and in 2008 it read "When was the last time you received an answer on your test? Data are not representative for the whole country.									

Source: The MSM Study, 2008. Malmö högskola

Indicator 8 IDU: Number of most-at-risk populations that have received an HIV test in the last 12 months and who know the results.

		Sex	2008				2009			
			0–24 years	25–49 years	+ 50 years	**Total**	0–24 years	25–49 years	+ 50 years	**Total**
Numerator:	Number of IDU respondents who have been tested for HIV during the last 12 months and who know the results	M	n/a	n/a	n/a		28	137	13	**178**
		F	n/a	n/a	n/a		8	20	7	**35**
		Total					**36**	**157**	**20**	**213**
Denominator:	Number IDU respondents population included in the sample	M	n/a	n/a	n/a		34	165	17	**216**
		F	n/a	n/a	n/a		9	26	8	**43**
		Total					**43**	**191**	**25**	**259**
Comment: The IDUs have been identified via the SHP sentinel surveillance study where the selection criteria are based on people with any form of substance abuse, i.e. where a total of 259 IDUs were identified during 2009. Data are not representative for the country.										

Source: SHP

		Sex	2008	2009	**Total**
Numerator:	Number of IDU respondents who have been tested for HIV during the last 12 months and who know their results	M	609	564	**1173**
		F	191	185	**376**
		Total	**800**	**749**	**1549**
Denominator:	Number IDU respondent population included in the sample	M	609	564	**1173**
		F	191	185	**376**
		Total	**800**	**749**	**1549**
Comment: In order to enter the NSEP in Malmö, it is obligatory to take an HIV test. Once part of the program, it is obligatory to re-take the HIV test every 3 months. In 2009 143 cases (114 in 2008) had their 'entry' test taken in 2007 and then dropped out of the program, e.g. went into substitution therapy, went to jail, moved, died or quit their abuse etc. Data are not representative for the whole country.					

Source: Malmö NSEP

Indicator 8 SW: Number of most-at-risk populations that have received an HIV test in the last 12 months and who know the results.

		Sex	2008				2009			
			0–24 years	25–49 years	+ 50 years	**Total**	0–24 years	25–49 years	+ 50 years	**Total**
Numerator:	Number of SW respondents who have been tested for HIV during the last 12 months and who know their results	M	n/a	n/a	n/a		3	15	1	**19**
		F	n/a	n/a	n/a		2	6	2	**10**
		Total					**5**	**21**	**3**	**29**
Denominator:	Number SW respondent population included in the sample	M	n/a	n/a	n/a		7	18	2	**27**
		F	n/a	n/a	n/a		2	6	2	**10**
		Total					**9**	**24**	**4**	**37**
Comment: The SWs has been identified via the IDU sentinel surveillance (SHP) where the selection criteria are based on people with any form of substance abuse, i.e. where a total of 259 IDUs were identified during 2009. SWs in the SHP study is defined as having sold sex in the last 12 months. Data are not representative for the country.										

Source: SHP

Indicator 9 MSM: Number of most-at-risk populations reached with HIV prevention programmes.

		Study 2006				Study 2008			
		0–24 years	25–49 years	+ 50 years	**Total**	0–24 years	25–49 years	+ 50 years	**Total**
Numerator:	Number of MSM respondents who replied “yes” to the question: “Do you know where you can go if you wish to receive an HIV test?”	n/a	n/a	n/a		744	2219	523	**3486**
Denominator:	Total number of respondents surveyed	n/a	n/a	n/a		934	2367	549	**3850**
Comment: Data are not representative for the whole country.									

Source: The MSM Study, 2008. Malmö högskola

Indicator 9 IDU: Number of most-at-risk populations reached with HIV prevention programmes.

		Sex	2008				2009			
			0–24 years	25–49 years	+ 50 years	**Total**	0–24 years	25–49 years	+ 50 years	**Total**
Numerator:	Number of IDU respondents who replied "correct" to all three prevention questions	M	n/a	n/a	n/a		3	14	0	**17**
		F	n/a	n/a	n/a		3	2	0	**5**
		Total					**6**	**16**	**0**	**22**
Denominator:	Total number IDU respondents included in the sample	M	n/a	n/a	n/a		34	165	17	**216**
		F	n/a	n/a	n/a		9	26	8	**43**
		Total					**43**	**191**	**25**	**259**
Comment: The IDUs have been identified via the SHP sentinel surveillance study where the selection criteria are based on people with any form of substance abuse, i.e. where a total of 259 IDUs were identified during 2009. Data are not representative for the country.										

Source: SHP

Indicator 9 SW: Number of most-at-risk populations reached with HIV prevention programmes.

		Sex	2008				2009			
			0–24 years	25–49 years	+ 50 years	**Total**	0–24 years	25–49 years	+ 50 years	**Total**
Numerator:	Number of SW respondents who replied "correct" to both prevention questions	M	n/a	n/a	n/a		2	9	0	**11**
		F	n/a	n/a	n/a		1	3	1	**5**
		Total					**3**	**12**	**1**	**16**
Denominator:	Number SW respondents population included in the sample	M	n/a	n/a	n/a		7	18	2	**27**
		F	n/a	n/a	n/a		2	6	2	**10**
		Total					**9**	**24**	**4**	**37**
Comment: The SWs has been identified via the IDU sentinel surveillance (SHP) where the selection criteria are based on people with any form of substance abuse, i.e. where a total of 259 IDUs were identified during 2009. SWs in the SHP study is defined as having sold sex in the last 12 months. Data are not representative for the country.										

Source: SHP

Indicator 10: Number of orphans and vulnerable children whose households received free basic external support in caring for the child.

Not applicable.

Indicator 11: Number of schools that provided life-skills based HIV education in the last academic year.

		Academic year 2009	
		Primary level	Secondary level
Numerator:	Number of schools that provided life-skills based HIV education in the last academic year	7977	3620
Denominator:	Number of schools surveyed	7977	3620
Comment: Primary level corresponds to grade 1–6 and secondary level corresponds to grade 7–9 and upper secondary school grades. Sex education is obligatory in Sweden. Data are representative for the whole country.			

Source: Swedish national Agency for Education

Knowledge and behavior

Indicator 12: Current school attendance among orphans and among non-orphans aged 10–14.

Not applicable.

Indicator 13: Number of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.

		Sex	15–19 years	20–24 years	**Total**
Numerator:	Number of respondents who replied correctly to all five knowledge questions	M	734	1110	**1844**
		F	878	1151	**2029**
		Total	**1612**	**2261**	**3873**
Denominator:	Number of respondents who gave answers, including “don’t know”, to all five knowledge questions	M	1397	1740	**3137**
		F	1555	1795	**3350**
		Total	**2952**	**3535**	**6487**
Comment: Certain of the knowledge questions were not applicable to the Swedish context and consequently were re-defined in the questionnaire. For the specific knowledge questions the respondent could also select the 'Don't know' answer meaning that a portion of the respondents who failed one or more of the five questions could have chosen the “don’t know” instead of the 'wrong answer'. Data are not representative for the whole country.					

Source: UNGKAB, 2009. Göteborgs universitet

Indicator 14 MSM: Number of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.

Not applicable. The 2008 MSM survey asked the respondents to grade the infection risk the respondent saw in a number of posed sexual situations, i.e. situations on a very technically high level. The UNGASS questions in their current format are not applicable on the knowledge level of the MSM MARP.

Indicator 14 IDU: Number of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.

		Sex	2009		
			0–24 years	+25 years	**Total**
Numerator:	Number of IDU respondents who replied correctly to all five knowledge questions	M	20	94	**114**
		F	7	25	**32**
		Total	**27**	**119**	**146**
Denominator:	Number of IDU respondents who gave answers, including “don’t know”, to all five knowledge questions	M	29	153	**182**
		F	9	32	**41**
		Total	**38**	**185**	**223**
Comment: The IDUs have been identified via the SHP sentinel surveillance study where the selection criteria are based on people with any form of substance abuse, i.e. where a total of 259 IDUs were identified in 2009. Data are not representative for the whole country.					

Source: SHP

Indicator 14 SW: Number of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.

		Sex	2009		
			0–24 years	+25 years	**Total**
Numerator:	Number of SW respondents who replied correctly to all five knowledge questions	M	4	11	**15**
		F	2	8	**10**
		Total	**6**	**21**	**27**
Denominator:	Number of SW respondents who gave answers, including “don’t know”, to all five questions	M	5	19	**24**
		F	2	8	**10**
		Total	**7**	**27**	**34**
Comment: The SWs has been identified via the IDU sentinel surveillance (SHP) where the selection criteria are based on people with any form of substance abuse i.e. where a total of 259 IDUs were identified during 2009. SWs in the SHP study is defined as having sold sex in the last 12 months. Data are not representative for the whole country.					

Source: SHP

Indicator 15: Number of young women and men aged 15–24 who have had sexual intercourse before the age of 15.

		Sex	15–19 years	20–24 years	**Total**
Numerator:	Number of respondents (aged 15–24 years) who reported the age at which they first had sexual intercourse as under 15 years	M	330	269	**599**
		F	445	358	**803**
		Total	**775**	**627**	**1402**
Denominator:	Number of all respondents aged 15–24 years	M	1397	1740	**3137**
		F	1555	1795	**3350**
		Total	**2952**	**3535**	**6487**
Comment: Data are not representative for the whole country.					

Source: UNGKAB, 2009. Göteborgs universitet

Indicator 16: Number of respondents aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months.

		Sex	16–19 years	20–24 years	25–44 years	**Total**
Numerator:	Number of respondents aged 16–44 who have had sexual intercourse with more than one partner in the last 12 months	M	89	68	47	**204**
		F	158	102	57	**317**
		Total	**247**	**170**	**104**	**521**
Denominator:	Number of all respondents aged 16–44	M	339	219	470	**1028**
		F	508	337	685	**1530**
		Total	**847**	**556**	**1155**	**2558**
The national survey for the general population only covers the age strata 16–19, 20–24, and 25–44. This will be changed in the upcoming study planned for 2011. Reported data are from the 2007 study. Data are representative for the whole country.						

Source: HIV/AIDS in Sweden, 1987–2007

		Sex	15–19 years	20–24 years	25–49 years	**Total**
Numerator:	Number of respondents aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	M	521	811	n/a	**1332**
		F	768	946	n/a	**1714**
		Total	**1289**	**1757**	**n/a**	**3046**
Denominator:	Number of all respondents aged 15–49	M	1397	1740	n/a	**3137**
		F	1555	1795	n/a	**3350**
		Total	**2952**	**3535**	**n/a**	**6487**
Comment: The UNGKAB survey covers only the age groups 15–19 and 20–24. For the age group 25–49 the latest data comes from the HIV/AIDS in Sweden, 1987–2007. Data are not representative for the whole country.						

Source: UNGKAB, 2009. Göteborgs universitet

Indicator 17: Number of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse.

		Sex	16–19 years	20–24 years	25–44 years	**Total**
Numerator:	Number of respondents, 16–44 year who have had unprotected casual sex (sexual intercourse on a first date without the use of a condom) during the last 12 months	M	69	60	45	**174**
		F	122	77	37	**236**
		Total	**191**	**137**	**82**	**410**
Denominator:	Number of all respondents aged 16–44	M	466	269	528	**1263**
		F	641	371	736	**1748**
		Total	**1107**	**640**	**1264**	**3011**
Comment: The national survey for the general population only covers the age strata 16–19, 20–24, and 25–44. This will be changed in the upcoming study planned for 2011. Reported data are from the 2007 study. This question includes all respondents who have had unprotected sex (without using a condom) in the last 12 months and does not exclusively separate the respondents who have had several partners during the last 12 months. Consequently this question does not fully correspond to the UNGASS Indicator No17. Data are representative for the whole country.						

Source: HIV/AIDS in Sweden, 1987–2007

		Sex	15–19 years	20–24 years	25–49 years	**Total**
Numerator:	Number of respondents aged 15–49 who have had more than one sexual partner in the past 12 months who also reported that a condom was used the last time they had sex	M	171	305	n/a	**476**
		F	199	271	n/a	**470**
		Total	**370**	**576**	**n/a**	**946**
Denominator:	Number of all respondents aged 15–49 who reported having had more than one sexual partner in the last 12 months	M	521	811	n/a	**1332**
		F	768	946	n/a	**1714**
		Total	**1289**	**1757**	**n/a**	**3046**
Comment: The UNGKAB survey covers only the age groups 15–19 and 20–24. For the age group 25–49 the latest data comes from the HIV/AIDS in Sweden, 1987–2007 study.						

Source: UNGKAB, 2009. Göteborgs universitet

Indicator 18: Number of female and male sex workers reporting the use of a condom with their most recent client.

		Sex	2008				2009			
			0–24 years	25–49 years	+ 50 years	**Total**	0–24 years	25–49 years	+ 50 years	**Total**
Numerator:	Number of SW respondents reporting the use of a condom the last time they had sex	M	n/a	n/a	n/a		0	4	0	**4**
		F	n/a	n/a	n/a		0	1	0	**1**
		Total					**0**	**5**	**0**	**5**
Denominator:	Number of SW respondents who reported having had sexual intercourse in the last month	M	n/a	n/a	n/a		6	12	2	**20**
		F	n/a	n/a	n/a		2	4	1	**7**
		Total					**8**	**16**	**3**	**27**
Comment: The SWs has been identified via the IDU sentinel surveillance (SHP) where the selection criteria are based on people with any form of substance abuse, i.e. where a total of 259 IDUs were identified during 2009. SWs in the SHP study is defined as having sold sex in the last 12 months. Data are not representative for the country.										

Source: SHP

Indicator 19 MSM: Number of men reporting the use of a condom the last time they had anal sex with a male partner.

Indicator no 19 A - Percentage of men reporting the use of a condom the last time they got penetrated when having anal sex with a male partner.		2006 study				2008 study			
		0–24 years	25–49 years	+ 50 years	**Total**	0–24 years	25–49 years	+ 50 years	**Total**
Numerator:	Number of men reporting the use of a condom the last time they got penetrated in anal sex with a male partner	98	242	31	**371**	176	385	68	**629**
Denominator:	Number of respondents who reported that they got penetrated when having anal sex at the last sexual encounter with a man	262	537	60	**859**	377	747	150	**1274**
Comment: 19 A. and 19 B. together make out the UNGASS indicator 19. Data are not representative for the whole country.									

Source: The MSM Study, 2008. Malmö högskola

Indicator no 19 B - Percentage of men reporting the use of a condom the last time they penetrated when having anal sex with a male partner.		2006 study				2008 study			
		0–24 years	25–49 years	+ 50 years	**Total**	0–24 years	25–49 years	+ 50 years	**Total**
Numerator:	Number of men reporting the use of a condom the last time they penetrated during anal sex with a male partner	96	224	34	**354**	137	403	101	**641**
Denominator:	Number of respondents who reported that they penetrated when having anal sex at the last sexual encounter with a man	225	502	65	**792**	283	742	186	**1211**
Comment: 19 A. and 19 B. together make out the UNGASS indicator 19. Data are not representative for the whole country.									

Source: The MSM Study, 2008. Malmö högskola

Indicator 20: Number of injecting drug users who report the use of a condom at last sexual intercourse.

			2008				2009			
		Sex	0–24 years	25–49 years	+ 50 years	**Total**	0–24 years	25–49 years	+ 50 years	**Total**
Numerator:	Number of IDU respondents reporting the use of a condom the last time they had sex	M	n/a	n/a	n/a		3	7	0	**10**
		F	n/a	n/a	n/a		0	0	0	**0**
		Total					**3**	**7**	**0**	**10**
Denominator:	Number of IDU respondents who reported having injected drugs and having had sexual intercourse in the last month.	M	n/a	n/a	n/a		24	86	10	**120**
		F	n/a	n/a	n/a		7	22	3	**32**
		Total					**31**	**108**	**13**	**152**
Comment: The IDUs have been identified via the SHP sentinel surveillance study where the selection criteria are based on people with any form of substance abuse, i.e. where a total of 259 IDUs were identified during 2009. The majority, or 125 out of the 152 IDUs, reported using amphetamine as main drug. Data are not representative for the whole country.										

Source: SHP

Indicator 21: Number of injecting drug users who reported using sterile injecting equipment the last time they injected.

		Sex	2008				2009			
			0–24 years	25–49 years	+ 50 years	**Total**	0–24 years	25–49 years	+ 50 years	**Total**
Numerator:	Number of IDU respondents who report using sterile injecting equipment the last time they injected drugs	M	n/a	n/a	n/a		11	73	13	**97**
		F	n/a	n/a	n/a		3	11	5	**19**
		Total					**14**	**84**	**18**	**116**
Denominator:	Number of IDU respondents who report injecting drugs in the last month	M	n/a	n/a	n/a		20	130	16	**166**
		F	n/a	n/a	n/a		6	21	6	**33**
		Total					**26**	**151**	**22**	**199**
Comment: The IDUs have been identified via the SHP sentinel surveillance study where the selection criteria are based on people with any form of substance abuse, i.e. where a total of 259 IDUs were identified during 2009. Data are not representative for the whole country.										

Source: SHP

Impact

Indicator 22: Number of young women and men aged 15–24 who are HIV infected.

		Sex	2008				2009			
			15–19 years	20–24 years	25–29 years	**Total**	15–19 years	20–24 years	25–29 years	**Total**
Numerator:	Number of respondents aged 15-29 tested positive	M	2	16	32	**50**	6	26	40	**72**
		F	6	21	31	**58**	4	19	36	**59**
		Total	**8**	**37**	**63**	**108**	**10**	**45**	**76**	**131**
Denominator:	Number of all respondents 15 years or older in Sweden	M	n/a	n/a	n/a		n/a	n/a	n/a	
		F	n/a	n/a	n/a		n/a	n/a	n/a	
		Total								
Comment: Reported data include both domestic youth population and youth who were infected prior to arrival in Sweden. Data are representative for the whole country. Reported data are incidence surveillance data per year.										

Source: SMI

Indicator 23: MSM Number of MSM who test positive for HIV.

		2008				2009			
		0–24 years	25–49 years	+50 years	**Total**	0–24 years	25–49 years	+50 years	**Total**
Numerator:	Number of MSM respondents who test positive for HIV	10	89	17	**116**	21	94	19	**134**
Denominator:	Number of MSM respondents tested for HIV	n/a	n/a	n/a		n/a	n/a	n/a	
Comment: Reported data include both domestic MSM population and MSM who were infected prior to arrival in Sweden. Data are representative for the whole country. Reported data are incidence surveillance data per year.									

Source: SMI

		Study 2006				Study 2008			
		0-24 years	25 - 49 years	+ 50 years	**Total**	0-24 years	25 - 49 years	+ 50 years	**Total**
Numerator:	Number of MSM respondents who test positive for HIV	2	71	13	**86**	3	94	31	**128**
Denominator:	Number of MSM respondents tested for HIV	634	1538	214	**2386**	930	2365	548	**3843**
Comment: In both surveys the question reads “What is your perception of your HIV status?” (In Swedish "Vad är din uppfattning om din hivstatus?"). Data are not representative for the whole country. In 2008 and 2009, a total of 116 and 134 HIV positive MSM were detected respectively via the national surveillance system (SMI) however, the number of people tested nationally cannot be reported upon. The latter data are representative for the whole country. Reported data are prevalence data of MSM respondents per study.									

Source: The MSM Study, 2008. Malmö högskola

Indicator 23 IDU: Number of IDU who test positive for HIV.

			2008				2009			
			0–24 years	25–49 years	+50 years	**Total**	0–24 years	25–49 years	+50 years	**Total**
Numerator:	Number of IDU respondents who test positive for HIV	M	0	18	3	**21**	0	17	4	**21**
		F	1	5	1	**7**	1	5	0	**6**
		Total	**1**	**23**	**4**	**28**	**1**	**22**	**4**	**27**
Denominator:	Number of IDU respondents tested for HIV	M	n/a	n/a	n/a		n/a	n/a	n/a	
		F	n/a	n/a	n/a		n/a	n/a	n/a	
		Total								
Comment: Data for testing is not collected in a comprehensive manner since testing is anonymous. Data are representative for the whole country. Reported data are incidence surveillance data per year.										

Source: SMI

			2008				2009			
			0–24 years	25–49 years	+50 years	**Total**	0–24 years	25–49 years	+50 years	**Total**
Numerator:	Number of IDU respondents who test positive for HIV	M	n/a	n/a	n/a		1	21	0	**22**
		F	n/a	n/a	n/a		0	2	0	**2**
		Total					**1**	**23**	**0**	**24**
Denominator:	Number of IDU respondents tested for HIV	M	n/a	n/a	n/a		34	165	17	**216**
		F	n/a	n/a	n/a		9	26	8	**43**
		Total					**43**	**191**	**25**	**259**
Comment: The IDUs have been identified via the SHP sentinel surveillance study where the selection criteria are based on people with any form of substance abuse, i.e. where a total of 259 IDUs were identified during 2009. Data are not representative for the whole country. Reported data are prevalence data of IDU respondents per respective year.										

Source: SHP

Indicator 23 SW: Number of SW who test positive for HIV.

			2008				2009			
			0–24 years	25–49 years	+ 50 years	**Total**	0–24 years	25–49 years	+ 50 years	**Total**
Numerator:	Number of SW respondents who test positive for HIV	M	n/a	n/a	n/a		0	0	0	**0**
		F	n/a	n/a	n/a		0	0	0	**0**
		Total					**0**	**0**	**0**	**0**
Denominator:	Number of SW respondents tested for HIV	M	n/a	n/a	n/a		7	1	2	**10**
		F	n/a	n/a	n/a		2	6	2	**10**
		Total					**9**	**18**	**4**	**31**
Comment: The SWs has been identified via the IDU sentinel surveillance (SHP) where the selection criteria are based on people with any form of substance abuse, i.e. where a total of 259 IDUs were identified during 2009. SWs in the SHP study is defined as having sold sex in the last 12 months. Data are not representative for the whole country.										

Source: SHP

Indicator 24: Percentage of adults and children with HIV known to be on treatment 12 months after initiating antiretroviral therapy.

			2009				
			0–15 years	15–24 years	25–49 years	+50 years	**Total**
Numerator:	Number of adults and children who are still alive and on ART at 12 months after initiating treatment	M	27	n/a	2631	n/a	**2658**
		F	30	n/a	1497	n/a	**1527**
		Total	**57**		**4128**		**4185**
Denominator:	Total number of adults and children who initiated ART during the twelve months prior to the beginning of the reporting period, including those who have died, those who have stopped ART, and those lost to follow-up.	M	27	n/a	2657	n/a	**2684**
		F	30	n/a	1523	n/a	**1553**
		Total	**57**		**4180**		**4237**
Comment: No patients were lost to follow-up. 52 patients died. Unfortunately patients treated were not divided into different age strata but very few patients in 15–24 and +50 were treated. Data are not representative for the whole country.							

Source: InfCare

Indicator 25: Percentage of infants born to HIV infected mothers who are infected.

		2008	2009	**Total**
Numerator:	Estimated number of new infant HIV infections	0	2	**2**
Denominator:	Estimated number of HIV positive pregnant women	40	43	**83**
Total		**40**	**45**	**85**
Comment: Children were born to mothers who were not known to be infected before delivery and therefore not treated.				

Source: SMI

B. NATIONAL COMPOSITE POLICY INDEX (NCPI)

Survey Response Details

Response Information

Started: 1/11/2010 7:22:23 AM
Completed: 3/1/2010 5:18:08 AM
Last Edited: 3/23/2010 10:31:05 AM
Total Time: 48.21:55:44.4500000

User Information

Username: ce_SE
Email:

Response Details

Page 1

1) Country

Sweden (0)

2) Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted for questions, if any:

Viveca Urwitz

3) Postal address:

The National Board of Health and Welfare (Socialstyrelsen) 106 30 Stockholm Sweden

4) Telephone:

Please include country code

?46 75 247 3857

5) Fax:

Please include country code

+46752473555

6) E-mail:

viveca.urwitz@socialstyrelsen.se

7) Date of submission:

Please enter in DD/MM/YYYY format

10/01/2010

Page 3

8) Describe the process used for NCPI data gathering and validation:

Data has been collected from: Commissioned scientific studies on KAP of several MARP from 4 Universities Epidemiological data on incidence and prevalence from The National institute of Disease Control. Reports from government Authorities. The monitoring reports records of

organisational structures, interventions and intermediary results from NGOs and local governments throughout Sweden from The National Board of Health and Welfare

9) **Describe the process used for resolving disagreements, if any, with respect to the responses to specific questions:**

All writers have had the possibility to review how their input has been used within the report. No time frame has been allowed for to discuss the report and its analysis in depth. This has to be done afterwards and there will be a meeting in the national Council for HIV prevention in May

10) **Highlight concerns -if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like):**

Data from 2009 are sometimes preliminary. Not all sources cover the whole of Sweden.

Page 4

11) **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	The National Board of Health & Welfare	Viveca Urwitz/Head of the HIV unit	A.I, A.II, A.III, A.IV, A.V

12)

	Organization	Names/Positions	Respondents to Part A [Indicate which parts each respondent was queried on]
Respondent 2	Swedish Institute for Infectious Disease Control	Malin Arneborn	A.III, A.IV, A.V
Respondent 3	Swedish Institute for Infectious Disease Control	Inga Velicko	A.III, A.IV, A.V
Respondent 4	Ministry for Foreign Affairs	Lennart Hjelmåker	A.I, A.II, A.III, A.V
Respondent 5	Swedish International Development Agency	Pia Engstrand	A.I, A.II, A.III, A.V
Respondent 6	Swedish National Agency for Education	Agneta Nilsson	A.I, A.III, A.IV, A.V
Respondent 7	Swedish National Institute of Public Health	Monica Nordvik	A.III, A.IV, A.V
Respondent 8	Swedish Prison and Probation Service	Maria Hägerstrand	A.III, A.IV, A.V
Respondent 9			
Respondent 10			
Respondent 11			
Respondent 12			
Respondent 13			

Respondent 14	
Respondent 15	
Respondent 16	
Respondent 17	
Respondent 18	
Respondent 19	
Respondent 20	
Respondent 21	
Respondent 22	
Respondent 23	
Respondent 24	
Respondent 25	

13) **If the number of respondents to Part A is more than 25, please enter the rest of respondents for Part A in below box.**

The NCPI part A has been filled in by the NBHW as the coordinating body in Sweden. However, the above listed governmental counterparts have contributed to the narrative report, from which many of the answers in the NCPI part A has been built upon.

14)

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	HIV-Sweden*	Andreas Berglöf	B.I, B.II, B.III, B.IV

15)

	Organization	Names/Positions	Respondents to Part B [Indicate which parts each respondent was queried on]
Respondent 2	AFRICANET		B.I, B.II, B.III, B.IV
Respondent 3	Afrikanska Kvinnors Nätverk		B.I, B.II, B.III, B.IV
Respondent 4	Arab Information and Cultural Centre		B.I, B.II, B.III, B.IV
Respondent 5	Asian Urdu Society		B.I, B.II, B.III, B.IV
Respondent 6	Convictus**		B.I, B.II, B.III, B.IV
Respondent 7	Föreningen Gay Camp		B.I, B.II, B.III, B.IV
Respondent 8	Föreningen Homosexuella Läkare		B.I, B.II, B.III, B.IV

Respondent 9	Hälsoteamet förebygger HIV	B.I, B.II, B.III, B.IV
Respondent 10	Heteroplus	B.I, B.II, B.III, B.IV
Respondent 11	IFMSA Sweden	B.I, B.II, B.III, B.IV
Respondent 12	Kamratföreningen Oasen	B.I, B.II, B.III, B.IV
Respondent 13	KCS - Kvinnocirkeln Sverige	B.I, B.II, B.III, B.IV
Respondent 14	Kongo Riksförbund i Sverige	B.I, B.II, B.III, B.IV
Respondent 15	LDA - Liberia Dujar Association	B.I, B.II, B.III, B.IV
Respondent 16	Noah's Ark**	B.I, B.II, B.III, B.IV
Respondent 17	Posithiva Gruppen	B.I, B.II, B.III, B.IV
Respondent 18	RFHL**	B.I, B.II, B.III, B.IV
Respondent 19	RFSL**	B.I, B.II, B.III, B.IV
Respondent 20	RFSU**	B.I, B.II, B.III, B.IV
Respondent 21	RIFFI	B.I, B.II, B.III, B.IV
Respondent 22	Riksföreningen Hepatit C	B.I, B.II, B.III, B.IV
Respondent 23	Sensus	B.I, B.II, B.III, B.IV
Respondent 24	SHAI	B.I, B.II, B.III, B.IV
Respondent 25	Stockholm Gay Life	B.I, B.II, B.III, B.IV

16)

If the number of respondents to Part B is more than 25, please enter the rest of respondents for Part B in below box.

Respondent 26: Swedish Hemophilia Society Respondent 27: The Somali Health Team *HIV-Sweden was chosen by the NGO community to function as their representatvie towards the NBHW when it came to answering the UNGASS NCPI part B. Consequently, all NGOs have been given the possibility to participate in the process. ** The following NGOs have actively participated in the NCPI part B report writing process.

Page 5

17)

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)

Page 7

18)

1.1 How long has the country had a multisectoral strategy?

Number of Years

0

19)

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	
Education	Yes	
Labour		
Transportation		
Military/Police		
Women		
Young people		
Other*	Yes	

Page 8

20) **If "Other" sectors are included, please specify:**

Migration, Justice, Social Welfare,

Page 9

21)

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	
g. Other specific vulnerable subpopulations*	Yes
Settings	
h. Workplace	Yes
i. Schools	Yes
j. Prisons	Yes
Cross-cutting issues	

k.HIV and poverty	
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

22)

1.4 Were target populations identified through a needs assessment?

Yes (0)

Page 10

23)

IF YES, when was this needs assessment conducted?

Please enter the year in yyyy format

2003

Page 11

24)

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

MSM, Vulnerable migrant groups, IDU, Youth and Young adults, people travelling to high endemic areas for HIV, persons buying and selling sex, pregnant women (to prevent MTCT), people living with HIV/AIDS living with HIV/AIDS

25)

1.6 Does the multisectoral strategy include an operational plan?

Yes (0)

26)

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?	Yes
e. A monitoring and evaluation framework?	No

27)

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

Active involvement (0)

Page 12

28)

IF active involvement, briefly explain how this was organised:

The Strategy was developed in 2003-2005. All major stakeholders including the main active NGOs were invited to part-take in the needs assessment and strategy development prior to the government bill was written.

Page 14

29)

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)

Page 16

30)

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

N/A (0)

Page 17

31)

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)

Page 18

32)

4.1 *IF YES*, which of the following programmes have been implemented beyond the pilot stage to reach a signifi cant 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	Yes

Page 19

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)

Page 20

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	Yes
f. Prison inmates	Yes
g. Migrants/mobile populations	Yes
Other: Please specify	

35)

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

All persons residing legally in Sweden have access to testing and treatment according to The Swedish Communicable Diseases and Prevention Act. Monitoring of testing and counselling procedures including confidentiality are carried out by The National Board of Health and Welfare There are laws to ensure human rights irrespective of gender, sexual orientation, ethnicity, functional handicaps, and for PLWHA etc. The ombudsman system for human rights and against discrimination for gender, sexual orientation, ethnicity and functional handicaps is institutionalised in Sweden Possibilities for NGO support on human rights issues for PLWHA.

36)

Briefly comment on the degree to which these laws are currently implemented:

All the above laws are implemented

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	
b. Young people	
c. Injecting drug users	
d. Men who have sex with men	
e. Sex Workers	
f. Prison inmates	
g. Migrants/mobile populations	Yes
Other: Please specify	

39)

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

Undocumented migrants to Sweden cannot legally access prevention, testing, counselling treatment and support

40)

Briefly comment on how they pose barriers:

see above

Page 23

41)

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

Yes (0)

Page 24

42)

7.1 Have the national strategy and national HIV budget been revised accordingly?

Yes (0)

43)

7.2 Have the estimates of the size of the main target populations been updated?

Yes (0)

Page 25

44)

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

Estimates of current needs only (0)

45)

7.4 Is HIV programme coverage being monitored?

Yes (0)

Page 26

46)

(a) IF YES, is coverage monitored by sex (male, female)?

Yes (0)

47)

(b) IF YES, is coverage monitored by population groups?

Yes (0)

Page 27

48)

IF YES, for which population groups?

MSM Migrants to Sweden IDU Youth and young adults Women and men Different age groups

49)

Briefly explain how this information is used:

To amend problems for groups in accessing treatment and support.

Page 28

50)

(c) Is coverage monitored by geographical area?

Yes (0)

Page 29

51)

IF YES, at which geographical levels (provincial, district, other)?

Monitoring exists at regional level and at national level through quality control registers.

52)

Briefly explain how this information is used:

To monitor the access to treatment and support

53)

7.5 Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs?

Yes (0)

Page 30

54)

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

6 (6)

55)

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

An overall communications strategy for all main actors An action plan for prevention among youth and young adults

56)

What are remaining challenges in this area:

Action plans for MSM and for vulnerable migrants groups. Better needs assessment on provision for IDUs

Page 31

57)

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

President/Head of government	
Other high officials	Yes
Other officials in regions and/or districts	Yes

58)

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

59)

2.1 IF YES, when was it created?

Please enter the year in yyyy format

2006

60)

2.2 IF YES, who is the Chair?

Name	Christer Wennerholm
Position/title	Politician appointed by the Prime Minister

61)

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?	No
have an action plan?	Yes
have a functional Secretariat?	Yes
meet at least quarterly?	Yes
review actions on policy decisions regularly?	Yes
actively promote policy decisions?	Yes
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

62)

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

11

63)

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

5

Page 34

64)

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

No (0)

Page 35

65)

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)

30

66)

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	No
Other: Please specify	

67)

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

68)

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

Yes (0)

Page 37

69)

IF YES, name and describe how the policies / laws were amended:

Needle exchange programs were made legal in Sweden when the National Strategy was launched

Page 38

70)

Overall, how would you rate the political support for the HIV programmes in 2009?

3 (3)

71)

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

Regional programs have been updated and acknowledged by the regional decision-makers

72)

What are remaining challenges in this area:

Coordination between sectors and funding on the regional and local levels

Page 39

73)

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

Yes (0)

Page 40

74)

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)
h. Abstain from injecting drugs (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)
o. Prevent mother-to-child transmission of HIV (0)

75)

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)

76)

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

Yes (0)

77)

2.1 Is HIV education part of the curriculum in:

primary schools?	Yes
secondary schools?	Yes
teacher training?	No

78)

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

Yes (0)

79)

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

Yes (0)

80)

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)

81)

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, 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, Clients of 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	Men having sex with men, Sex workers, Other populations
Vulnerability reduction (e.g. income generation)	Sex workers
Drug substitution therapy	Injecting drug user
Needle & syringe exchange	Injecting drug user

Page 43

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

Newly arrived migrants to Sweden Pregnant women to prevent MTCT Youth and Young Adults

Page 44

83)

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

3 (3)

84)

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

Better coordinated regional policies and programs concerning newly arrived migrants and refugees

85)

What are remaining challenges in this area:

national policies concerning IDU , persons buying and selling sex, in prisons

Page 45

86)

4. Has the country identified specific needs for HIV prevention programmes?

Yes (0)

Page 46

87)

4.1 To what extent has HIV prevention been implemented?

HIV prevention component	The majority of people in need have access
Blood safety	N/A
Universal precautions in health care settings	N/A
Prevention of mother-to-child transmission of HIV	N/A
IEC* on risk reduction	Agree
IEC* on stigma and discrimination reduction	Agree
Condom promotion	Agree
HIV testing and counselling	Agree
Harm reduction for injecting drug users	Don't 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	Agree
HIV prevention for out-of-school young people	Agree
HIV prevention in the workplace	Agree
Other: please specify	Agree

Page 47

88)

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

6 (6)

89)

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

Better targeted interventions on MSM , Youth; IDU and newly arrived asylum seekers and refugees

90)

What are remaining challenges in this area:

Even better targeted and more locally funded interventions

Page 48

91)

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

92)

1.1 IF YES, does it address barriers for women?

Yes (0)

93)

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

Yes (0)

94)

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

Yes (0)

Page 50

95)

IF YES, how were these determined?

Through need assessments and dialogues with NGOs

96)

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

HIV treatment, care and support service	The majority of people in need have access
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	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: please specify	

Page 53

97)

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

9 (9)

98)

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

No development of resistance to treatment A person diagnosed who could comply with treatment could access treatment

99)

What are remaining challenges in this area:

To offer treatment for undocumented migrants To reduce the number of late testers through better access to testing for vulnerable migrants group and travellers to high endemic areas.

Page 54

100)

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

101)

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

In progress (0)

Page 63

102)

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

Yes (0)

Page 64

103)

IF YES, briefly describe how often a national M&E assessment is conducted and what the assessment involves:

Assessment is done through regular monitoring the work and outcome in regions and the work of NGOs Evaluations are conducted for several defined reasons: 1. To establish evidence or best practice in projects 2. To assess if the work of a particular actor or a specific project is line with the national strategy

104)

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

In progress (0)

Page 68

105)

What are the major challenges?

To increase the knowledge of M&E among key stake holders To use funds for M&E instead of activities and interventions

Page 69

106)

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

No (0)

Page 70

107)

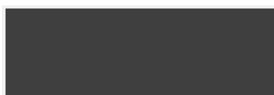
7. Is there a central national database with HIV- related data?

No (0)

Page 72

108)

7.3 Is there a functional* Health Information System?



At national level	Yes

At subnational level Yes

Page 73

109) **For Question 7.3, you have indicated "Yes" to "subnational level", please specify at what level(s)?**

At regional and national levels

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

Yes (0)

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

9.1 in developing / revising the national AIDS strategy?:

4 (4)

112) **Provide a specific example:**

A yearly analysis is submitted to the MoHW. On the basis of this report priorities are set for targeted funding

113) **What are the main challenges, if any?**

To write the M&E plan

Page 74

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

9.2 for resource allocation?:

4 (4)

115) **Provide a specific example:**

Evaluation of the national outreach program resulted in a smaller amount of funding

116) **What are the main challenges, if any?**

to change funding from one NGO to another

Page 75

117)

9. To what extent are M&E data used

9.3 for programme improvement?:

4 (4)

118)

Provide a specific example:

An evaluation of the national outreach program totally changed the method and outcome of the program.

119)

What are the main challenges, if any?

Methods and costs of evaluation

Page 76

120)

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

Yes, but only addressing some levels (0)

Page 77

121) **For Question 10, you have checked "Yes, but only addressing some levels", please specify**

at subnational level (0)

122)

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

123)

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

Yes (0)

Page 80

124)

IF YES, describe what types of activities:

Seminar for regional coordinators

Page 81

125)

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

5 (5)

126)

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

All NGO work has been evaluated an was found to be contributing towards reaching the objectives of the national strategy

Page 82

127)

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 specifi cally mention HIV, focus on schooling, housing, employment, health care etc.)

Yes (0)

Page 83

128)

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

129)

2.1 *IF YES,* for which subpopulations?

a. Women	Yes
b. Young people	No
c. Injecting drug users	No

d. Men who have sex with men	Yes
e. Sex Workers	No
f. prison inmates	No
g. Migrants/mobile populations	No
Other: Please specify	

130)

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

The Equality Ombudsman was formed on 1 January 2009 when the four previous anti-discrimination ombudsmen were merged into a new body. The previous authorities were the Equal Opportunities Ombudsman (JämO), the Ombudsman against Ethnic Discrimination (DO), the Disability Ombudsman (HO) and Ombudsman against Discrimination on grounds of Sexual Orientation (HomO).

131)

Briefly describe the content of these laws:

On 1 January 2009 a new comprehensive Discrimination Act, which covers more areas than before, came into force. The Discrimination Act prohibits discrimination on grounds of sex, transgender identity or expression, ethnicity, religion or other belief, disability, sexual orientation or age.

Page 85

132)

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

133)

3.1 *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	Yes
f. prison inmates	Yes
g. Migrants/mobile populations	Yes
Other: Please specify	Yes

Page 87

134)

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

Yes (0)

Page 88

135)

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?

Yes (0)

Page 89

136)

IF YES, briefly describe this mechanism:

How the Equality Ombudsman can help you - Receive and investigate your discrimination complaints. - Provide information on the rights protected by anti-discrimination legislation. - Provide advice on how to assert your rights when you have been discriminated against. - Represent you in court. - Receive and investigate your complaint if you feel you have been treated less favourably because of parental leave. - Provide advice on how to promote equal rights and prevent discrimination. - Provide education on protection against discrimination.

137)

6. Has the Government, through political and fi nancial 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

138)

IF YES, describe some examples:

- The National Council for Coordination of HIV Prevention (Nationella Hivrådet) includes organizations representing HIV-positive people, most at-risk populations and other vulnerable groups. - The National Board of Health and Welfare has prior to 2009 created a civil society forum which still is in place (Organisationsforum).

139)

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	No

Page 91

140)

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

141)

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)

142)

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

143)

IF YES, briefly describe the content of this policy:

- In the Swedish National Strategy to Combat HIV/AIDS and other Certain Diseases it states that: "An important starting point for preventive and supportive efforts is to make the groups that are most at risk from HIV/AIDS visible. It is vital that targeted measures are implemented to reduce the vulnerability of these groups. The groups considered most in need of targeted measures are: - men who have sex with men - injecting drug misusers, - young people and young adults - people from foreign backgrounds - people travelling abroad - pregnant women - people who are the victims of prostitution."

Page 94

144)

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

No (0)

145)

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

146)

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

No (0)

Page 96

147)

– 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

Yes (0)

148)

– 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)

149)

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

No (0)

Page 97

150)

IF YES on any of the above questions, describe some examples:

- The Equality Ombudsman monitors this.

Page 98

151)

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)

152)

– Legal aid systems for HIV casework

Yes (0)

153)

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

No (0)

154)

– Programmes to educate, raise awareness among people living with HIV concerning their rights

No (0)

155)

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

No (0)

Page 100

156)

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)

157)

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

- Sweden has presented its international strategy: The Right to a Future – policy for Sweden's international HIV/AIDS efforts.

Page 101

158)

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

4 (4)

Page 102

159)

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

3 (3)

Page 103

160)

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)?

0

Page 104

161)

a. the national AIDS strategy?

4 (4)

162)

b. the national AIDS budget?

3 (3)

163)

c. national AIDS reports?

0

Page 105

164)

a. developing the national M&E plan?

0

165)

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

0

166)

c. M&E efforts at local level?

0

167)

Comments and examples:

- Civil society are being monitored and evaluated, but not involved.

Page 106

168)

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)

169)

Comments and examples:

- The National Board of Health and Welfare involves civil society in HIV and AIDS efforts through its Civil Society Forum (Organisationsforum). Included in that Forum are networks of people living with HIV, AIDS service organizations, MSM, LGBT youth organization, migrants, sex education and IDU organizations.

Page 107

170)

a. adequate financial support to implement its HIV activities?

3 (3)

171)

b. adequate technical support to implement its HIV activities?

2 (2)

Page 108

172)

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	25-50%
- Sex workers	<25%

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

173)

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

1 (1)

Page 110

174)

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

Yes (0)

Page 111

175)

IF YES, how were these specific needs determined?

- Through a government proposition and also via the Swedish National Strategy to Combat HIV/AIDS and other Certain Diseases

176)

1.1 To what extent has HIV prevention been implemented?

HIV prevention component	The majority of people in need have access
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	Don't 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
Migrants & Undocumented	Don't agree

Page 112

177)

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

2 (2)

Page 113

178)

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

Yes (0)

Page 114

179)

IF YES, how were these specific needs determined?

- Via statistics from the Swedish Institute for Infectious Disease Control (SMI), via the Swedish National Strategy to Combat HIV/AIDS and other Certain Diseases and via civil society.

180)

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

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

Page 115

181)

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

7 (7)

Page 116

182)

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

N/A (0)