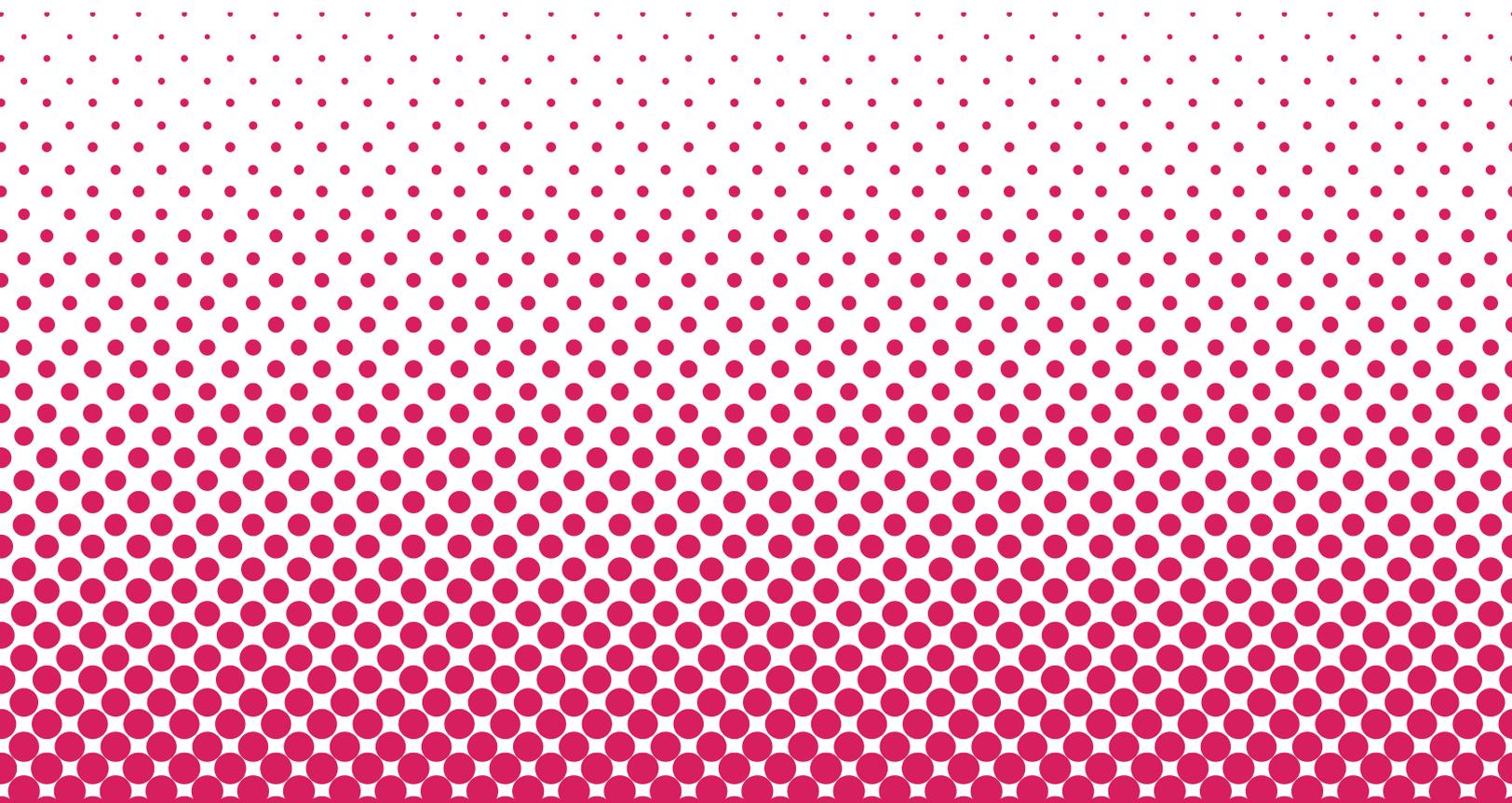


Global AIDS Response Progress Report 2012

Sweden



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Sammanfattning

I juni 2011 enades FNs medlemsländer om en ny deklARATION *Political Declaration on hiv/aids: Intensifying our Efforts to eliminate hiv/aids* som innehåller mål för arbetet med hiv och aids i världen. Denna deklARATION bygger vidare på den så kallade UNGASS deklARATIONEN från 2001. I enlighet med denna deklARATION rapporterar Sverige vartannat år till UNAIDS resultatet av det nationella hivpreventiva arbetet. Den här rapporten, The Global AIDS Response Progress Report 2012 (GARP), är en del i denna rapportering och Smittskyddsinstitutet ansvarar för att sammanställa och presentera data för Sverige i enlighet med deklARATIONEN. Rapporten syftar till att beskriva hivsituationen i Sverige samt att redogöra för preventionsarbetet och dess resultat för åren 2010-2011.

Det svenska hivarbetet styrs av den Nationella strategin mot hiv/aids och vissa andra smittsamma sjukdomar (Prop.2005/06:60) som omfattar tre delmål; 1) halvera antalet nyupptäckta fall där smittöverföringen skett i Sverige, 2) hiv hos asylsökande, nyanlända anhöriginvandrare och utlandsresenärer ska identifieras kort efter ankomsten till Sverige och 3) kunskapen om hiv/aids och om hur det är att leva med sjukdomen ska förbättras. Dessutom belyser strategin sju olika grupper vilka kan vara mer sårbara för att smittas av hiv. Dessa grupper är män som har sex med män, unga, immigranter, de som köper och säljer sex, utomlandsresenärer, gravida kvinnor (för att förhindra mor till barn smitta) och injektionsmissbrukare. Dessutom ingår också de personer som lever med hiv.

Rapporten visar på följande huvudresultat:

- I slutet av 2011 hade totalt 9 891 fall av hivinfektion rapporterats i Sverige och ungefär 5 800 personer lever i Sverige idag med en känd hivdiagnos.
- En svagt ökande trend av antalet rapporterade fall av hivinfektion har observerats i Sverige sedan 2003. Ökningen är framför allt relaterad till immigration och ett ökat antal rapporterade fall bland immigranter smittade före ankomsten till Sverige.
- En ökning av antalet rapporterade hivinfektioner observerades bland män som har sex med män under åren 2005-2009. Ett färre antal fall har rapporterats under 2010 och 2011 smittade via homosexuell kontakt mellan män, men det är fortfarande bland män som har sex med män som den inhemska smittspridningen av hiv är som störst.
- Färre fall ses även bland injektionsmissbrukare med endast 14 fall rapporterades i gruppen under 2011. Om denna minskning i antal rapporterade fall beror på ändrade injektionsvanor, ökad tillgång till rena sprutor och nålar eller minskad testing är oklart.
- Få fall av heterosexuellt överförd hivinfektion rapporteras bland unga (15-24 år) i Sverige idag, men kondomanvändningen är låg och klamydia vanligt förekommande, vilket tyder på högt sexuellt risktagande.

En rad olika hivpreventiva insatser och aktiviteter har pågått under 2010-2011, framförallt på regional och lokal nivå via landsting, regioner och frivilligorganisationer runt om i landet med stöd av Smittskyddsinstitutet. Vidare har Smittskyddsinstitutet initierat och utvecklat flera projekt på nationell nivå.

För att motverka smittspridningen av hiv bland män som har sex med män har en handlingsplan som riktar sig till den gruppen tagits fram och kommer publiceras under 2012. Vidare deltog Sverige i en studie kring sexuellt beteende samt risktagande bland män som har sex med män inom ramen för ett europeiskt samarbete, EMIS, och en svensk rapport kommer att publiceras 2012. En europeisk konferens, FEMP (The Future of European Prevention among MSM), anordnades av Smittskyddsinstitutet i november 2011 för att belysa och lyfta fram kunskap och stärka det förebyggande arbetet riktat till män som har sex med män.

Studier för att följa upp stigmatisering och diskriminering av personer som lever med hiv har planerats.

Ett stort nationellt arbete med finansiellt stöd från Europeiska kommissionen att vidta åtgärder för att öka tillgången till och kunskapen om hälsoundersökningar för nyanlända och anhöriginvandrare har påbörjats.

Åtgärder för att förbättra kondomanvändningen och minska riskbeteenden bland ungdomar och unga vuxna har vidtagits. Till exempel har resultatet från UngKAB09, en studie om kunskap, attityder och sexuella handlingar bland unga som genomfördes 2009, publicerats och spridits genom seminarier till olika aktörer. En metod för beteendeförändring, motiverande samtal (MI), har utvecklats med fokus på sexuell hälsa. Två nationella informationskampanjer som riktat sig till unga och unga vuxna har genomförts.

Ytterligare ett sprututbytesprogram har startat i Skåne under perioden och ett beslut har tagits om att starta ett program i Stockholm. Framtagande av en nationell handlingsplan som riktar sig till gruppen injektionsmissbrukare har påbörjats.

Fortsatta utmaningar inom det svenska hivpreventiva arbetet:

- Även om färre fall av hivinfektion har rapporterats bland män som har sex med män under perioden 2010-2011 finns det fortfarande en pågående smittspridning i denna grupp i Sverige. Detta innebär att fortsatta insatser riktade till män som har sex med män behövs och att det hivpreventiva arbetet behöver utvecklas.
- Ingen pågående heterosexuell smittspridning av hiv ses bland unga i Sverige idag, men kondomanvändningen är låg och klamydia vanligt förekommande i gruppen vilket är oroande. Fortsatta insatser för att öka kondomanvändningen bland unga är nödvändiga.
- Sextio procent av alla hivfall 2011 upptäcktes i ett sent skede, det vill säga att de vid tillfället för diagnosen redan hade en sådan påverkan på sitt immunförsvar att hivbehandling rekommenderas enligt de gällande svenska behandlingsriktlinjerna (CD4<350). Majoriteten av de som diagnosticerades sent var immigranter som smittats heterosexuellt före ankomsten till Sverige,

men sen diagnos förekommer även bland svenskfödda. Detta tyder på att det ofta tar lång tid mellan smittotillfället tills det att man blir diagnosticerad samt att det finns ett mörkertal av personer som bär på hiv utan att veta om det. Att öka testningen i preventionsgrupperna (såsom immigranter, MSM och injektionsmissbrukare) är viktigt i det hivpreventiva arbetet.

- ÿ Preventiva insatser riktade till injektionsmissbrukare behöver stärkas. Sprutbytesprogram finns idag på tre platser i Sverige och fler program behöver startas. Även testing och rådgivning via häktesprogram behöver byggas ut i hela landet.
- ÿ Många av de frivilligorganisationer som riktar sig till immigranter behöver utveckla sitt arbete för att nå fler i denna heterogena preventionsgrupp.
- ÿ System för att samla in data för att kunna följa utvecklingen vad gäller kunskap, beteende och behov i de olika preventionsgrupperna behöver utvecklas för framför allt immigranter och injektionsmissbrukare.

I. Status at a glance

The inclusiveness of the stakeholders in the report writing process

The National Coordination of HIV and STI Prevention Unit at the Swedish Institute for Communicable Disease Control (SMI) was responsible for the coordination process of Global Aids Progress Reporting 2012 in Sweden. This responsibility included collecting indicator data, and writing and collating the narrative report and the NCPI Part A. In this process, relevant stakeholders such as the National HIV Council, the National Board of Health and Welfare (NBHW), the Swedish National Agency for Education, the Swedish Prison and Probation Service and the steering committee of InfCareHIV – a medical decision support and quality register for Swedish HIV care – were consulted and contributed data and information. The NCPI Part B was coordinated by HIV–Sweden¹, who invited all NGOs receiving governmental funding to prevent HIV/AIDS and other STIs and the consequences of HIV to complete the NCPI Part B concerning civil society.

The status of the epidemic

By the end of 2011, a total of 9 891 HIV positive cases had been reported in Sweden since HIV surveillance started in the mid-1980s. Today about 5 800 individuals are known to be living with HIV in Sweden. The number of new cases reported has been relatively stable over time, with a slowly increasing trend since 2003, mainly due to immigration of people infected prior to arrival in Sweden. Between the late 1980s and 2002, approximately 280 new cases (3/100 000 population and year) were reported annually. Since 2003 an average of 440 cases have been reported per year (5/100 000 population and year). An increase in reported HIV infections was observed among men who have sex with men over the period 2005-2009. However, a decreasing number was reported in this group in 2010-2011, although the number of cases reported still remains at a higher level than before 2005 with 125 and 106 cases reported in 2010 and 2011 respectively. A decreasing number of cases has been observed among injecting drug users since 2007, and only 14 cases were reported in this transmission group in 2011. The number of reported AIDS cases peaked in 1995, and since then the number of cases per year has declined and stabilised. During the previous decade an average of 60 AIDS cases were reported per year and in 2010-2011 about 50 AIDS cases were reported annually, mainly in immigrants from countries with a generalised HIV epidemic.

¹ HIV-Sweden is a national umbrella organization including six different organizations for people living with HIV. HIV-Sweden works with interest issues for persons living with HIV and monitors and seeks to strengthen the rights of these people in society.

The policy and programmatic response

National strategic policy

The national HIV prevention work is governed by the National Strategy to Combat HIV/AIDS and Certain Other Communicable Diseases adopted by the Swedish Parliament, extending from 2006 to 2016 [1, 2]. The strategy emphasises an integrated response from all relevant sectors, including health, education, social welfare, prison and probation services and migration services. The strategy requires close cooperation and coordination between sectors, government bodies and non-governmental organisations (NGOs). The Government annually grants funding for preventive efforts at national and regional levels. The Minister of Health and Social Affairs is responsible for areas such as health and medical care, public health and social services policy and also bears overall responsibility for HIV policy and prevention.

Sweden's HIV prevention work incorporates a rights-based approach with an emphasis on sexual rights, such as the right to decide if, when, how and with whom to have sex. Everyone, regardless of gender, ethnic background, age, sexual orientation or disability, has the right to appropriate information about their own body and sexuality and access to services.

The strategy identifies seven key populations at higher risk of HIV exposure, among them men who have sex with men (MSM), youth, immigrants and injecting drug users, people travelling abroad (in this report used as travellers), pregnant women (to prevent mother-to-child transmission) and people buying and selling sex. The strategy also includes strategies to reach people living with HIV.

The main objective of the strategy is to limit the spread of HIV and other sexually transmitted infections (STIs), and the consequences of the infections for society and the individual. The three interim objectives are:

- ÿ The incidence of HIV infections transmitted within Sweden should be reduced by half.
- ÿ People who seek asylum and newly arrived close relatives of previously arrived asylum seekers should be offered testing and counselling within two months of arrival. The same services should be offered within six months to other groups of people who have stayed in countries with a generalized HIV epidemic.
- ÿ Knowledge about HIV and what it is like to live with the disease should be improved in the public sector, in working life and in society as a whole.

Leadership, coordination and main actors

Since July 2010 the SMI has been responsible as coordinator of national preventive work in Sweden, including allocating governmental funding to prevent HIV, other STIs and the consequences of HIV. The government has allocated an annual HIV grant, SEK 146 million, since 2006 aimed at supporting HIV preventive work at

national and regional level. A National HIV Council, consisting of key stakeholders, serves as an advisory board to SMI.

The Swedish education, health and social care systems are decentralised, and responsibility for preventive measures aimed at the population at large and at key populations at higher risk of HIV exposure lies with the county councils (health care) and the municipalities (schools and social services). The funding for these measures is integrated into regular budgets for education, health care and social services in over 270 different entities and is regulated by various laws, such as the Communicable Disease Prevention Act (SFS 2004:168) and the Health and Medical Services Act (SFS 1982:763). Due to this decentralized system it has not been possible to estimate total national spending on HIV prevention.

The role of NGOs is emphasised in the National Strategy for HIV prevention as being particularly important. Major NGOs maintain close contacts with prevention groups and are able to provide information and insights that can be difficult for society to communicate. NGOs are important partners in producing plans and strategies for measures to prevent HIV and other STIs.

Indicator data overview table

Indicator	Description	Value 2012	Comment
Target 1	Reduce sexual transmission of HIV by 50 per cent by 2015		
Indicators for the general population	1.1 Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Percentage who correctly identify ways of preventing sexual transmission of HIV = 91%; Percentage who reject major misconceptions about HIV transmission = 63%; Percentage giving correct answers to all three questions = 73%	Data not representative Source: Ungdomsbarometern 2011, an annual internet survey based on a self-selected sample.
	1.2 Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15	22%	Data not representative Source: UngKAB09 survey conducted in 2009
	1.3 Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	In the age group 16-49=20%; In the age group 16-24= 30%	Data not representative due to low response rate (25%) Source: Non published data. Plantin. A population based survey conducted in 2011. Data covers the age strata 16-19, 20-24 and 25-49.

	1.4 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	In the age group 16-49=28%; In the age group 16-24=30%	Data not representative due to low response rate (25%) Source: Non published data. Plantin. A population based survey conducted in 2011. Data covers the age strata 16-19, 20-24 and 25-49.
	1.5 Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	11%	Data not representative due to low response rate (25%) Source: Non published data. Plantin. A population based survey conducted in 2011. Data covers the age strata 16-19, 20-24 and 25-49.
	1.6 Percentage of young people aged 15-24 who are living with HIV	Topic relevant, indicator not relevant	The HIV epidemic in Sweden is concentrated to specific key populations such as MSM, IDUs and migrants
Indicators for sex workers	1.7 Percentage of sex workers reached with HIV prevention programmes	Topic relevant, indicator relevant, data not available	
	1.8 Percentage of sex workers reporting the use of a condom with their most recent client	Topic relevant, indicator relevant, data not available	
	1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results	Topic relevant, indicator relevant, data not available	
	1.10 Percentage of sex workers who are living with HIV	Topic relevant, indicator relevant, data not available	
Indicators for MSM	1.11 Percentage of men who have sex with men reached with HIV prevention programmes	59%	Source: data was collected through the EMIS survey, an internet survey including self selected respondents recruited via gay internet communities.
	1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	42%	Source: EMIS
	1.13 Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	31%	Source: EMIS
	1.14 Percentage of men who have sex with men who are living with HIV	6%	Source: EMIS
Target 2.	Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015		
Indicators IDU	2.1 Number of syringes distributed per person who injects drugs per year by	214	Data is not representative for the whole country. In 2011 official needle-syringe programmes were ongoing in only three

	needle and syringe programmes		municipalities in one county, Skåne. Data includes both needles AND syringes distributed.
	2.2 Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	8%	Data is not representative for the whole IDU population in Sweden. Source: Svenska häktesprogrammet, 2010, a second generation surveillance program ongoing in remand prisons in Stockholm and Gothenburg.
	2.3 Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	65%	Data is not representative for the whole IDU population in Sweden. Source: Svenska häktesprogrammet, 2010.
	2.4 Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	38%	Data is not representative for the whole IDU population in Sweden. Source: Svenska häktesprogrammet, 2010. Data is not comparable to data reported in 2009 as study participants tested at time of the interview were included in that number making it higher.
	2.5 Percentage of people who inject drugs who are living with HIV	5%	Data is not representative for the whole IDU population in Sweden. Source: Svenska häktesprogrammet, 2010. Known HIV positives are included in the prevalence data.
Target 3.	Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths		
Indicators MTCT	3.1 Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	100%	Regional data from Stockholm County collected in December 2011. All known HIV positive pregnant women in Sweden receive antiretroviral drugs to reduce the risk of mother-to-child transmission. All pregnant women should be offered an HIV test by the health care providers. In 2011 18 pregnant women were identified as HIV positive in the screening program.
	3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	Topic relevant, indicator not relevant	All new born children with an HIV positive mother are tested and monitored according to national guidelines (www.rav.se).
	3.3 Mother-to-child transmission of HIV (modelled)	Topic relevant, indicator not relevant	All pregnant women should be offered an HIV test by the health care providers. All known HIV positive pregnant women in Sweden receive antiretroviral drugs to reduce the risk of mother-to-child transmission. Since 2000 four known cases of MTCT of HIV have occurred in children born in Sweden.
Target 4.	Have 15 million people living with HIV on ART by 2015		

Indicators ART	4.1 Percentage of eligible adults and children currently receiving antiretroviral therapy*	99%	Data was collected in December 2011 from InfCareHIV- a medical decision support and quality register for the Swedish HIV care monitoring all HIV patients in Sweden. All patients eligible for ART receive treatment. The few patients (about 50 patients) who do not receive treatment according to recommendations either do not want treatment or have other medical reasons for not receiving ART. Mainly these patients are IDUs.
	4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	98%	Data from InfCareHIV in December 2011
Target 5.	Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015		
Indicator TB	5.1 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	100%	Data from InfCareHIV in December 2011 All HIV positive patients who are diagnosed with TB receive treatment for both HIV and TB.
Target 6.	Reach a significant level of annual global expenditure in low- and middle-income countries		
Indicator expenditure	6.1 Domestic and international AIDS spending by categories and financing	No data	Due to a decentralized political system where county councils are responsible for providing and financing health care it has not been possible to estimate total national spending on HIV. Available data is supplied in annex
Target 7.	Critical enablers and synergies with development sectors		
Indicators synergies (NCPI)	7.1 National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)		Uploaded in the online reporting tool, available on www.unaids.org
	7.2 Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	Topic not relevant	There are no indications of a need to monitor prevalence of recent intimate partner violence in women in relation to the Swedish HIV epidemic. Violence against children, women and men is monitored by Brå – the Swedish National Council for Crime Prevention. Men's domestic violence against women is criminalized since 1858 in Sweden, and against children since 1979.
	7.3 Current school	Topic not relevant	School is compulsory and free of charge for

	attendance among orphans and non-orphans aged 10–14		all Swedish residents aged 7-16 years.
	7.4 Proportion of the poorest households who received external economic support in the past 3 months	Topic not relevant	There are no indications of a need to monitor proportion of the poorest households who received external economic support in the past 3 months in relation to the Swedish HIV epidemic. Approximately 247 210 of the Swedish households received economic support in 2010, which represents 6.5% of all households in the population. The distribution of the households that received economic support shows that single households are the most common group to receive economic support. Source: The National Borad of Health and Welfare, http://www.socialstyrelsen.se/publikationer2011/2011-6-25

Additional European indicators according to the Dublin declaration

Indicator	Description	Value 2012	Comment
EUR I.	HIV Treatment: Antiretroviral Therapy among People Diagnosed with HIV Infection		
Indicator	Percentage of people diagnosed with HIV infection who need antiretroviral therapy and who receive it	99%	Data was collected from InfCareHIV in December 2011- a medical decision support and quality register for the Swedish HIV care monitoring all HIV patients in Sweden. All patients eligible for ART receive treatment. The few patients (about 50 patients) who do not receive treatment according to recommendations either do not want treatment or have other medical reasons for not receiving ART. Mainly these patients are IDUs.
EUR II.	Late HIV Diagnosis		
Indicator	Percentage of people with HIV infection who already need antiretroviral therapy at the time of diagnosis	58% (<350 CD4 at time of diagnosis)	Data was collected from InfCareHIV in December 2011.
EUR III	Migrants: Condom Use		
Indicator	Percentage of migrants from countries with generalized HIV epidemics who had sex with more than one partner in the past 12 months who used a condom during their last sexual intercourse	Topic relevant, indicator relevant, data not available	
EUR IV	Migrants: HIV Testing		
Indicator	Percentage of migrants from countries with	Topic relevant, indicator relevant,	

	generalised HIV epidemics who received an HIV test in the past 12 months and know their results	data not available	
EUR V	Migrants: HIV Prevalence		
Indicator	Percentage of migrants who are living with HIV	Topic relevant, indicator relevant, data not available	In 31 of December 2011 3 434 foreign-born persons were living with HIV in Sweden, i.e. 59% of all people living with a known HIV infection in Sweden. In the end of 2011 a total of 1 427 296 people living in Sweden were foreign-born. Using this denominator (number of HIV tested foreign-born is unknown) the HIV prevalence in foreign-borns is 0,2% compared to 0,06% (5 800 PLWH/9 482 855 population) in the total population.
EUR VI	Prisoners: HIV Prevalence		
Indicator	Percentage of prisoners who are living with HIV	Topic relevant, indicator relevant, data not available	
	NCPI Government+Civil society		Uploaded in the online reporting tool, available on www.unaids.org

II. Overview of the HIV epidemic

The Swedish HIV epidemic has, over the years, followed the same pattern as most western European countries with a low incidence rate after the initial peak in the mid-1980s followed by a slow increase over the last decade (Figure 1). Initially, the epidemic was driven mainly by men who have sex with men and injecting drug users infected in Sweden. Since 1990 the largest proportion of new cases consists of migrants infected heterosexually prior to arrival in Sweden (Figure 2). Of domestic cases, the MSM population still accounts for the largest proportion.

Figure 1

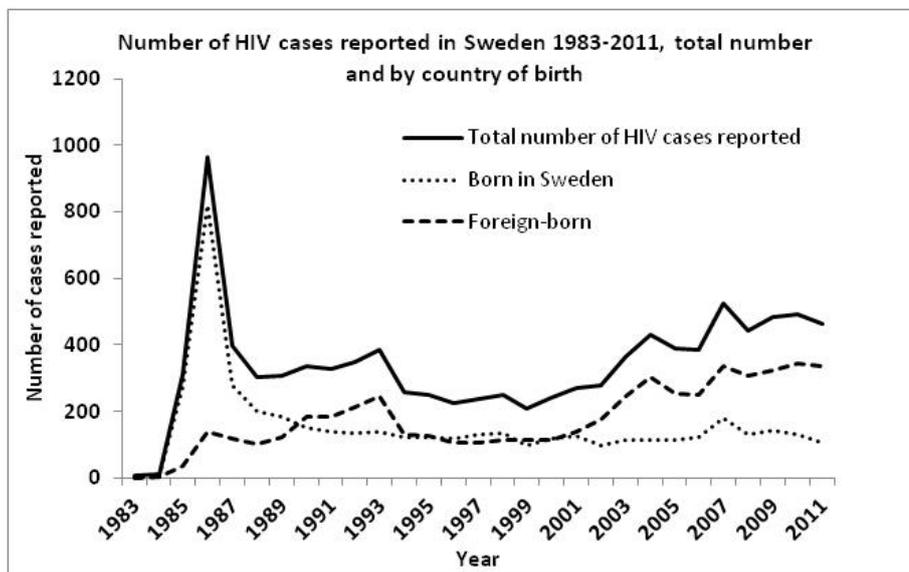
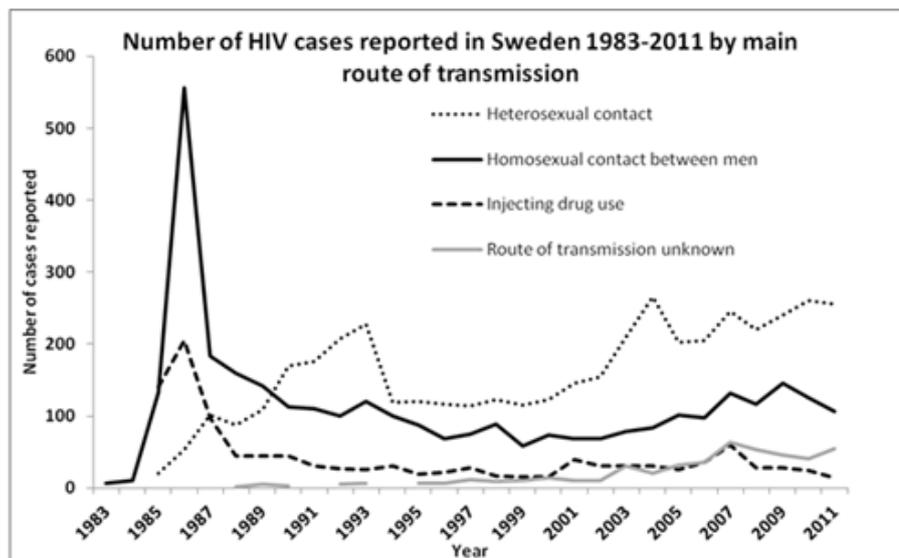


Figure 2



By the end of 2011 a total of 9 891 HIV positive cases had been reported in Sweden and 5 800 persons were known to be living with HIV in Sweden. The proportion of undiagnosed people living with HIV in Sweden has been estimated to be 15% [3] and the true number of people living with HIV in Sweden by the end of 2011, diagnosed as well as undiagnosed, is estimated to be about 6 600.

During 2010 and 2011 a total number of 493 and 465 cases were reported, respectively, out of which 61% were men and 39% were women. At least 71% of all people reported with an HIV-infection during 2010 and 2011 were foreign-born.

Heterosexual transmission

In 2010 and 2011, 261 and 255 HIV cases, respectively, associated with heterosexual contact were reported. Of all these cases 80 % (414 cases) were foreign-born, of which at least 60% (246 cases) had arrived in Sweden in 2009 or later. During 2010-2011 the most common country of birth in the foreign-born population was Thailand (60 cases) followed by Eritrea (44 cases) and Ethiopia (42 cases). Of all the foreign-born cases reported in 2010-2011, 9% (36 cases) most probably contracted HIV in Sweden, indicating that foreign-borns are a key population for heterosexual transmission in Sweden. Among people born in Sweden, about 45 cases associated with heterosexual contact were reported per year in 2010-2011. A majority of these cases (65%) contracted the disease abroad, mainly in Thailand (60%).

Important key populations at higher risk of HIV exposure through heterosexual contacts are immigrants, travellers and sex workers. By the end of 2011, 59% of all people living with HIV in Sweden were foreign-born. No comprehensive system is yet in place to monitor knowledge, attitudes, behaviours or disease prevalence in these key populations.

Heterosexual transmission of HIV in youths in Sweden is rare. In 2010-2011 seven cases of HIV associated with heterosexual transmission in Sweden in the age group 15-24 were reported, none of the cases being younger than 18 and 6 out of 7 being foreign-born. At the end of 2011 only 3% of all diagnosed persons living with HIV in Sweden were in the age group 15-24. However, Chlamydia is highly endemic among 15-24 year olds in Sweden, with more than 2000 reported cases per 100 000 population and year, and studies show that although people in this age group know how to prevent STI transmission, high sexual risk taking is widespread. Data from 2011 indicate that 91% of people in the 16-24 age group know that condom use is an effective measure to reduce the risk of transmission of HIV and other STIs (see indicator 1.1). In this age group 30% reported that they had had sexual intercourse with more than one partner in the past 12 months (see indicator 1.3), and only 30% of these reported that they had used a condom during their last intercourse (see indicator no 1.4) [4].

Men who have sex with men

An increase in HIV infections was observed among men who have sex with men over the period 2005-2009. A decreasing number was reported in this group in

2010-2011. However, the number of cases reported still remains at a higher level than in 2005, with 125 cases reported in 2010 and 106 cases reported in 2011. The distribution of reported cases in MSM is concentrated in the three counties that include the three major metropolitan areas, Stockholm, Malmö and Gothenburg. They account for 87% of all reported HIV cases in MSM in 2010-2011.

A majority (57%) of all HIV cases in MSM were infected in Sweden. Of all domestic HIV cases, the MSM group accounts for the largest proportion, about 50%. However, the trend over the last few years has been positive, since the number of domestic HIV cases in MSM has decreased by 25 % since 2007. It is notable that 34% of the domestic cases reported in MSM in 2010-2011 were foreign-born. By the end of 2011, MSM accounted for 31% of all people living with HIV in Sweden.

Self-reported data on HIV status in the national MSM internet survey from 2006 and 2008 and the Swedish results from the European EMIS study indicate that HIV prevalence among MSM in Sweden is about 3-6% (see indicator 1.14). Only 42% of the MSM participating in the EMIS study reported they used a condom the last time they had anal intercourse with a male partner (see indicator 1.12). However, if condom use in MSM is looked at more specifically, the last time they had anal intercourse with a *non-steady* partner the rate of condom use was higher, about 80% [5].

Injecting drug users

Fewer cases were reported among injecting drug users (IDU) in 2010-2011 compared to 2008-2009, as 24 cases were reported in 2010 and only 14 cases in 2011. Although the number of reported cases among injecting drug users has been relatively low in the past two years, needle-syringe programmes still only reach some Swedish IDUs. By the end of 2011 IDU accounted for 7% of people living with HIV in Sweden.

Prevalence data based on IDUs tested in remand prisons in Gothenburg and Stockholm in 2009 and 2010 show HIV prevalence varying between 5 and 9% (see indicator 2.5). The needle-syringe programmes in Skåne County have had a positive impact in preventing new HIV cases in the region. No new HIV cases were found among the participants in 2010-2011.

Available non-representative data on risk behaviours in the IDU population indicate high risk behaviour in this group with 65% reporting that they used sterile injecting equipment the last time they injected (see indicator 2.3.), and only 8% reported they used a condom during their last sexual intercourse (see indicator 2.2).

Mother-to-child transmission

During the period 2010-2011, 41 HIV cases infected by mother-to-child transmission (MTCT) were reported, all but two in immigrants infected prior to arrival in Sweden. Four known cases of MTCT of HIV have occurred in children born in Sweden since 2000.

Blood transfusion

Since 1985 all blood donated in Sweden has been screened for HIV and since 1986 no HIV transmission through blood transfusion in Sweden is known to have occurred. About 250 000 persons are active blood and plasma donors in Sweden, and over the last ten years about 40 000 people per year have registered as new blood donors. On average one case (0-2 cases) of HIV has been detected per year during the last five years in this screening programme.

AIDS

Between 1985 and 2005 both HIV and AIDS cases were subject to mandatory reporting in the surveillance system. Since 2005 AIDS, as well as HIV/AIDS-related deaths, has only been reported as additional information (non-mandatory) in completing the HIV notification. Due to the non-mandatory reporting system for AIDS and HIV/AIDS-related deaths these complications are probably underreported. Up to December 2011 a total of 2 428 HIV cases had also been reported as AIDS cases and 2 131 out of all HIV cases had been reported as deceased.

After a peak of reported AIDS cases in 1995, the number of reported AIDS cases per year has stabilised. During the previous decade the average number of reported AIDS cases per year was 60 cases, and in 2010-2011 about 50 AIDS cases were reported per year. The decline in new AIDS cases in Sweden after 1995 is an effect of universal access to antiretroviral therapy (ART) since 1996 for diagnosed patients in need of treatment. Among reported AIDS cases, about two-thirds are reported in migrants mainly infected prior to arrival in Sweden.

III. National response to the HIV epidemic

General response

HIV testing

HIV testing is free of charge in Sweden under the terms of the Swedish Communicable Disease Prevention Act (SFS 2004:168). Anonymous HIV testing, if requested, is sanctioned by law. Voluntary Counselling and Testing (VCT) for HIV is available throughout Sweden, and is mainly offered in the primary health care centres in the municipalities and in STI clinics, infectious disease clinics and gynaecological clinics in public hospitals. Further, contact tracing/partner notification is mandatory for all clinicians 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 are obliged to undergo HIV testing under the Communicable Disease Prevention Act (SFS 2004:168), which also states that anyone who suspects that he or she may be infected with HIV should undergo HIV testing.

The rate of HIV testing in the general population is low: recent data indicate that only about 11% of women and men aged 15-49 were tested in the past 12 months and know their results (see indicator 1.5). However, looking specifically at the MSM population, the EMIS survey shows that 31% of the participating MSM had an HIV test in the past 12 months and know their results (see indicator 1.13). Data covering IDUs in remand prisons in Gothenburg and Stockholm indicate that 38% of the IDUs had an HIV test in the past 12 months and know their results (see indicator 2.4).

Increasing testing in key populations and consequently being able to improve earlier diagnosis remains a challenge. About 60% of all HIV patients diagnosed in 2011 were late presenters, meaning that they were diagnosed at a time when treatment is already recommended (CD4 <350 at time of diagnosis) (see indicator EUR II). The majority of these patients were heterosexual immigrants, but late presenters exist in all the different key populations. A study including 100 patients diagnosed in Sweden between 2009-2010 describes late presenters per transmission route. Out of all patients 69% were late presenters (CD4 <350). Out of all late presenters 70% were immigrants from non-European countries out of which 57% had lived more than one year in Sweden. These immigrants had the highest overall risk of being diagnosed late (37/45, 82%) followed by IDU's (3/5, 60%), heterosexuals from the EU (7/12, 58%) and MSM (14/28, 50%) [6].

HIV screening

There are no population-based or key population-based screening programmes for HIV testing in Sweden, except the requirement for repeated HIV testing every six months for IDUs who are active in the needle-syringe programmes. However, all blood donors are universally screened for HIV both before their first donation and, if approved as donors, 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, the health care system should offer all pregnant women HIV testing which is performed as an opt-out routine.

Further, the Health and Medical Care for Asylum Seekers and Others Act (SFS 2008:344) states that county councils are to offer a health examination to individuals newly arrived in Sweden who are covered by this law. This includes a health interview, laboratory tests including voluntary screening for HIV and other examinations when necessary. The examination 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. However, the proportion of asylum seekers offered a health examination upon arrival in Sweden is low. In 2010, the proportion of asylum seekers who had undergone a health examination was as low as 42%. There are considerable differences between different parts of the country with respect to the proportion of asylum seekers undergoing a health examination [7].

Care, treatment and support

Any person who is legally present in Sweden and needs ART has access to treatment. Around 98% of all relevant patients receive therapy and the remaining 2% are mainly people who live with drug addiction and are unable to maintain adherence to ART. The cost of the full treatment is covered by the national health insurance scheme and is estimated to be around SEK 100 000-120 000 per year per patient. In December 2011 5 016 (2 556 men and 2 359 women, aged 15 years and older, and 101 children aged 14 years and younger) were receiving ART, approximately 80% of all the people living with a known HIV infection in Sweden.

According to current recommendations in Sweden, treatment for an asymptomatic adult infected with HIV should be started before their CD4 cell count falls 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. All Swedish patients are monitored in InfCareHIV, a medical decision support and quality register for Swedish HIV care, to ensure high quality of care [8]. One remaining challenge is that the proportion of patients who are diagnosed at a time when treatment is already recommended (<350 CD4 cell counts) is as high as 60% (see indicator EUR II).

The Swedish Communicable Disease Prevention Act (2004:168) gives the health care system and especially the treating physician an important role in supporting

persons living with HIV. The psychosocial support offered should ensure the patients and next of kin the opportunity to live as normally as possible with the infection. Further, SMI allocates almost 50% of NGO funding to NGOs that work on support to and human rights for people living with HIV.

Stigma and discrimination

One of the interim objectives in the National Strategy for HIV prevention states that knowledge about HIV and what it is like to live with the disease should be improved in the public sector, in working life and in society as a whole. One intervention to meet this objective started at World Aids Day in 2011 when SMI, together with the main NGOs, started a Facebook campaign. Two persons living with HIV and one as a family member write about their lives on Facebook, making it possible for individuals to follow their situation and to interact with them..

Sweden has a foundation of anti-discriminatory laws and regulations in the Discrimination Act (SFS 2008:567), which prohibits discrimination of people on the grounds of sex, transgender identity or expression, ethnicity, religion or other beliefs, disability, sexual orientation or age. A person who considers himself or herself to be discriminated against may report this to the Equality Ombudsman, a government agency responsible for investigating complaints of discrimination. Few cases of discrimination connected to HIV have been officially reported. There is a strong need for more knowledge about the life situation of people living with HIV in Sweden, including stigma and discrimination. A review of international studies has been done and will be published in 2012. Further, a survey targeting people living with HIV is planned to be conducted in 2013.

Response targeting specific key population at higher risk of HIV exposure

Injecting drug users

The National Strategy for HIV prevention identifies IDUs as one key population at higher risk of HIV exposure. Epidemiological and behavioural surveillance, promotion of voluntary counselling and testing and prevention of hepatitis B and C in this group is of importance, as well as offering opioid substitution therapy to those in need. The strategy also recognises the need for improved knowledge about HIV as well as stigma and discrimination in professions working with IDUs.

Studies on prevalence regarding problem drug use (PDU) have been undertaken sporadically in Sweden. The latest case-finding study dates back to 1998, with an estimated population of 26 000 PDU individuals. The most recent study from 2007 suggests a slight increase with an estimated population of 29 500 PDU individuals [9]. Stockholm, Skåne and Västra Götaland, the three counties in Sweden with the highest populations, account for 22%, 15% and 18% respectively of the total PDU population. The PDU rate for 1998 was estimated to be 2.9 per 1000 population compared to 3.2 per 1000 population in 2007. Various studies suggest that the IDU population accounts for between 70 and 90% of the PDU population.

About 3,700 IDUs were on substitution treatment in 2011, which is about 50% of the total number of estimated opioid users. Official needle-syringe programmes are currently only ongoing in one county; Skåne. In 2011 about 28-37% of the IDUs in Skåne participated in a needle-syringe programme. 214 needles and syringes were distributed per participating IDU (see Indicator 2.1).

Key national initiatives 2010-2011

SMI is in the process of developing a national action plan for HIV/STI prevention targeting IDUs. A workshop was arranged by SMI in 2010 involving participants from NGOs, health care institutions, scientists and various relevant local and governmental agencies to form a framework for the action plan which is scheduled to be launched in late 2012.

In early 2011 the NGO National Association for Aid to Drug Abusers, RFHL, finished a three-year project funded by SMI. The project aimed at educating detainees as well as personnel within the institutions of the National Board of Institutional Care. The National Board of Institutional Care (known in Swedish as Statens institutionsstyrelse), is a government authority which runs individually tailored compulsory care for young people and for adults with substance abuse problems in Sweden. The project focused on information about the risk of contracting hepatitis B, C and HIV infection if practising unsafe injections or unsafe sex. A peer-to-peer model was used, meaning that the information was given by a former IDU. The project was successful and discussions are now ongoing on how to use this model to an increasing extent in preventive work targeting IDU and IDU at risk of contracting hepatitis B, C and HIV infection.

In late 2011 Karolinska Institutet, together with SMI, conducted a study on the attitudes of County Medical Officers (CMOs) to needle-syringe programmes. Conclusions drawn from the study show that the CMOs have a positive attitude towards needle-syringe programmes.

Key regional initiatives in 2010-2011

In 2010 a new needle-syringe programme was launched in Helsingborg Municipality. In addition, a political majority decision was taken at both county council and municipality level to start a needle-syringe programme in Stockholm in 2012. For the time being, only individuals aged 20 or over can participate in the needle-syringe programmes despite evidence from studies suggesting that the median age in Sweden for the first narcotics injection is 19 [10, 11]. New needles and syringes can normally be distributed only in exchange for used ones.

Men who have sex with men

The National Strategy for HIV prevention argues that preventive measures aimed at MSM should be given high priority. Sex between men accounts for about half of all endemic HIV cases reported annually in Sweden, and the prevalence of HIV in this group is many times higher than in the general population. The reported incidence of STIs such as syphilis and gonorrhoea is also higher among MSM.

Key national initiatives 2010–2011

Internet-based intervention is essential when communicating safer sex information to MSM. SMI supports several initiatives in this area, for example the website “Sentry.nu” with current information, articles, videos and news about HIV and other STIs for MSM. This website is connected to the Internet community “Qruiser.se”, the largest Swedish gay community, which has more than 100 000 members.

Sweden took part in and supported the pan-European MSM Internet survey EMIS in 2010. More than 3 000 Swedish MSM in the 15–79 age group responded to the questionnaire about knowledge, attitudes, needs and sexual behaviour with regard to HIV and STI transmission. The questionnaire incorporated items from the national Swedish MSM survey that was carried out in 2006 and 2008. Researchers from Malmö University have analysed the Swedish data from EMIS, and a national report will be published by SMI in 2012. According to the EMIS survey 59% of the MSM who answered the questionnaire were reached with HIV prevention programmes, compared with 54% in 2008 according to the national MSM survey (see Indicator 1.11).

SMI is in the process of launching a national action plan for HIV/STI prevention targeting homo- and bisexual men and other MSM. It will be published during the first half of 2012. The development process of the plan has involved participants from NGOs, health care institutions, scientists and various local and governmental agencies. The plan will be a guideline for the work at national and regional levels during the period 2012–2016 in line with the aims of the National Strategy for HIV prevention. It will serve as a framework and guidance for follow-up, evaluation, development and improvement of efforts and should particularly strengthen efforts to prevent HIV infection and other STIs among MSM. The action plan will also form the basis for SMI’s priorities for prevention efforts targeting MSM and the allocation of funds to the various stakeholders such as NGOs and health-care providers within the county councils.

In November 2011 SMI, with grants from the European Commission (EAHC), organised the conference *FEMP 2011 in Stockholm - The Future of European Prevention among MSM*. It was the first European conference ever on HIV/STI prevention targeting MSM with the aim of bringing together all main actors in the prevention field targeting MSM in both Western and Eastern Europe: government agencies in healthcare, disease control and prevention with NGOs targeting MSM and the research community, as well as representatives from commercial businesses targeting the gay community. About 500 persons from 37 different countries from all parts of Europe as well as the United States and Australia attended the conference. A conference report will be published by SMI in spring 2012 with the aim of establishing a common knowledge base shared by all actors [12].

A new group intervention project – COMPASS – for young gay, bisexual and transgender people is presented in chapter IV under “Best Practices”.

Key regional initiatives 2010–2011

Through the distribution of financial resources and in cooperation with the county councils, SMI indirectly supports the work of various organisations and preventive efforts targeting MSM at the local and regional levels. Safe sex information and condom and lubricant distribution targeting MSM are channelled mainly through local outreach initiatives by local NGOs, e.g. the Sexperts (www.sexperterna.com) developed by the Swedish Federation for Lesbian, Gay, Bisexual and Transgender Rights (RFSL) in Stockholm. The Sexperts target MSM with peer-to-peer activities both in local gay clubs in Stockholm and through Internet gay communities and chat rooms with an evidence-based peer-to-peer education method.

RFSL has initiated a nationwide programme for LGBT certification of societal institutions such as youth clinics and STI clinics, thereby improving MSM competence in the health care system.

Some local initiatives have been taken to improve accessibility of testing among MSM. In 2011 a pilot project, Check-point Skåne, started in Malmö, a community-based drop-in services for rapid testing of HIV and counselling targeting MSM in the south of Sweden. The service is run by the RFSL counsellors in Skåne County. Similar community-based drop-in rapid testing services targeting MSM are for the time being also available in Stockholm, where they are run by the NGO Noaks Ark in co-operation with Venhälsan – the gay men's health clinic.

Immigrants

Sweden has a population of 9.5 million, and approximately 1.4 million (15%) were born outside of Sweden and almost 20 % have a foreign background (born abroad or two parents born outside Sweden) [13]. The numbers of asylum seekers arriving in Sweden have for many years been approximately 30 000 per year, and Sweden is one of the top recipient countries in Europe. During the reporting period most asylum seekers came from Afghanistan and Somalia, and a majority of immigrants arriving on the basis of family ties with Swedish citizens came from Thailand and Iraq. The effect immigration has on the HIV epidemic in Sweden depends to a large extent on which part of the world the immigrants come from, countries with a generalized HIV epidemic or not.

Key national initiatives in 2010-2011

During 2011 SMI together with some other authorities, organisations and universities made an application to the European Refugee Fund (ERF). A grant was accepted for a project aiming at improving the structure and cooperation in relation to health examination for asylum seekers upon arrival in Sweden. The project will begin in January 2012.

New national regulations and guidelines on health examination of asylum seekers and others (SOSFS 2011:11) from the National Board of Health and Welfare (NBHW) came into effect on 1 January 2012. The regulations highlight the importance of ensuring both physical and mental health of the asylum seeker. The health examination should include testing based on the needs of the asylum seeker

and the epidemiological situation in the country/countries where the asylum seeker has lived or stayed.

The NBHW has highlighted to the government the general poor and risky health and social conditions under which undocumented migrants are living in Sweden. A government inquiry (SOU 2011:48) in May 2011 proposed that all asylum seekers and undocumented migrants in Sweden should be given access to subsidised health care on the same terms as Swedish citizens. Today undocumented migrants only have access to emergency medical care if they can pay for it. The number of undocumented migrants in Sweden is estimated to be between 10 000-35 000.

The NBHW has published a literature review based on peer-reviewed articles on sexual vulnerability and risk situations in connection with migration in order to gain a better understanding of the phenomena and the needs for preventive methods in this group [14].

During 2011 an extended literature review was conducted by SMI on the overall theme of migration and prevention with a focus on sexual health. This study will be published in 2012.

People travelling abroad

The National Strategy for HIV prevention identifies people travelling to and from countries with a generalized HIV epidemic as a key population at higher risk of HIV exposure. Studies indicate that people residing in Sweden but working and travelling in the long term abroad demonstrate higher risk factors than the average population [15]. Studies and epidemiological data also indicate that travellers take sexual risks abroad [16, 17]. Risk alcohol and drug use, widespread sex tourism and poorly developed travel health sectors are among the possible factors explaining the insufficient perception of risk among travellers [28]. Recent research shows that there are strong and increasing bonds between Sweden and a few specific countries such as Thailand in terms of Swedish residents actively searching for a partner abroad [19]. Further, African immigrants residing in Sweden tend to become infected while visiting their home countries with a higher HIV prevalence [14]. All in all, travellers are a heterogeneous group, and prevention work targeting this group is complex and needs to be further explored.

Key national initiatives

In late 2011 SMI funded several research projects at Lund University and Karolinska Institute studying travel habits in different key populations and sexual risk taking. The studies will be conducted in 2012-2013.

Persons buying and selling sex

Estimates of the number of people who buy and sell sex in Sweden vary widely and are hard to confirm since the practice is mostly hidden and initiated primarily through the Internet or by telephone. Although street prostitution does occur it is assumed to account for only a fraction of total prostitution. Stockholm Police

estimate a ten-year decrease from 80-100 to 10-15 women selling sex on the streets regularly [20].

Annual reports from Swedish social workers who meet buyers and sellers of sex indicate that the number of Swedish men who pay for or give other than a monetary form of compensation for sex is increasing. The increase seems to be due to purchase of sex when travelling to places where the sale of sexual services is common rather than purchase of sex within Sweden [21]. HIV and STIs are often endemic in these destinations.

Key national initiatives 2010-2011

In order to address the knowledge gap with regard to prostitution, the Swedish Government adopted a national action plan aimed at combating prostitution in Sweden and human trafficking for sexual purposes for the period 2008-2011 [22]. All major government actors have contributed to this work. SMI has had no specific responsibilities in the action plan, and none of the reported remits focus entirely on HIV/STIs. SMI has nevertheless been active in the work of developing methodological training material for staff (health care, social services, youth clinics and sheltered housing), which includes information on HIV and other STIs.

The follow-up of the national action plan was done in late 2011 and showed that 19 of 21 counties now have collaboration groups for combating prostitution/trafficking. Social services, the police, the public prosecution service and the immigration service are collaborating. However, the link to health care still needs to be strengthened.

Youth

Heterosexual transmission of HIV in young people within Sweden is very rare. However, Chlamydia is highly endemic among youth and studies show that although people in this age group know how to prevent STI transmission high risk taking is widespread, and it therefore continues to be important to target young people with HIV/STI prevention.

Key national initiatives in 2010-2011

In 2011 a new national curriculum was introduced in the Swedish school system. With the aim of improving sexual health education, the new curriculum integrates sexual health education into all disciplines more than in earlier practice. There is still no mandatory training for teachers in sexual health education, but the Swedish National Agency for Education has been tasked with training qualified teachers in issues of sexuality and personal relations, including HIV.

In 2011, the UngKAB study on Sexuality and Health among young people aged 15-29 years, carried out in 2009, was published [23]. The overall aim of the study was to generate a scientific baseline concerning sexual health among adolescents and young adults. In 2011 SMI took the initiative for and financed ten methodological seminars to which professionals from all parts of Sweden were invited to discuss the results of the UngKAB study. A total of about 600 medical

doctors, midwives and social workers working in the field of sexual health participated in the seminars, discussing how to improve the HIV/STI preventive work directed at adolescents and young adults in Sweden.

Two information interventions targeting youths and young adults were launched during the summers of 2010 and 2011 and on World Aids Day 2011. The information intervention has been mostly taken place on social media such as Facebook. The first one had an awareness theme, to make young people aware of the numbers of indirect sexual contacts and their sexual network (www.knulltradet.se). The other intervention promoted condom use as being a luxury way of having sex (www.knulldeluxe.se).

During 2010 the Coordination of HIV and STI Prevention Unit was involved in a government remit to prepare and organise a Nordic conference focused on unwanted pregnancies. The conference took place in November 2010. The conference highlighted the importance of bringing the issues of disease control (condom use) and unwanted pregnancies (contraceptive use) together to meet the needs of young people in prevention of HIV/STIs and sexuality and health. Results from UngKAB09 indicate that the main reason for not using condoms is the use of other contraceptives.

IV. Best Practices

Many good projects were undertaken for the period 2010-2011. In this section we will focus on two successful projects.

Motivational Interviewing (MI)

Motivational Interviewing (MI) is an evidence-based and widely used method. It has been used in behavioural interventions for a wide variety of problems, ranging from substance use to reducing risky behaviours and increasing client engagement in treatment. MI is focused on resolving the ambivalence that might be an obstacle to change.

A project supported by SMI using the MI method was carried out in one county council in Sweden during 2010 -2011. The aim of the project was to study MI as a risk-reducing method concerning sexual risk-taking. The researchers developed and evaluated tools to facilitate MI-based counselling for reducing high-risk sexual behaviour. The MI counselling was offered to patients who had had at least four sexual partners during the previous year and were seeking STI treatment.

A structured manual was developed containing 14 questions. Patients attending a drop-in STI service were offered 20-30 minutes of MI-based risk-reducing counselling. To ensure high quality of intervention, the MI skills of the counsellor were assessed using the Motivational Treatment Integrity Coding System (MITI 3.0.). At baseline 12% of the men and 14% of the women had a genital Chlamydia infection. 12 months after the intervention none of the patients receiving MI-based counselling was re-infected (Data was presented at the 19th meeting of the International Society for Sexually Transmitted Diseases Research in Québec, Canada, in July 10 to 13, 2011 but are not yet published). Further studies are ongoing to explore the effect of the intervention. The structured manual is being spread to other STI clinics and youth clinics in other counties.

KOMPASSEN – The COMPASS

The Swedish Federation for Lesbian, Gay, Bisexual and Transgender Rights, Youth Section in Stockholm is an NGO that, with support from SMI, has developed the COMPASS. The COMPASS is a group intervention for young gay, bisexual and transgender people with the aim of strengthening participants and helping them develop strategies for dealing with difficult situations relating to sex and identity. The material can also be used in groups that are not explicitly LGBT-identified. The method has an HIV-preventive purpose, and the goal is to reduce negative behaviour and increase self-esteem in participants. The COMPASS method is based on theories of social learning, and the focus is on identifying and reinforcing positive behaviour of participants. Another important element is highlighting the role of emotions in risky situations.

An important tool in the method is 15 short films that serve as a basis for exercises and discussions. In the films we meet young LGBT people in everyday situations at school, at home with their families or with friends. Based on the films, participants analyse difficult situations to find ways of dealing with them and practise strategies in a safe environment.

V. Major challenges and remedial actions

Progress made on key challenges reported in the previous UNGASS report

Challenges reported in the previous UNGASS report concerned an observed increasing trend in HIV incidence in MSM, stigma and discrimination in people living with HIV, low uptake of health examinations in family reunification migrants, development of a national action plan targeting MSM and monitoring of the implementation of the action plan targeting youths and young adults (Chlamydia national action plan) as well as improvement of the monitoring system for IDUs.

Since 2010, there has been an ongoing discussion on how to improve monitoring of stigma and discrimination among HIV positive individuals. A plan was adopted during the autumn of 2011 which will involve researchers in conducting a study among people living with HIV in Sweden. A review of international studies has been done and will be published in 2012.

In order to meet the HIV and STI prevention needs in the MSM population a national action plan targeting MSM is soon to be finalised. A broad group of stakeholders started the work in 2008. Further, an EU-sponsored conference, The Future of European Prevention among MSM, (FEMP) was hosted by SMI in November 2011. The overall objective of the conference was to challenge and change the continuously increasing trends for HIV and other STIs among MSM in Europe. Sweden also participated in the European MSM internet survey, EMIS, in 2010. A national report will be published in 2012.

SMI, together with the Migration Board and other authorities, has applied for and received an EU grant from the European Refugee Fund with the aim of developing and improving the structure and co-ordination of health examinations and information offered to asylum seekers arriving in Sweden. This grant will last until 2014.

A questionnaire survey on sexuality was conducted at the end of 2009 among adolescents and young adults– UngKAB09 [23]. The survey focuses on the young people's knowledge, attitudes and experiences of sexuality. The survey results, which were published in January 2011, will be used as a basis for identifying and reinforcing the health-promoting work concerning matters of sexuality, i.e. actions to improve condom use and reduce risk behaviour among adolescents and young adults. The results have been disseminated by the researchers involved and SMI through conferences in all parts of the country, involving county councils officials and members of NGOs. The result will be useful as a baseline in evaluating the national action plan targeting adolescents and young adults (Chlamydia national action plan) in 2014.

Two national information campaigns targeting youths and young adults have been launched during 2010-2011. These campaigns have mainly used social media, such as Facebook, to reach the target group.

Challenges faced throughout the reporting period (2010-2011)

In January 2010 the Coordination of HIV and STI Prevention Unit underwent reorganisation and were relocated within the National Board of Health and Welfare (NBHW). In the spring of 2010 the unit was involved in a government remit to prepare and organise a Nordic conference focused on unwanted pregnancies. The remit involved two Programme officers, nearly full-time, until the conference took place in November 2010. In July 2010, in accordance with a government decision, the unit was again relocated, this time from the NBHW to the Swedish Institute for Communicable Disease Control (SMI). The unit's responsibilities are still to implement the National Strategy for HIV prevention and during the autumn of 2011 responsibility for national epidemiological surveillance of HIV, hepatitis B, C and D, HTLV I and II, Chlamydia, syphilis and gonorrhoea infections was also allocated to the unit. Additional work in transferring human and physical resources and responsibilities is time-consuming and slowed down the overall work of the unit during 2010 and 2011. The work on action plans in accordance with the National Strategy for HIV prevention has consequently slowed down and systematic visits to NGOs have not been undertaken as planned.

The establishment of a research-based second generation surveillance (SGS) system is still a challenge, although surveys on knowledge, attitudes and behaviours (KAB survey) have been done targeting adolescents and young adults and MSM. Further, Sweden participated in the European MSM survey EMIS. However, a robust SGS system monitoring trends in migrants, IDUs, people living with HIV, travellers and sex workers is still lacking.

The ongoing transmission of HIV among MSM in Sweden remains a challenge, although a decrease has been observed in numbers of reported new cases in the last two years. Hopefully the outcome of the FEMP conference and the MSM national action plan will improve work at local level and among NGOs to prevent HIV transmission among MSM in the future.

There is still a lack of systematic prevention efforts targeting IDUs in Sweden. In 2010 and 2011 official needle-syringe programmes were only running in three municipalities in Skåne County in the south of Sweden. However, a decision to start a needle-syringe programme in Stockholm was taken in 2011, and several other county councils are in the process of deciding on whether to start needle-syringe programmes or not.

There is a strong need for more knowledge about the life situation of people living with HIV in Sweden, including stigma and discrimination. A survey targeting people living with HIV is planned to be conducted in 2013.

Many NGOs supporting immigrants need to be strengthened in order to reach larger groups of their members. An evaluation of NGO activities demonstrated that many ethnic and other NGOs that are funded by the national HIV grant contribute to an increase in understanding and willingness to test for HIV among newly arrived immigrants in Sweden. However, these efforts are not sufficient to reach the many migrants coming from countries with a generalized HIV epidemic and are not evenly spread across the country. This is an important challenge for the next coming years.

Increasing condom use among adolescents and young adults remains a challenge. Despite the fact that young people have good knowledge and report a positive attitude to condom use in surveys, there must be continuous efforts to promote condom use. The issues of disease control (condom use) and unwanted pregnancies (contraceptive use) have to be brought together to meet the needs of young people in prevention of HIV/STIs today.

Approximately 60% of newly diagnosed HIV patients are late presenters, meaning that they already meet the criteria for starting antiretroviral treatment at the time of diagnosis. Increased testing in all key populations for earlier diagnosis of HIV is an important challenge for the next coming years.

Concrete remedial actions planned to ensure achievement of agreed UNGASS targets

The following actions are so far planned for the period 2012-2013 at the National Coordination of HIV and STI Prevention Unit at the Swedish Institute for Communicable Disease Control:

The monitoring of stigma and discrimination will be improved, alongside activities aimed at minimising such conditions for people living with HIV. A survey targeting people living with HIV is planned to be conducted in 2013. A questionnaire will be developed with the help of many stakeholders, researchers and NGOs representing people living with HIV. The study will investigate how activities aimed at minimising stigma and discrimination in people living with HIV can be improved.

The national action plan for MSM will be finalised and implemented.

The work with the EU project focusing on health examinations of asylum seekers will start and continue.

A national action plan will be developed for IDUs, and the monitoring mechanisms for IDUs will be strengthened. A second generation surveillance (SGS) system will be developed in collaboration with the needle-syringe programmes that are currently running, and the SGS system that is currently ongoing in a remand prison in Stockholm will be promoted to extend the programme and involve more custodial facilities.

New technology, webinars, will be used in order to disseminate better and reach relevant stakeholders with information, e.g. information on evidence-based

interventions to different types of organisations working with prevention. Webinars are live seminars broadcast on the Internet where participants have an opportunity to interact with each other.

The research-based second generation surveillance systems covering migrants, IDUs, people living with HIV, sex workers and travellers is not complete and will be further developed during the period.

The unit will continue to allocate resources to NGOs, and the allocation process should be of high quality and transparency.

Information interventions will be initiated in coordination and collaboration with the county councils and NGOs. National information campaigns targeting adolescents and young adults will be launched during the summers and for World Aids Day.

The annual report to the Government with an analysis of present work and suggestions for the next three years will be delivered in June 2012.

VI. Monitoring and evaluation environment

Overview of the current monitoring and evaluation system

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 for HIV prevention and national action plans. Monitoring and evaluation play an important part in understanding whether designated targets are reached and whether prevention work is effective or not. The current monitoring system in Sweden is extensive and dispersed among a large number of actors, government bodies, research institutions and NGOs. Epidemiological data are collected by SMI. As a complement, SMI supports a number of large national surveys to collect data on knowledge, behaviours and attitudes among the general population and key populations. The data collected are used to monitor the epidemic and evaluate preventive efforts in line with the National Strategy for HIV prevention.

Epidemiological surveillance of HIV

The epidemiological surveillance of HIV in Sweden is performed by SMI in collaboration with the county medical officers (CMO). HIV has been notifiable in Sweden since 1985, and AIDS was a notifiable condition between 1983 and 2005. Both the treating doctor and the diagnosing laboratory are required to report a diagnosed case to SMI and the CMO. An electronic reporting system known as SmiNet (www.sminet.se) is used. HIV cases are reported with an anonymous code which is not unique, and one person might be reported several times. Although data are continuously cleaned at county level, duplicates might occur in the database.

National KAB-surveys and second generation surveillance studies

National knowledge, attitude and behavioural (KAB) surveys and second generation surveillance studies are briefly described below.

Youth

UngKAB: Knowledge, attitudes and acts in the area of sexuality. A Study on Sexuality and Health among young people aged 15-29 years, 2009/2010, published 2011 [23].

The overall aim of the study was to generate a scientific baseline concerning sexual health among adolescents and young adults. It applies a broad socio-sexual perspective focusing particularly on HIV, other STIs and unwanted pregnancies. The study, with over 15 000 respondents, is the largest sexual behaviour study of its kind ever carried out in Sweden. The study was conducted with a mixed-model design. The respondents were of two types: a representative sample of the general population of the relevant age groups in Sweden, and a self-selected sample from online communities. Due to the low response rate in the representative sample

(24%) it was difficult to generalise the results to the whole population group of young people. The study was published in April 2011, and the results have been well used at local, regional, national and international levels by academics, government/institutional organisations and NGOs. A summary of this study, focusing on the methods used, has been translated into English [24]

The Youth Barometer (Ungdomsbarometern): The barometer of knowledge and attitudes of the youth/young adults. 2010/2011

This study is carried out annually, through a self-selected sample on the Internet. The study is advertised through a number of popular young people's websites. The questionnaire had open access on the Internet during a month and approximately 5000 respondents aged 15 to 24 completed the part containing questions about sexuality [4].

Men who have sex with men

The European MSM survey, EMIS.

In 2010, Sweden was one of the countries participating in the European Internet survey EMIS. The Swedish report will be published in 2012.

The national MSM survey

The MSM study survey covers knowledge, needs, attitudes, sexual behaviours and self-reported HIV and STI status and testing among the MSM population. It was conducted through a self-selected survey on the Internet in 2006 and 2008. The next study is planned to take place in 2013, or will, if possible, be integrated into the next EMIS survey.

Knowledge and attitudes about HIV in the general population

HIV in Sweden (Hiv i Sverige): Knowledge and attitudes about HIV, a population-based study in Sweden.

This study has been conducted every four years since 1987 in Sweden and is a large, broad survey concerning knowledge and attitudes about HIV. It targets the adult population, aged 16-44, with a sample of approximately 4000-6000 people. The latest survey was carried out in the autumn of 2011, using the methods of a mixed-mode study design: a representative postal survey part and a web-panel part. A report will be published in late 2012. However, due to the low response rate (25%) it will be difficult to generalise the results from the 2011 study to the whole population.

The quality of life of people living with HIV in Sweden

This survey is planned to cover the quality of life and experiences of discrimination and stigma among people living with HIV in Sweden. The survey will cover both adults and young people. The study design and planning for the study were done in 2011, and the study will be carried out in 2012/2013.

Injecting drug users

Swedish remand prison programme:

As a way of monitoring trends in risk behaviours in IDUs, a programme, Svenska häktesprogrammet, has been running in remand prisons in the two largest cities in Sweden, Stockholm and Gothenburg, and since 2011 has run in Stockholm only. In this programme nurses not only systematically test and vaccinate, they also provide risk reduction counselling to IDUs held on remand. In addition, the nurses conduct behaviourally oriented interviews targeting the IDUs' knowledge, attitudes and practices. As 80 % of all IDUs are estimated to pass through remand prisons over a three-year period this setting has been chosen for regular data collection regarding IDUs and risk behaviours. Preliminary data show that approximately 2,500 IDUs have participated in the programme, and 31 new HIV infections were diagnosed during the period 2002–2011.

The data currently collected in this programme are not representative of IDUs in Sweden. However, the programme will be promoted with the aim of involving more remand prisons in order to get more representative data.

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

A national action plan for monitoring and evaluation is needed, as it would clarify the roles of all the actors collecting information as well as helping to identify gaps and overlaps in the monitoring systems. Due to non-unique codes being used to notify new HIV cases, duplicates exist in the surveillance database, making the epidemiological surveillance of HIV in Sweden more difficult. Another important challenge is the observed decrease in response rate in national surveys, reducing the opportunities to generalise study results to a whole population group.

Remedial actions planned to overcome the challenges

A national action plan covering the monitoring and evaluation work is planned to be developed in collaboration with key actors. SMI will host a meeting in the spring of 2012, inviting Nordic colleagues from national agencies. At this meeting methodological issues and future collaboration will be discussed with the aim of developing surveys to collect relevant and representative data for monitoring and evaluation.

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Annex

International and domestic spending

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 EUR 16 million). This grant is designated for three areas; SEK 21 million to national NGOs, SEK 95 million to support the work in all counties and the three main metropolitan areas 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. The Swedish Institute for Communicable Disease Control distributes the funding according to government instruction. The funding is directed towards key populations.

Other domestic and international AIDS spending by categories and financing sources 2011:

	<u>Recipient</u>	<u>Amount</u>
SIDA	STD control including HIV/AIDS	SEK 332 387 887
SIDA	Social mitigation of HIV/AIDS	SEK 130 080 153
Swedish MFA	Global fund	SEK 600 000 000
Swedish MFA	UNAIDS	SEK 266 000 000
SIDA	Domestic / International research	SEK 31 000 000

The main focus of Sida's HIV/AIDS support is on prevention, where gender, human rights and youth are prioritized. Almost 80% of Sida's HIV/AIDS funding goes to sub-Saharan Africa, the worst affected region.

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