

**UNITED NATIONS GENERAL ASSEMBLY SPECIAL SESSION ON  
HIV/AIDS**

## **Country Progress Report 2008**

**Sweden**

<b>ABBREVIATIONS.....</b>	<b>3</b>
<b>ACKNOWLEDGEMENTS.....</b>	<b>4</b>
<b>STATUS AT A GLANCE .....</b>	<b>1</b>
NATIONAL INDICATOR DATA.....	2
OVERVIEW OF THE EPIDEMIC .....	4
<i>1 January 2006-30 October 2007</i> .....	5
<b>NATIONAL RESPONSE TO THE AIDS EPIDEMIC.....</b>	<b>7</b>
THE NATIONAL STRATEGY .....	7
LEADERSHIP AND COORDINATION.....	8
<i>The National Board of Health and Welfare</i> .....	8
<i>Mechanisms for the control of grants to county councils and city municipalities</i> .....	9
PREVENTION AND BEHAVIOUR .....	9
<i>Men who have sex with men</i> .....	11
<i>Injecting drug users</i> .....	15
<i>People involved in commercial sex</i> .....	18
<i>Young people and young adults</i> .....	20
<b>CHALLENGES AND REMEDIAL ACTIONS.....</b>	<b>25</b>
ORGANISATION AND LEADERSHIP .....	25
PEOPLE NEWLY ARRIVED IN SWEDEN.....	25
<b>MONITORING AND EVALUATION.....</b>	<b>26</b>
NATIONAL LEVEL.....	26
REGIONAL AND LOCAL LEVELS .....	27
<b>BEST PRACTICES.....</b>	<b>28</b>
THE HIV SCHOOL.....	28
WWW.SEXAKTUELLT.SE .....	29
THE MAIN THREAD – A HANDBOOK ON SEXUALITY AND PERSONAL RELATIONSHIPS AMONG YOUNG PEOPLE.....	31
<b>SWEDEN IN THE INTERNATIONAL WORK AGAINST HIV/AIDS.....</b>	<b>33</b>

## Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug User
KI	Karolinska Institutet
LAFA	Stockholm County AIDS Prevention Programme
LGBT	Lesbian, Gay, Bisexual and Transgender
MSM	Men who have sex with men
NBHW	National Board of Health and Welfare
NCPI	National Composite Policy Index
NGO	Non-Governmental Organization
RFSL	Swedish Federation for Lesbian, Gay, Bisexual and Transgender Rights
RFSU	Swedish Association for Sexuality Education
SEK	Swedish Crown
SIDA	Swedish International Development Agency
SMI	Swedish Institute for Infectious Disease Control
STI	Sexually Transmitted Infection
SW	Sex Worker
UNGASS	United Nations General Assembly Special Session on HIV/AIDS

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The following agencies, institutions and organisations have contributed to this report:

<b>Dalarna Research Institute</b>	Behavioural data, general population
<b>Karolinska Institutet</b>	Injecting drug users Epidemiological data
<b>Karolinska University Hospital</b>	Antiretroviral Therapy
<b>LAFA</b>	Young people and young adults
<b>Malmö University</b>	Men who have sex with men
<b>The Swedish Institute for Infections Disease Control (SMI)</b>	Epidemiological data
<b>The Socialmedicinska Häktesprojekt</b>	Injecting drug users
<b>The National Board of Health and Welfare, NBHW</b>	Coordination of the UNGASS report NCPI Part A
<b>The Spiral Project</b>	Sex workers
<b>Venhälsan</b>	Men who have sex with men

The following organisations participated in the work with the National Composite Policy Index Part B:

**HIV-Sweden**

**RFSL**

**RFSU**

**The Somali Health Team**

**Noah's Ark**

## Status at a glance

The reported number of diagnosed cases of HIV-infection in Sweden remained relatively stable between 1994 and 2002 with approximately 250 new cases each year. The number of new cases increased during the subsequent four years (2003-2006) to approximately 400 reported cases per year.

The HIV epidemic in Sweden has been influenced by the fact that a large proportion of the reported cases have been infected outside of Sweden. Most of these infections have occurred prior to immigrating to Sweden. The majority of those cases are believed to have become infected many years before the diagnosis is made. Infection from heterosexual contact has, since 1990, been the most common route of infection among the newly diagnosed. A relatively low fraction of those infected by heterosexual contact have been infected while in Sweden.

An increase in the number of people infected before arrival in Sweden has been observed during the period 2001-2005. The number of cases among injecting drug users has been observed to be higher during the period 2001-2007, when compared to the period 1996-2000. A small increase has also been noted among men who have sex with men and among heterosexual people infected in Sweden.

Other trends in recent years have included an increase in the incidence of Chlamydia infection, an increase in the number of abortions among young people, and stable but relatively low condom use. Such trends have necessitated measures to improve the work to prevent the spread of HIV, as they are indicative of high-risk sexual behaviour. Improved forms for collaboration and increased coordination are sought, in agreement with the "Three Ones" principle promoted by UNAIDS, namely:

- **One** agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners.
- **One** National AIDS Coordinating Authority, with a broad-based multisectoral mandate.
- **One** agreed country-level Monitoring and Evaluation System.

A new policy for the prevention of the spread of HIV, was adopted in December 2005, namely, the "National Strategy against HIV/AIDS and Certain Other Contagious Diseases", Government Bill 2005/06:60. This will be referred to here as the "National Strategy". This policy is now being implemented. The National Board of Health and Welfare, (NBHW) has received a clear mandate for the planning, coordination and monitoring of the strategy, and began its work in June 2006. A National Council for the Coordination of HIV Prevention has been formed, consisting of one chairperson appointed by the government and nine other members. The primary mandate of the council is coordination and monitoring. The members of the National Council represent the most important stakeholders in the response: authorities, municipalities, county councils and NGOs. The Unit for National Coordination of HIV Prevention is located at the NBHW. This body is the operative unit for planning, coordination, monitoring and management of a targeted government grant. New mechanisms have been developed to guide the work towards reaching the national objectives and the desired results.

## National indicator data

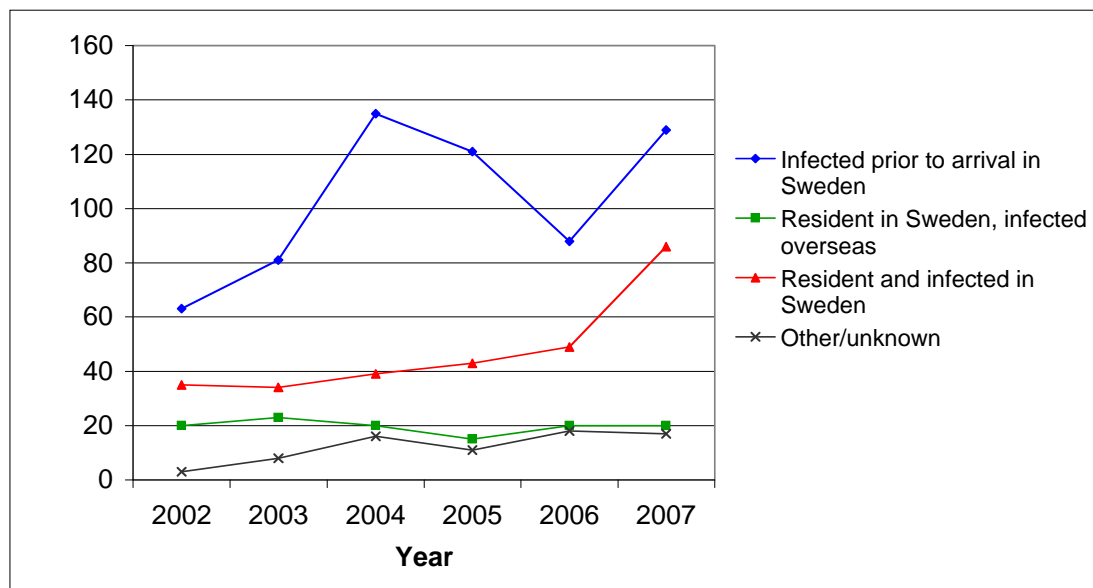
Indicators		Value	Comments
<b>National Commitment and Action</b>			
1.	Domestic and international AIDS spending by categories and financing sources		Data not available
2.	National Composite Policy Index		See annex
3.	% of donated blood units screened for HIV in a quality assured manner	<b>100%</b>	<u>Numerator</u> : nr. of donated blood unit screened for HIV: <b>568,314</b> <u>Denominator</u> : total number of blood unit donated: <b>568, 314</b>  <i>Data source: SMI</i>
4.	% of adults and children with advanced HIV infection receiving antiretroviral therapy	2006: <b>73,9%</b>  2007: <b>76,5%</b>	<u>Numerator</u> : 2006: <b>498</b> adults + <b>17</b> children, 2007: <b>577</b> adults + <b>15</b> children <u>Denominator</u> : 2006: <b>680</b> adults + <b>17</b> children, 2007: <b>759</b> adults + <b>15</b> children  The adults represent 65% of reported HIV positive adults; the children represent 60% of reported HIV positive children. Definition of AHI for adults: >350 CD4 cell count, AHI for children: 15% of total nr. of lymphocytes.  <i>Data source: Karolinska University Hospital</i>
5.	% of HIV-pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	2006: <b>96,9%</b>  2007: <b>95,8%</b>	<u>Numerator</u> : 2006: <b>31</b> , 2007: <b>23</b> <u>Denominator</u> : 2006: <b>32</b> , 2007: <b>31</b>  Data for 2007 incl. 1 Jan. – 1 Sept. Data from Stockholm that represents 65% of HIV positive pregnant women in Sweden  <i>Data source: Karolinska University Hospital</i>
6.	% of estimated HIV-positive incident TB cases that received treatment for TB and HIV		Not applicable
7.	% of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results		Data not available
8.a	% of SW that have received an HIV test in the last months and who know their results	34%  15/9-07 22/10-07	<b>Data not representative</b> <u>Numerator</u> : nr. of respondents who have been tested for HIV during the last 12 months and who know the results: <b>17</b> <u>Denominator</u> : nr. of SW in the sample: <b>50</b>  <i>Data source: The Spiral Project</i>
8.b	% of IDU that have received an HIV test in the last months and who know their results	83,6%	<b>Data not representative</b> <u>Numerator</u> : 133, <u>Denominator</u> : 159 <i>Data source: The HIV-bus</i>
8.c	% of MSM that have received an HIV test in the last months and who know their results		Data not available 41% (<1% do not receive test results)  <i>Data source: MSM- Survey 2006</i>
9.a	% of SW reached with HIV prevention programmes	50%	<b>Data not representative</b> <u>Numerator</u> : Nr. of respondents who replied yes to both questions: <b>25</b> <u>Denominator</u> : Total nr. of respondents: <b>50</b>  <i>Data source: The Spiral Project</i>
9.b	% of IDU reached with HIV prevention programmes	27,4%	<b>Data not representative</b> <u>Numerator</u> : <b>43</b> , <u>Denominator</u> : <b>157</b>  <i>Data source: The HIV-bus</i>
9.c	% of MSM reached with HIV prevention programmes		No data available
10.	% of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child		Not applicable
11.	% of schools that provided life skills-based HIV education in the last academic year		Data not available

Indicators		Value	Comments
<b>Knowledge and Behaviour</b>			
12.	Current school attendance among orphans and among non-orphans aged 10-14		Not applicable
13.	% 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		Data not available
14.a	% of SW who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	46%	<b>Data not representative</b> <u>Numerator:</u> Nr. of respondents who gave the correct answers to all questions: <b>23</b> <u>Denominator:</u> Total nr. of respondents who gave answers: <b>50</b>  <i>Data source: The Spiral Project</i>
14.b	% of IDU who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission		Data not available
14.c	% of MSM who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission		Data not available
15.	% of young women and med aged 15-24 who have had sexual intercourse before the age of 15	<b>18%</b>	<i>Data source: The Youth Barometer 07/08</i>
16.	% of women and med aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months		No data available 23% of women and men aged 16-44 had >1 partner in the last 12 months <u>Numerator:</u> <u>Denominator:</u>  <i>Data source: Herlitz</i>
17.	% of women and men aged 15-49 who had more than one sexual partner in the last 12 months reporting the use of a condom during their last sexual intercourse		Data not available
18.	% of female and male sex workers reporting the use of a condom with their most recent client	22%	<b>Data not representative</b> <u>Numerator:</u> Nr. of SW who reported that a condom was used with their last client in the last 12 months: <b>11</b> <u>Denominator:</u> Nr. of SW who reported having commercial sex in the last 12 months: <b>50</b>  <i>Data source: The Spiral Project</i>
19.	% of men reporting the use of a condom the last time they had anal sex with a male partner		Data not available  % MSM reporting the use of a condom the last time they had anal sex (the last month): 42,2%  <i>Data source: MSM- Survey 2006</i>
20.	% of IDU reporting the use of a condom the last time they had sexual intercourse	24,6%	<b>Data not representative</b> <u>Numerator:</u> 15, <u>Denominator:</u> 61 <i>Data source: the HIV-bus</i>
21.	% of IDU reporting the use of sterile injecting equipment the last time they injected	37,6%	<b>Data not representative</b> <u>Numerator:</u> <b>41</b> , <u>Denominator:</u> <b>109</b>  <i>Data source: the HIV Bus</i>
<b>Impact</b>			
22.	% of young women and med aged 15-24 who are HIV infected		Data not available
23.a	% of SW who are HIV infected		Data not available
23.b	% of IDU who are HIV infected	5,8%	<u>Numerator:</u> <b>31</b> <u>Denominator:</u> <b>534</b> The data from The Socio-Medical Remand Project is from 2006 only, since data from 2007 has not been controlled for double counting. Only active IDUs are included in the sample. <i>Data source: The HIV Bus, The Socio-Medical Remand Project</i>
23.c	% of MSM who are HIV infected		Data not available
24.	% of adults and children with HIV known to be on treatment 12 months after initiation of ART		Data not available
25.	% of infants born to HIV-infected mothers who are infected	<b>0%</b>	1999 – 1 October 2007  <i>Data source: Karolinska University Hospital, SMI</i>

## Overview of the epidemic

A total of 7,508 people living in Sweden have been reported infected with HIV up to and including 2006, 70 percent of those reported were men. Three routes of infection dominate: sexual intercourse between men, injecting drug use, and heterosexual intercourse. In Sweden, the two first routes of infection are most common, while most of the people infected by heterosexual activity are infected abroad, principally in high prevalence regions. The Swedish Institute for Infectious Disease Control (SMI) routinely monitor surveillance data on the country of transmission, which is important epidemiological information.

**Figure 1. Reported HIV cases the first six months 2002-2007, according to place of residence and place of transmission**



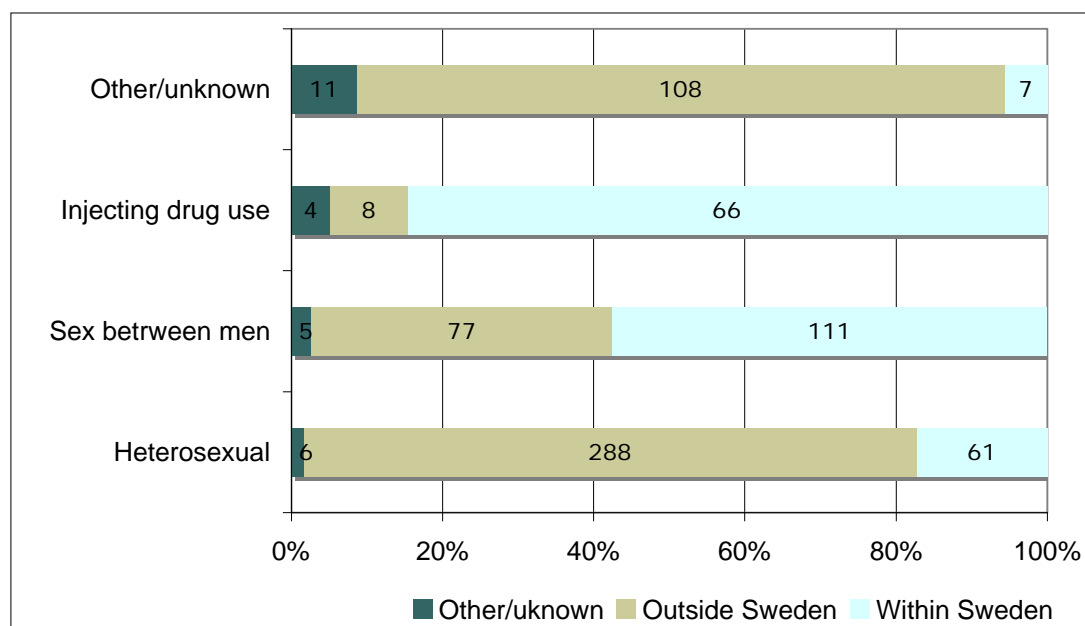
Source: *The Swedish Institute for Infectious Disease Control (SMI)*

In 2006, 390 cases of HIV-infection were reported. Of these, 96 (24.6%) had been infected through sexual contact between men, 195 (50%) had been infected through heterosexual contact, 35 (8.9%) through injecting drug use, and six (1.5%) through mother-to-child transmission abroad. A further 58 infections were reported as "unknown route", which would include infection mechanisms such as health care received abroad. In general, the average age of the reported cases is higher than that of other sexually transmitted infections. The average age at diagnosis for those infected by the three most common routes of infection (heterosexual infection, sex between men and injecting drug use) is 35-40 years. Few of the reported cases are young people. The majority of people under 25 that have been infected with HIV have been infected prior to their arrival in Sweden.

## 1 January 2006-30 October 2007

Between 1 January 2006 and 30 September 2007, 752 cases of HIV (466 men and 286 women) were reported to the Swedish Institute for Infectious Disease Control. The increase in the incidence of infection in Sweden that has been observed in recent years has continued. Figure 2 shows the distributions of the routes of infection for those infected abroad and those infected in Sweden.

**Figure 2 HIV-infections reported from 2006 up to and including September 2007, classified according to route of infection and place of transmission**



Source: The Swedish Institute for Infectious Disease Control (SMI)

### Sex between men

During this period, 193 (25.6%) cases were reported where sex between men had been specified as the transmission route. Of these, 103 stated that they had been infected in Sweden, 29 were resident in Sweden and infected abroad, and half of them reported having been infected in Europe. Most of those infected before arrival in Sweden were infected in Europe. The mean age was determined to be 39 years.

### Injecting drug users

Seventy-eight (10.4%) cases, 58 male and 20 female, were reported having been infected by injecting drug use. The greatest proportional increase occurred in this group. Sixty-five of those reported stated that they had been infected in Sweden and five in Europe. Information about the country of transmission was not available for eight cases. The region covered by Stockholm County Council provides 59 (76%) of the cases reported. The remaining cases are evenly distributed throughout Sweden. The mean age was 39 years.

### Infection by heterosexual contact

During the period, 355 (47.2%) cases of heterosexual infection were reported, 207 (58%) of them female and 148 of them male. Most of the cases of heterosexual

infection (81%), were stated to have been infected before arrival in Sweden. The mean age of those infected by heterosexual contact was 39 years.

### **Mother-to-child transmission**

The national screening programme for pregnant women offers testing to all pregnant women. Since 1999, there has been no known case in Sweden of a child born to a HIV-positive mother becoming infected. All reported 13 cases of mother-to-child transmission have taken place before arrival in Sweden. Eleven of the children were infected in Africa, one in Europe and one in South America.

### **Blood Safety**

A compulsory HIV test before each donation of blood was introduced in 1985. There are approximately 250,000 active blood donors, and a further 40,000 new donors are added each year. "New donor" is here used to denote people who register as a blood donor for the first time or who return to donating blood after an inactive period of at least five years. A total of 568,314 units of blood were donated and tested in Sweden during 2006. Two cases of HIV was found among the blood donors.

### **Estimated HIV prevalence**

There is no official estimate of the total number of HIV-infected persons (including undiagnosed cases) in Sweden. The Karolinska Institutet (KI) and the Swedish Institute for Infectious Disease Control (SMI) have estimated the total number of HIV-infected persons to be 4,790 in 2006 and 4,960 in 2007. The Communicable Diseases Act (2004:168) states that all persons, known to be infected with HIV, must have contact with a treating physician. The number of persons with such a contact has then been adjusted for an estimate of the number of persons who lack such a contact (using the figure of 15 percent as the estimated factor for unreported cases). The prevalence of HIV was estimated to be 0.054 percent as of 1 April 2007.

### **HIV prevalence among adults and young people 15-49 years**

KI and SMI also estimated the prevalence in the age group 15-49 years. An analysis of the age distribution of HIV-infected in Stockholm (used here as proxy for the whole of Sweden) allowed the prevalence to be estimated as 0.079 percent in 2006 and 0.082 in 2007.

### **Antiretroviral therapy**

Any person who is legally present in Sweden and needs antiretroviral therapy has access to treatment. For undocumented persons, solutions are sought locally, however official regulations do not guarantee access to antiretroviral therapy for persons whose legal status is undetermined. The costs of the treatment are covered by the national health insurance scheme. The figures presented here concerning antiretroviral therapy have been obtained from the Karolinska University Hospital in Stockholm and from the Sahlgrenska Hospital in Gothenburg. The patients at these clinics constitute approximately 65 percent of the known HIV-infected persons in Sweden. In 2006, 515 persons (498 adults and 17 children) received antiretroviral treatment. The number receiving treatment had in 2007 risen to 592, (577 adults and 15 children). According to recommendations in Sweden, treatment for an asymptomatic adult infected with HIV is started when their CD4 cell count falls below 250. 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.

Information concerning HIV-positive children who receive ART has been obtained from Karolinska University Hospital, at which approximately 60 percent of all known

HIV-positive children in Sweden are patients. The definition of severe immunodeficiency for children differs from that used for adults. The definition used in this report for children is that severe immunodeficiency is present when the CD4 cell count lies below 15 percent of the total lymphocyte count.

## **National response to the AIDS epidemic**

The Swedish government initiated a review of Sweden's HIV and STI prevention measures following the Declaration of Commitment in 2001. This review was also prompted by a worrying increase in certain sexually transmitted infections, which indicated a change in the patterns of certain risk factors. The major stakeholders involved in the response took part in the review process. The review was able to demonstrate that a great deal of good work was being carried out, but that national coordination and monitoring were nonetheless deficient in some respects. The review concluded that globalisation, new methods of communication, and changes in sexual behaviour of large groups in society placed new and more serious demands on preventive work.

### **The National Strategy**

The review resulted in a government bill that was passed in December 2005: the "National strategy against HIV/AIDS and certain other contagious diseases". The national strategy is principally a document that is to guide work in promoting health and preventing disease, and to guide the work of support for HIV-infected people and their families. It was the intention of the Swedish government through this decision to renew and update Swedish prevention efforts with the requirements posed by recent developments. Guidelines and the monitoring of treatment and other care are located within the relevant sectors and are only affected to a very small degree by this bill.

Work is currently under way to operationalize the National Strategy and to develop a monitoring and evaluation plan. The operational strategy is structured around people whose behaviour places them at greater risk, identified in the National Strategy. People whose behaviour places them at greater risk include: men who have sex with men, injecting drug users, people whose origins are in high prevalence areas, young people and young adults, people who travel abroad, pregnant women, people who are the victims of prostitution, and people who are living with HIV infection. The following national plans of action are currently being finalised, before being integrated into the operational strategy:

- a plan of action for the prevention of Chlamydia infection – measures targeted at young people and young adults
- a plan of action to increase access to health checks for persons seeking asylum and newly arrived immigrant relatives
- an overall strategy for communication that is to coordinate and guide the work of communication.

The National Strategy emphasises the need for more programmatic work, and for improved monitoring and evaluation. The purely medical work of testing, care,

treatment and support works well within the health-care sector, and maintains a high quality. Preventive counselling, however, needs to be improved. Schools provide education related to sexuality and relationships, but the quality of this education varies. Work directed towards migrants must be considerably reinforced, and the epidemiological surveillance of the situation among injecting drug users must be improved. Young men who have sex with men must be more aware of the risk of

### **National strategy against HIV/AIDS and certain other contagious diseases**

#### OVERALL OBJECTIVES AND INITIATIVES:

- to limit the spread of HIV and other STIs
- to limit the consequences of these infections for society and for the individual.

#### INTERIM OBJECTIVES:

- The number of newly registered cases of HIV infection where the infection has been transmitted in Sweden is to be halved by 2016.
- HIV infection among people seeking asylum and newly arrived relatives is to be identified within two months, and for others who have visited regions with high prevalence, within six months.
- Knowledge of HIV and of AIDS and how to live with HIV is to be improved in the public sector, in working life and in society at large.

HIV-infection, as do others whose behaviour places them at greater risk, and young people and young adults in general. The use of condoms must increase significantly in Sweden. Prevention and psychosocial support must be better coordinated between the many sectors and stakeholders, both at a national level and at a regional and local level.

## **Leadership and coordination**

The National Strategy places a clear mandate for coordination of ongoing work onto the National Board of Health and Welfare, NBHW. A national council whose chairperson has been appointed by the Government has been coupled with the NBHW. The National Council for the Coordination of HIV-prevention includes representatives from important stakeholders with responsibility for the implementation of the National Strategy.

### ***The National Board of Health and Welfare***

The National Board of Health and Welfare established a unit for the national coordination of HIV-prevention. The unit started its work in June 2006, and is closely associated with the National Unit for Infectious Disease Control. The Unit for HIV Prevention is responsible for the national day-to-day operational work for planning, coordination and monitoring. Its tasks are as follows:

- to develop plans of action and operative objectives, including overall strategies for communication
- to develop a comprehensive country-level planning and monitoring document with indicators
- to coordinate at the country level and to support coordination at the regional level
- to distribute and monitor the government grant, as commissioned by the government
- to initiate and evaluate initiatives, and to by other methods deepen knowledge about preventing HIV
- to deliver each year strategic background information in preparation for the national budget and in preparation for the agreement to be reached with the Swedish Association of Local Authorities and Regions
- global analysis and monitoring of the situation of people whose behaviour places them at greater risk
- to follow the international development and take part in EU collaboration on issues related to HIV
- to function as secretariat for the national council for HIV prevention.

The Unit for HIV Prevention has regular meetings with 24 nominated collaborators for county councils and city municipalities, and with the organisations that receive government funds.

### ***Mechanisms for the control of grants to county councils and city municipalities***

Sweden is politically decentralised, with independent government authority at regional and local levels, each with the power to collect tax. The county councils are responsible at the regional level for health care and public health work. The municipalities have a certain responsibility for public health work at a local level, and they are responsible for schools and social care. They both plan and execute their work independently following national guidelines. The national government cannot direct the regional and local level to carry out initiatives that are not provided with funding or that are not legally regulated. The government grant for the prevention of HIV and STIs is used as guiding mechanism. County councils and city municipalities can apply for grants that are intended to finance three areas:

1. grants to components of work that is of national interest from the perspective of prevention and that is located in the city regions. Most of those infected with HIV are found in these geographical regions, as are those whose behaviour places them at greater risk, and other general risk factors.
2. grants to develop regional centres of expertise and to support knowledge development and coordination.
3. grants to renewal and implementation of preventive measures and safer sexual behaviour throughout Sweden.

## **Prevention and Behaviour**

### **HIV testing**

Due to anonymous testing, the number of individuals who take a test for HIV cannot be determined. Legislation from 1986 (SFS 1986:198) allows a person who so desires, to be tested for HIV anonymously, with what is known as a “reserve number” that is used instead of the name and civil registration number. If the result of the test is positive, the identity of the person must be revealed to the treating physician. All cases of HIV that are diagnosed are reported as specified by the Communicable Diseases Act using a code number, so as not reveal the identity of the person to the County Medical Officer of Communicable Disease Control and to the Swedish Institute for Infectious Disease Control.

Anyone who suspects or knows that he or she has been infected with HIV is obliged by the Communicable Diseases Act to visit a physician and take an HIV test. Contact tracing is also compulsory, and this means that a physician who makes a diagnosis of HIV infection is obliged to trace the patient’s contacts or to ensure that other health care personnel with the required skills carry out the contact tracing. The patient in turn is obliged to provide all information that he or she is able to provide about persons with whom he or she has had sexual contact or shared non-sterile injecting equipment, and who may be infected. Any person designated as a contact in the contact tracing is obliged to take an HIV test.

The responsibility for providing counselling and testing for people whose behaviour places them at greater risk and for providing client-initiated testing rests with the health and medical care systems. A national screening programme for HIV is used solely for pregnant women and blood donors. Apart from these provisions, there are no special recommendations, national screening programmes for HIV testing or national prevalence studies for groups or individuals whose behaviour places them at greater risk, except for an agreement between the government and the county councils that responsible authorities are to offer health counselling and health checks to newly arrived refugees and those seeking asylum.

Targeted clinics that offers counselling and testing to men who have sex with men are available in Stockholm and Gothenburg, and special initiatives targeted at injecting drug users are also available in the major cities in the form of health checks for persons remanded in custody and special clinics for the homeless. Needle and syringe exchange programmes are currently in place only in Malmö and Lund in the Skåne Region Venereology clinics are available at all county hospitals and at some other hospitals in the large cities. These routinely offer HIV testing to all who attend for an STI examination. Furthermore, HIV testing does take place to a certain extent at youth centres and within the framework of other health care such as clinics of infectious diseases and within primary health care.

Current information about the number of HIV tests carried out each year is not available at the national level. In a survey conducted 2007, a total of 3,008 people answered the question of whether they had been tested for HIV and, if so, in what context.<sup>1</sup> The results show that it is most common for people to get tested in relation to pregnancy and blood donation. For client initiated testing, it is most common for men in the age group 25-34 and women in the age group 20-24 to have been tested for HIV.

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<sup>1</sup> Cleas Herlitz, HIV/AIDS in Sweden 1987-2007: Knowledge, attitudes and behaviours of the general population during 20 years, Dalarna Research Institute

**Table 1. People who had been tested for HIV, for various reasons in the period 2004-2006, classified by sex and age. (%)**

Men	Blood donation %	Pregnancy %	Client initiative %	Other reason %
16-17	1	-	2	0
18-19	2	-	2	2
20-24	5	-	5	3
25-34	12	-	9	5
35-44	8	-	2	4
<b>16-44</b>	<b>8%</b>	-	<b>5%</b>	<b>4%</b>
Women				
16-17	1	2	1	2
18-19	5	2	5	1
20-24	9	7	8	4
25-34	9	29	6	3
35-44	6	9	2	3
<b>16-44</b>	<b>7%</b>	<b>14%</b>	<b>4%</b>	<b>3%</b>

*Källa:* Herlitz, HIV/AIDS in Sweden 1987-2007.

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

Men who have sex with men (MSM), is the group in which the greatest endemic spread of HIV-infection is occurring. The annually reported cases of HIV in this group have remained comparatively stable, taking the relatively low numbers into account, with small changes between the years 2000 and 2006. However, the incidence for the whole period has increased by approximately 25 percent: 73 cases were reported in 2000, which is to be compared with 96 in 2006. The first half of 2007 has seen a more distinct increase in this trend, with 62 cases being reported in which sex between men has been given as infection route, to be compared with 38 cases in each six-month period during the preceding five-year period.

The transmission of HIV among men who have sex with men takes place most often in Sweden. In those cases in which infection has occurred outside of Sweden, it is most common that it has occurred in Europe. The mean age was, as previously, 39 years. The newly reported cases of HIV infection for men who have sex with men were mainly concentrated to the major urban areas of Stockholm, Gothenburg and Malmö. These accounted for 90 percent of the cases nationally.

### **Required measures, as specified by the National Strategy**

The National Strategy argues, based upon the epidemiological situation, that preventive measures aimed at men who have sex with men should be given a high priority. Special information initiatives are needed for people whose background lies in cultures that have a less tolerant view of men who have sex with men. The role of NGOs in preventive work is emphasised as being particularly important. Regular HIV testing and counselling must be offered to a greater extent to men who have sex with men outside of that offered by the specialist clinics. Knowledge within the field of the behavioural sciences, and epidemiological surveillance and analysis must be reinforced for this group.

## Knowledge and behaviour – a baseline study

A baseline study of men who have sex with men commissioned by the NBHW was carried out during 2006, (*the MSM- survey 2006*). An initial report of its findings will be published at the end of 2007. The aim of the study has been to survey sexual behaviour, testing habits, knowledge needs and the need for HIV preventive measures of men who have sex with men in Sweden. Data collection took place through targeted advertising in the largest Swedish Internet community, [www.cruiser.com](http://www.cruiser.com), the principal target of which is homosexual and bisexual men and women. A total of 2,564 men who have sex with men respondents are included in the final analysis, which constitutes a representative sample on which to base the design of future preventive work.

## Testing

The baseline study showed that it is most common for men who have sex with men to be tested for HIV at special health centres for MSM. As many as, 42 percent of the men in the study, had had their most recent HIV test at such a clinic. For the younger men in the study, 31 percent had had their most recent HIV test at a youth centre and this illustrates how important the LGBT<sup>2</sup>-expertise at youth clinics throughout Sweden is.

**Table 2. Percentage of men who have sex with men that received an HIV test in the last 12 months**

<25	>25	All men
37.3 %	42.6 %	41.2 %

Source: *The MSM- Survey 2006*

The study does not reveal how many of the men who had tested for HIV in the last 12 months, had also received a test result. According to Venhälsan, a specialist clinic in Stockholm targeting men who have sex with men, it is very uncommon for persons that have been tested not to receive their test results. The clinic tests approximately 3,000 men who have sex with men each year, and more than 99 percent of men tested collect their test result within one month.

The prevalence of HIV among men who have sex with was estimated in 2005. The prevalence of men who have sex with men among the male population in the age range 16-69 years was estimated to be 2.5 percent<sup>3</sup> and this allowed the prevalence of HIV among men who have sex with men to be estimated to be 2 percent. The prevalence in the large urban areas Stockholm, Gothenburg and Malmö is higher than it is in the country as a whole.

## Protected and unprotected anal intercourse

The baseline study shows that just over seven of ten men had had their last sexual contact with someone that they knew previously (their partner or boyfriend, a regular sexual contact or a casual sex partner who was known from previously). Thus, it is less frequent for these men to have sex with someone who is totally unknown.

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<sup>2</sup> LGBT- Lesbian, Gay, Bisexual and Transgender

<sup>3</sup> Lewin, Fugl-Meyers, Helmius, Lalos & Månsson, 1997, Macdonald et al., 2004

Research and literature studies show that sexual practices and the use of condoms vary to a large extent, depending on whether sex is with a "regular partner" or with a "casual sexual contact". Unprotected anal intercourse is significantly more common in the context of a relationship in which the partner is known than it is in sexual contact with a more casual partner, outside of the stable relationship.

Just under half of the respondent in the study were living in a stable relationship. It has been shown to be relatively uncommon to use a condom systematically within such a relationship. Table 3 shows condom use within the relationship. The figures are nearly inversed for sexual contacts outside of the relationship, table 4.

**Table 3. Condom use within the relationship (%), classified by age**

Age	<25	26 – 35	36 – 46	>47
Yes	16	14	14	14
No	73	75	71	46
Have not had anal intercourse the last 12 months	10	11	14	40

**Table 4. Use of condoms outside of the relationships (%), classified by age**

Age	<25	26 – 35	36 – 46	>47
Yes	21	30	40	40
No	16	20	15	16
Have not had anal intercourse outside of the relationship the last 12 months	64	50	46	44

Source: *The MSM- Survey 2006*

Table 5 below presents the percentages of men reporting condom use the last time they had anal sex with a male partner. It is, unfortunately, not possible to report the exact denominator for UNGASS indicator nr.19: (number of respondents who reported having had anal sex with a male partner in the last six months). The baseline study used a different denominator, namely: number of men who reported having had anal intercourse with a man during the preceding *month*.

**Table 5. Men reporting the use of a condom the last time they had anal sex with a male partner**

< 25	>25	All men
38 %	43.7 %	42.2 %

Source: *The MSM- Survey 2006*

The table above shows that 42, 2 percent of the men reported condom use last time they had sex with a male partner. It is clear that younger men tend to be engaged in high-risk sex to a greater extent than older men. Only 38 percent of the men below 25 years used a condom during their most recent anal intercourse, while 43.7 percent of men above 25 years did. The younger men are also clearly the greater risk-takers when it comes to unprotected anal intercourse during the last twelve months and unprotected intercourse with a partner outside of the relationship who's HIV status is unknown (see Table 6). It is too early to draw any conclusions concerning risk-taking among the men in the study since most of the unprotected intercourses have taken place with a partner or boyfriend. It is possible in these relationships to use a joint HIV test in order to obtain knowledge about the HIV status

of the other person. A more detailed analysis is required before any conclusions about risk-taking can be drawn.<sup>4</sup>

**Table 6. High-risk behaviour classified by age (%)**

Age	<25	26 – 35	36 – 46	>47
Unprotected anal intercourse during the last 12 months	60	55	53	40
Unprotected anal intercourse with a partner of unknown HIV status outside of the relationship (on the most recent occasion)	14	9	9	7

Source: *The MSM- Survey 2006*

### Knowledge needs

Preliminary results from the base-line study show deficient knowledge among younger men who have sex with men with respect to routes of infection, assessment of risk, and strategies for safer sex. The young men also told of needs for information and knowledge that were not satisfied, and gave details of the areas in which they themselves considered that they needed more knowledge. There are very clear differences in the needs of different age groups. Men in the youngest age group generally express a significantly higher need for knowledge than other men in the study (see Table 7).

**Table 7. The knowledge needs among men who have sex with men (%)**

The Knowledge needs among MSM	<25	>25	All men
Men who consider that they do not have sufficient knowledge of HIV	50	31.7	36.9
Men who consider that they do not have sufficient knowledge of safe sex	14.9	10.5	11.7
Men who consider that they do not have sufficient knowledge of how to avoid condom breakage	30.3	16.1	20
Men who consider that they do not have sufficient knowledge of what it is like to live with HIV	61	47.8	51.4

Source: *The MSM- Survey 2006*

The differences in need for knowledge are greatest for knowledge about HIV. Of men under 25 years, 50 percent state that they consider that they do not have sufficient knowledge of HIV. For the men who consider that their knowledge of how to practice safer sex is insufficient, the relatively low figure can be seen as confirmation that the work to promote HIV prevention based on a positive attitude to sexuality has been successful. The fraction of men who consider that they have insufficient knowledge in this field is low in both age groups, but is still higher among the younger men than among the older.

### Important activities 2006-2007, and initiatives with high priority in 2008

Extensive initiatives have been started during 2006 and 2007 in collaboration with research institutes, NGOs and the NBHW concerning the development of knowledge

<sup>4</sup> The analysis will be first published in a report from Malmö University at the end of 2007.

and methods, and concerning research into behaviour of men who have sex with men. The results from the "MSM Survey 2006" are being analysed during 2007, and will be presented to all interested partners in the field of prevention towards the end of the year. A summary of evidence-informed methods for prevention directed towards men who have sex with men has been prepared during 2007, under commission from the NBHW. Initiatives in education concerning the implementation of working methods and measures that have proved to be effective in action plans and programmes have been started in 2007. Thus, the areas given priority in 2008 are:

- initiatives for young men who have sex with men
- initiatives for men who have sex with men whose ethnic background is not Swedish
- the implementation of evidence-informed methods for prevention, and testing and counselling
- initiatives within communication particularly targeted at gay tourism.

### ***Injecting drug users***

A total of 35 HIV-positive persons were reported during 2006 where the route of infection was specified as the injection of drugs. This was 40 percent higher than the figure for 2005. The greatest increase was noted in Stockholm, where 29 cases were reported in 2006, to be compared with 20 reported cases in 2005.

During the first six months of 2007, 29 cases of infection by this route were reported. The infection was reported to have taken place in Sweden for 25 of these, and all except one of these 25 had been infected in Stockholm. The figures can be compared with a mean of eight cases for each of the preceding 5 years, a comparison that shows that the greatest proportional increase is taking place among those who inject drugs. Furthermore, it is worth noting that the fraction of women in the reported group has increased significantly. This fraction has been approximately 10% in recent years, while one third of the total number of reported cases among injecting drug users in 2007 have been women.

### **Risk factors**

The most important risk factor contributing to the spread of HIV-infection among injecting drug users is the substance addiction itself. This contributes to increased high-risk behaviour in the form of the use of non-sterile injecting equipment, and unprotected sex.

Results from a study carried out by The Socio-Medical Remand Project, show that approximately 60 percent of remanded injecting drug users have either used someone else's equipment or allowed someone else to use their equipment over the last 12 months. Results from a corresponding project, the field project The HIV Bus, showed that only 41 percent of the respondents had used sterile injecting equipment last time they injected.

Low condom use is a potential risk factor for infection by HIV of injecting drug users. Results from The Socio-Medical Remand Project show that only 15 percent of users used a condom during their most recent intercourse. The corresponding figure from the respondents in The HIV Bus was 19 percent.

### **Required measures as specified by the National Strategy**

The National Strategy states that recruitment of new injecting drug users must decrease. Furthermore, the opportunities for readily available testing for persons who inject drugs must be improved, as must information and reliable counselling. There should be a greater focus and more investment in interventions against the spread of hepatitis B and hepatitis C infection. Epidemiological surveillance and analysis in this field also require reinforcement.

### **Injecting equipment exchange**

One component of National Strategy has been the introduction of the *Act (2006:323) Relating to the Exchange of Syringes and Cannulae*. The aim has been to prevent the spread of HIV-infection and the spread of other blood-borne infections among people who inject drugs. The act came into force on 1 July 2006, and makes it possible for the county councils to start injecting equipment-exchange programmes. There are currently two established needle and syringe exchange programmes, based at Clinics for Infectious Diseases, one in Malmö, the other in Lund. The programmes have developed from being purely HIV preventive initiatives, to become a broad forum for medical and psychosocial support. The programmes have been run as projects since the 1980s, and the introduction of the act has allowed them to become permanent. The possibility of further county councils establishing such programmes has been discussed, but it requires the county council to collaborate with municipal drug-user care programmes. The NBHW is responsible for granting permission, and for the regulations determining the application process, staffing, organisation, programme and reporting procedures. Permission may be granted for a maximum period of two years at a time.

The programmes in Malmö and Lund receive approximately 14,000 visits a year from a total of approximately 1,100 individuals. In 2006 the programme performed 1,144 HIV tests of men and 282 tests of women. Since 2002, no cases of HIV have been detected among injecting drug users in the region who were tested in this programme, however, a few cases have been detected among people who have moved to Malmö or have been infected with HIV when travelling abroad.

### **Important initiatives and results in 2006-2007**

There has been a noticeable rise in the amount of infection in Sweden from the use of injected drugs during the preceding year. Thus, the NBHW, together with other stakeholders, has started a number of initiatives during 2006 and 2007 with the aim of reinforcing epidemiological surveillance and improving the availability of counselling and testing for persons who inject drugs. The following initiatives have been started, in accordance with the priorities that were suggested for 2007:

- research into the molecular epidemiology of HIV-infection among Swedish injecting drug users
- a survey of the research into networks of equipment use among injecting drug users
- projects to test injecting drug users at locations where the users are found.

### **The Socio-Medical Remand Project**

The Socio-Medical Remand Project in Stockholm has received support during this period for a survey on prevalence and incidence of HIV and hepatitis, and on high-risk behaviour among injecting drug users remanded in custody, at the remand

centres in Stockholm. The project has not only a epidemiological aim: it also has preventive ambitions in that counselling is given during the interview into preventive measures, and in that the regular testing of the users contributes in itself to limiting the spread of HIV.

In 2006, 375 injecting drug users were tested while on remand. Twenty-three of them were found to be HIV- infected, six of them being given the diagnosis for the first time. These were thus reported as new cases. In the period January-June 2007, 193 injecting drug users were tested at the remand centres. Eighteen of the tested were HIV-infected, eight of these being new cases. The number of new cases during the first half of 2007 shows an increase in the group compared with the number from 2006. Results from the first six months of 2007 from The Socio-Medical Remand Project also show that the fraction of sampled HIV-infected injecting drug users who have their own household is increasing. These results may indicate that HIV is now being spread in the group of injecting drug users who are not at the extreme margin of society.

A corresponding project for those on remand was started in 2005 in Gothenburg, where it is organised and financed locally by the regional unit for the prevention of infectious diseases. Forty-nine persons, one of them a woman, were tested during the first six months of 2007. Ten had hepatitis C, no other blood-borne infections were identified during the period.

### **Projects testing for HIV in new locations – a baseline study**

Karolinska Institutet started in 2007, together with a number of partners<sup>5</sup>, a baseline study of blood-borne infections among injecting drug users. This is the first time a baseline study has been conducted in Sweden. The study is being carried out in two stages, and its aims are to survey the spread of infection and to offer vaccination and socio-medical services. Stage 1, The HIV Bus, was conducted in the field and visits were made to injecting drug users at various locations in Stockholm. The participants were interviewed, tested for HIV and hepatitis, and offered counselling and vaccination against hepatitis A and B. Stage 2 is institution based, and started on 1 September 2007. Its aim is to interview and test a further 800 injecting drug users that come into contact with the medical care system, the prison and probation service, the social services, and NGOs. This report presents results from Stage 1 only, and the results are therefore not yet representative.

A total of 263 persons were interviewed and tested during the period 1 July- 31 August 2007, by The HIV Bus at various locations in the county of Stockholm. Of these, 159 had injected drugs at least once during the last 12 months. Eight of these active injecting drug users were HIV-infected (5.1 percent of all cases were men older than 40 years). Four of the cases were already known, while four cases were a first-time diagnosis. The HIV Bus also discovered three new cases of HIV-infection among non-active injecting drug users, whose most recent injection had been more than a year ago.

The interviews with participants showed that there are no significant differences related to sex or age with respect to high-risk behaviour, such as using non-sterile injecting equipment. This may be a result of the sample size of this study, that is not yet sufficiently large to allow reliable statistical analysis.

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<sup>5</sup> Maria Addiction Centre, Beroendecentrum Stockholm, The Socio-Medical Remand Project, The Social Services Committee in Stockholm, The Stockholm City Mission and The Salvation Army

**Table 8. UNGASS indicators for injecting drug users disaggregated by sex and age (%), and the total number in the sample (n)**

UNGASS Indicators for injecting drug users	Men <25	Men >25	Women <25	Women >25	Total
% IDUs that have received an HIV-test in the last 12 months and who know their results	66,7 n=6	83,5 n=109	75 n=8	88,9 n=36	83,6 n=159
% IDUs who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	33,3 n=6	25,9 n=108	37,5 n=8	28,6 n=35	27,4 n=157
% IDUs reporting the use of a condom the last time they had sexual intercourse	0 n=2	28,9 n=38	0 n=5	25 n=16	24,6 n=61
% IDUs reporting the use of sterile injecting equipment the last time they injected	50,0 n=6	37,5 n=72	25 n=8	39,1 n=23	37,6 n=109
% IDUs who are HIV infected	0 n=6	7,4 n=108	0 n=8	0 n=34	5,1 n=156

Source: *The HIV Bus*

### **Initiatives to be given priority**

The injection of drugs constitutes a significant risk factor for infection with HIV. A great emphasis must be placed on offering care and treatment for persons with problems of substance abuse. Further efforts must be made during 2008 to meet the actual and the potential spread of infection of HIV and STIs, together with hepatitis, among injecting drug users:

- targeted initiatives for female drug users, young users, injecting drug users who are involved in commercial sex, and homeless users
- a survey of the extent of testing and the willingness of injecting drug users to take tests
- a survey of whether knowledge of preventive measures needs to be reinforced among those who meet injecting drug users within the health care service, social services and the prison and probation service
- development of a communication strategy for the target group.

### ***People involved in commercial sex***

The term commercial sex is not applicable in Sweden since the purchase of sexual services is illegal. The Swedish term is people who are victims of prostitution. The NBHW has not yet analysed specifically the risk factors for HIV and STIs in this group, nor has it analysed the current preventive measures. It is clear, however, that some injecting drug users also buy and sell sex, and that persons involved in commercial sex have an increased risk of being infected by HIV and STIs through a sexual transmission route, since they have a potentially higher number of sexual partners. A survey of the situation covering the current risk situation, risk factors and possible measures should take place during 2008-2009.

### **Required measures, as specified by the National Strategy**

The National Strategy states that persons, independent of their sex, who are involved in prostitution and commercial sex exploitation are to be considered as persons whose behaviour places them at an increased risk. The strategy also states that the correlation between the exploitation by men of persons involved in commercial sex and the spread of HIV and STIs should be made visible. This means that both those

who sell and those who buy sex run a higher risk of infection with HIV and STIs, but that it is the behaviour of the buyers, most often men, that constitutes the defined problem that the strategy intends to change. Collaboration between authorities within the field of infectious diseases, the police and the social services must be strengthened in order to achieve the long-term goal: that commercial sex and trafficking for sexual purposes should cease.

### People who sell sexual services

Estimates of the number of people involved in commercial sex in Sweden vary widely. Researchers have stated that a significant portion of commercial sex is assumed to be hidden initiated primarily through contact through the Internet or telephone. The Stockholm municipality and the Stockholm county council are jointly running The Spiral Project in Stockholm, 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. The Spiral Project reported 400 visitors during 2006, and the outreach personnel of the unit met approximately 150 more persons involved with street-based commercial sex. Approximately 40 women were identified as the victims of trafficking. The unit published a report into Internet-based commercial sex in May 2006, focussing on persons in the Stockholm region. In the period March 2005 until March 2006, 327 persons who had received payment for sexual services were identified. The National Criminal Investigation Department has stated that approximately 1,000 persons each year are involved in commercial sex in Stockholm and its surroundings. Approximately 500 women each year are brought to Sweden for sexual purposes.

The Spiral Project started to collect data for the UNGASS indicators in September 2007 and the data is therefore not yet representative. The questionnaire has been available at the clinic for just over one month and has been answered during that period by 50 people, 49 women and one man. The results are shown in the table below.

**Tabell 9. UNGASS indicators for sex workers**

UNGASS indicators for sex workers	Women <25	Women >25	Men >25
Number of SWs who received an HIV test in the last 12 months and received a result	13,5% (n =10)	23% (n =17)	1,3% (n =1)
Number of SWs reached with HIV prevention programmes	12,2% (n =9)	37,8% (n =28)	1,3% (n =1)
Number of SWs who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	24,3% (n =18)	27% (n =20)	1,3% (n =1)

*Source: The Spiral Project*

The social services personnel in the three largest urban areas in Sweden all have knowledge of men who sell sex to men, but no estimate of the magnitude of this has been made. It is generally believed that contact often takes place over the Internet and/or by mobile phone. "The Prostitution Group" in Stockholm carried out an outreach project during 2002 during which around 50 men in the age range 18-25 years who sold sex in public locations could be identified.

## **Legislation**

Purchasing and attempting to purchase sexual services became criminal acts in Sweden in 1999 when the law forbidding the purchase of sexual services (The Penal Code, Chapter 6, Section 11) came into force. The law was a result of the Kvinnofridsutredningen 1995/60, (the Commission of Violence against Women). The law expresses in a practical form a will for gender equality, with the premise that men are normally buyers of sex and women sellers. The historical focus of commercial sex being a phenomenon closely associated with women who sell sex has now been moved to men who buy sex, and 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 Swedish legislation remains the only one of its type in an international perspective. The terms of punishment include fines or a maximum of six months' imprisonment. The selling party never runs the risk of any judicial consequences. This legislation governing the buying of sex has not yet been evaluated. Research that is coupled to possible consequences of the legislation is, however, under way, and examples of areas that may be relevant for examination include the significance of the Internet in commercial sex, and homosexual commercial sex.

## **Important initiatives during 2006-2007**

The National Board of Health and Welfare started a project during this period, in consultation with the Social Services Administration in Stockholm, with the aims of offering testing for HIV and STIs and gaining increased knowledge of high-risk behaviour in the target group of women who sell sex. The results will be presented in 2008. The NBHW will take the initiative again in 2008 for a survey of the target group, related to HIV and STIs. This is to be complete by 2009, in order to be able to assess the level of risk, identify risk factors, and propose measures to take.

The three largest cities offer counselling programmes under the auspices of the Social Services Administration for those involved in commercial sex. The municipalities have programmes 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 programme for former female injecting drug users with experience of commercial sex. "FAST" (The sale of sexual services) is another Malmö programme specifically targeted to people selling sexual services outside the street environment. Certain police officers in the three cities work specifically with street-based commercial sex. These cities also have programmes called "KAST" (The buying of sexual services) directed towards people who buy sex. The co-operation 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 level.

## ***Young people and young adults***

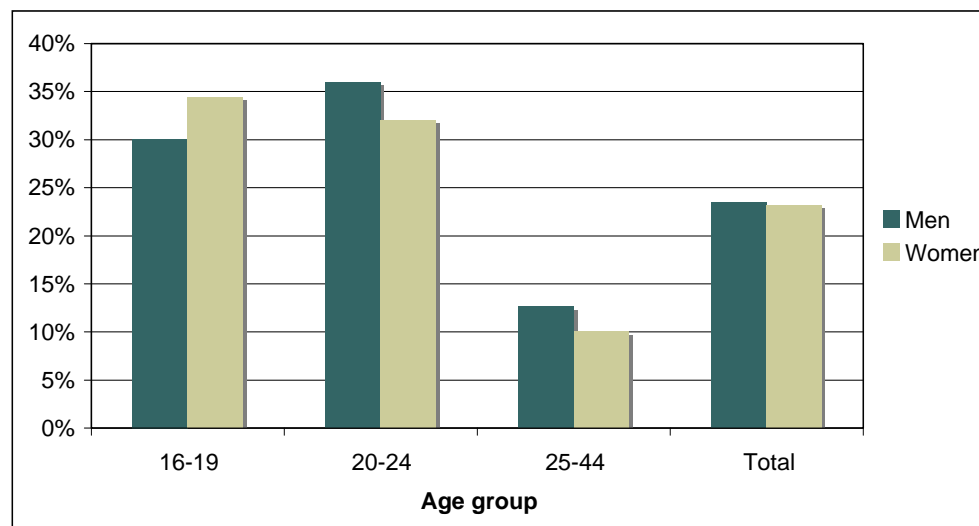
Young people constitute a relatively low proportion of those infected with HIV in Sweden. The average age of the reported cases of HIV infection is higher than that of cases of other sexually transmitted infections. The average ages at diagnosis of HIV infection for the three most common routes of infection are between 35 and 40

years. Although the number of those infected with HIV is low among young people, the number of Chlamydia infections is high and increasing, as is the number of unwanted pregnancies. This suggests that many young people today engage in high-risk sexual behaviour.

### Behaviour changes

Swedish young people are generally well informed in sexual matters. During the last decade, changes in attitudes and behaviours in a direction towards more high-risk sexual behaviour have been observed. An increasing proportion of young people are of the opinion that it is not necessary to be in love with someone in order to have a sexual relationship. A recent study<sup>6</sup> of sexual behaviour found that only one third of people in the age-range 16-24 agree fully or partially with the statement "Intercourse should take place only within steady relationships." An increasing fraction of young people has experienced sex on the first date, and this fraction is now just over one third in the age-range 16-24 for both women and men. These ever-more permissive attitudes to sex outside of steady relationships are found in all age-ranges and for both sexes, and they are matched by changes in sexual behaviour. Sexual partners are exchanged more frequently than has been the case previously. This is particularly the case for young people, and especially for young women.

**Figure 3. Women and men who have had sexual intercourse with more than one partner in the last 12 months**



Source: Herlitz, HIV/AIDS in Sweden, 1987–2007.

Figure 3 shows, that 23 percent of people in Sweden had more than one sexual partner in the last 12 months. It was most common for women aged 16-19 years and for men aged 20-24 years to have more than one partner during one year. The same study reveals several changes in sexual habits over time. The fraction of men aged 16-17 years who had not had any sexual partner during the last 12 months was 48 percent in 2007, which is to be compared with 60 in 1989. Corresponding figures for women aged 16-17 were 34 percent in 2007 and 49 in 1989. Thus, a reduction has taken place at approximately the same rate for both men and women, but the fraction of women who have not had a sexual partner during the preceding 12 months remains significantly higher than the fraction of men.

<sup>6</sup> Claes Herlitz, HIV/AIDS in Sweden, 1987-2007: Knowledge, attitudes and behavior of the general population during 20 years, Dalarna Research Institute

The Internet has expanded rapidly during the twenty-first century. Extensive communication concerning sex now takes place over the Internet. Nearly all of those aged 16-24 years use the Internet. The Internet as a communication medium has created new forms of contact in which it is possible to seek sexual partners based on other preconditions than those that have been prevalent previously. It is conceivable that the increase in the number of sexual partners and casual sexual contacts among young people during the twenty-first century is associated with the new opportunities that the Internet offers.

### Sexual debut

The median age at first intercourse has remained around 16 years from the end of the 1970s until 2004. A study of young people conducted in 2007/2008<sup>7</sup> shows that the median age was exactly 16 years in 2007. Further it shows that 18 percent of young people aged 15-24 years had had their sexual debut before their 15th birthday (see table 10). It is also clear that it is more common for women to have their sexual debut before the age of 15 years than it is for men. It is also worth noting that young people aged 15-19 years at the time of the study had had their sexual debut at a younger age than those aged 20-24 years.

**Table 10. Percentages of young people aged 15-24 years who had had their sexual debut before the age of 15 years.**

Age	15-19 years		20-24 years		15-24
	Men	Women	Men	Women	Total
Age of debut <15 years	25 %	34 %	8 %	13 %	18 %

Source: *The Youth Barometer, 07/08*

There may, however, be differences in the age of sexual debut between groups of young people, based on socio-economic class and/or Swedish/non-Swedish background. Studies have shown that young people taking vocational study programmes at upper secondary schools have their sexual debut somewhat younger than those taking theoretical study programmes.<sup>8</sup> Women with a background from outside of Sweden typically experience their debut later than women with a Swedish background, while men of non-Swedish background have a sexual debut somewhat younger, or at approximately the same age as men of Swedish background.<sup>9</sup>

### Condom use

A report summarizing seven consecutive KAB-studies in the general Swedish population demonstrates a recent increasing confidence in the use of condom. Table 11 shows the percentages of those sexually active in different age groups who have used a condom on some occasion the last month.

**Table 11. Percentage of sexually active, who used a condom the last month.**

Year	1989		1994		1997		2000		2003		2007	
Age	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women

<sup>7</sup> The Youth Barometer 07/08)

<sup>8</sup> Edgardh, K. (1992). *Tonåringar, sex och samlevnad.*: Förlagshuset Gothia. Häggström-Nordin, E. (2005). *Worlds Apart? Sexual Behaviour, Contraceptive Use, and Pornography Consumption among Young Women and Men*, Uppsala University.

<sup>9</sup> Forsberg, M. (2005). *Brunettes and Blondes. Youth and Sexuality in Multi-Cultural Sweden*. Gothenburg University.

<b>16-17</b>	52	26	55	36	56	42	63	33	52	46	67	42
<b>18-19</b>	43	28	38	28	41	32	37	30	44	31	42	30
<b>20-24</b>	24	23	28	24	32	19	34	21	28	26	33	29

Source: Herlitz, HIV/AIDS in Sweden, 1987–2007.

The table shows that the use of condoms revealed by the survey in 2007 was higher among those aged 16-17 than it was in the other age groups. Sixty-seven percent of men and 42 of women replied that they or their partner had used a condom during the preceding month. Table 12 shows that 37 percent of young people in the age-range 15-24 years used a condom during their last intercourse. The table also shows that use of condoms is more prevalent among the youngest age groups noted in the study.

**Table 12. Percentages of young people reporting the use of a condom during their last sexual intercourse**

Age	15-19 years		20-24 years		15-24
Sex	Men	Women	Men	Women	Total
Used a condom	49%	33 %	39 %	29 %	37 %

Source: The Youth Barometer 07/08

Condoms are available in Sweden through a broad distribution network and can be bought in shops, pharmacies, and over the Internet. It has been estimated that approximately 18 million condoms were sold in Sweden during 2004, at a total cost of approximately SEK 90 million (approx. 14 million USD) with the average price of a condom equal to SEK 5 (approx. 0.77 USD). Distribution of condoms free of charge by the county councils has increased markedly since 1987, and amounts now to approximately 20% of consumption.

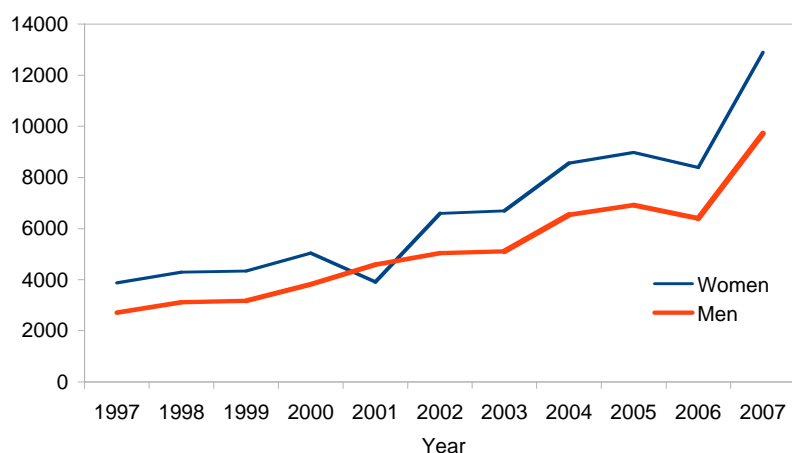
### **Chlamydia infection**

Chlamydia today is by far the most commonly reported sexually transmitted infection in Sweden. Chlamydia has been included in the Communicable Diseases Act since 1988. The number of those infected has increased continuously from the figure of 13,905 cases reported in 1997. Just over 33,100 cases were reported in 2005. The number of infected reported decreased in 2006, which may be explained by the discovery of a mutated variant of the Chlamydia bacterium in the autumn of 2006 that it was not possible to diagnose using the test methods that were currently used at about half of the test laboratories in Sweden. It is also probable that there is a large number of unreported cases in which people, and in particular men, carry the infection without knowing about it. Men are seriously underrepresented in statistics of people who take a Chlamydia test, and men amount to only 40 percent of reported cases. There are also large differences between regions and variations from one year to the next in the number of recorded cases of Chlamydia. There may be several reasons for this, including access to testing and counselling, and different practices and procedures within the health and medical care systems.

During the first half of 2007, 22,610 cases of Chlamydia infection were reported, an increase of 52 percent over the corresponding period of 2006. This increase is to a large extent a result of better diagnosis of the new genetic variant of *Chlamydia Trachomatis*. A further element of the explanation may be that the number of people examined increased. It is, therefore, difficult to compare directly the figures with those of previous years. It is usual that fewer cases are reported during the first six

months of the year than under the subsequent six months, a fact that may be a result of more people becoming infected during the summer and taking a test when they return from holiday (Figure 4). As previously, more than half of the cases were women (57%).

**Figure 4. Numbers of cases of Chlamydia reported per six-month period, 1997-2007**



Source: SMI

The mean age was, as previously observed, 20 years for women and 22 years for men. The greatest increase was seen in the age-range 15-19 years (the figure for 2007 was 72 percent greater than that for 2006), and in the age-range 20-24 years (54%). The increase in the same period recorded in those counties that mainly used the Becton Dickinson test in 2006 (which identified also the new variant) was 27 percent. Chlamydia continues to be an infection whose principal route of infection is heterosexual (94% of all cases during the past year.) Chlamydia is an infection that spreads most significantly indigenously within Sweden.

### Abortion

The current Swedish law on abortion came into force in 1975 and entails essentially free abortion until the end of the 18th week of pregnancy. Exclusively women decide to have an abortion and request that it be carried out. The number of abortions each year has increased since 2000. There were 36,045 abortions carried out in 2006, compared to 34,978 in 2005. This means that the number of abortions has increased from 20.2 per 1,000 women in 2005 to 20.6 per 1,000 women in 2006, an increase of two percent. For teenage abortions the figure is 25.4 per 1,000 women in 2006, an increase of five percent from 2005.

### Youth Clinics

There are 227 Youth Clinics in Sweden today. The overall aims of the clinics are to promote physical and mental health, reinforce young people in the development of their identities such that they can manage their sexuality, and prevent unplanned pregnancies and sexually transmitted infections. The youth clinics should be able to receive all young women and men. The upper age limit lies between 20 and 25 years. The most common upper age limit is 23 years. Most of the clinics do not have a lower age limit.

The work comprises individual counselling, examinations, treatment, group activities and outreach. Outreach activities may consist of receiving study visits from school classes, providing information for schools, and acting as a supplement to the education into sex and relationships given by schools. The Youth Clinics can also work with targeted group activities, such as groups of boys or girls, young people with disability, or immigrant youths. A clinic always has midwives, counsellors and/or psychologists, and physicians. The clinics may have access to further categories of personnel in addition to these, based on local needs and conditions.

## **Challenges and remedial actions**

### **Organisation and leadership**

Sweden has carried out preventive measures for HIV-infection since the middle of the 1980s. This work has been evaluated, and a new National Strategy against HIV/AIDS and Certain other Contagious Diseases was adopted in 2006. Although a lot of good work has been done the review demonstrated a need for more systematic approaches. Several factors had given rise to a need for the work to be reinforced and renewed. It was clear that the organisation concerning the responsibility for planning, coordination and monitoring needed clarification, as did the control of how resources were deployed. All of these factors led to a major reorganisation of HIV/STI preventive work in Sweden. The renewal and reorganisation of HIV/STI prevention and funding mechanisms, while keeping up effective preventive work has been a challenge.

During the review process there was a slowing down of new initiatives. A change in government naturally also led to the delay of the establishment of, the National Council for HIV Prevention since the Prime Minister appoints the Chair. This council has a special role in coordinating the multisectoral work between authorities and other stakeholders. A further consequence of the change of government was the shelving of a planned reform for upper secondary education that contained new guidelines for education related to sexuality and HIV. However many general new initiatives in the education sector form a potential platform for improved prevention work.

The reorganisation of the Swedish welfare system with ongoing processes of restructuring and privatisation poses a fundamental structural challenge to HIV/STI prevention. Preventive measures are often perceived as a marginal activity of health care and education and can therefore be given low priority during restructuring.

The new clearer mechanisms for coordination and monitoring that are being put in place, will give better possibilities to monitor and adjust the work continually.

### **People newly arrived in Sweden**

An agreement between the Swedish government and the Swedish Association of Local Authorities and Regions states that county councils are to offer persons newly arrived in Sweden who are covered by the agreement (those seeking asylum, and others) health counselling and health checks in which HIV testing is included. 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. The fraction of the target group that undergoes such a health check has been estimated to be as low as 40 percent. There are also large differences between different parts of the country with respect to the proportion of asylum-seekers who undergo health checks. The conduct of the counselling and health check also differs throughout Sweden. Publication 1995:4 ("Health and Medical Services for Asylum-Seekers and Refugees") by the NBHW gives a certain amount of advice on how the counselling and examination is to proceed. Immigrant relatives, many of whom come from regions with high HIV prevalence, constitute a large group of immigrants who are currently offered health checks on a very limited basis.

Interim objective 2 of the National Strategy states that HIV-infection among people seeking asylum and newly arrived relatives is to be identified within two months. Epidemiological surveillance should be deepened and methods to reach persons at a higher risk among those of foreign background should be developed. The national strategy also emphasises the importance of health checks for asylum-seekers, immigrant relatives, etc., in the work to prevent the spread of HIV.

A project is under way at the NBHW the aim of which is to create a broadly supported plan of action to significantly increase the amount of health counselling, the number of health examinations, and testing for HIV, other STIs and certain other diseases for newly arrived asylum-seekers, immigrant relatives, etc. This project is being carried out within the framework of a project entitled "Human Rights in Health and Medical Care and the Social Services", a comprehensive project covering several programmes of the NBHW. One of the aspects that the project is to investigate whether those individuals who today have the right to be offered such an examination are really reached, and also whether others whose behaviour is believed to place them at greater risk should be given the same rights. The NBHW is working towards the inclusion of all new immigrants, not just asylum-seekers, among those who are to be offered health counselling and health checks on their arrival in Sweden.

## **Monitoring and evaluation**

### **National level**

Sweden has not previously had a national action framework for HIV prevention. Work is currently under way to operationalize the National Strategy that was passed in 2005 and that is to guide the Swedish work on HIV prevention. This operative strategy has been divided into eight areas, based on the classification of those whose behaviour places them at greater risk laid down by the National Strategy: men who have sex with men, injecting drug users, people whose origins are in high prevalence areas, young people and young adults, people who travel abroad, pregnant women, people involved in commercial sex, and people who are living with HIV infection. Objectives are to be drawn up and the identification of suitable indicators for monitoring the strategies and activities that are specified in the government bill has begun. The indicators are to be harmonised as far as is possible, in order to make it possible to follow the development in Sweden over time, to make

it possible to compare data with other countries, and to improve the monitoring of the Declaration of Commitment. National action frameworks within the various fields are to be drawn up and incorporated into the operative strategy.

The establishment of an HIV prevention unit within the NBHW with a clear mandate for coordination, monitoring and evaluation will make systematic monitoring easier in the future. The greatest challenge facing the establishment of a well-functioning monitoring system in Sweden is to achieve a system of regular reporting of information from the county councils and municipalities to the national level.

## **Regional and local levels**

The responsibility for carrying out preventive measures directed at the general public and at those whose behaviour places them at greater risk lies to a large extent with municipalities and county councils. The government can control work at local and regional levels that is regulated by legislation: the Communicable Diseases Act and the Health and Medical Services Act. Broad work across several sectors directed at public health is not regulated, and can only be controlled by other means, such as the granting of national funding and the spread of knowledge. The government grant for HIV and STI prevention amounts to SEK 146 million, (approx. 22 million USD). Two thirds of this has been reserved for regional and local work.

The NBHW collects information about activities implemented with the support of the state funding, in order to follow up the regional and local work. The Swedish Institute for Infectious Disease Control monitors the epidemic through the regional county medical officers of communicable disease control, who report the number of HIV cases. This monitoring is well - established. The NBHW coordinated broad regional distribution of funds for various people whose behaviour places them at greater risk, and the organisation of the regional and local work.

A further method is that of knowledge management. This involves offering support and the development of knowledge, and in this way providing a basis of regional and local preventive work. Focal points on HIV and STI issues have been appointed within each county council and large urban municipality during 2006-2007. Training in the method of the "logical framework approach" has been organised both for focal points and for organisations that receive government funding for HIV preventive work.

Regional and municipal work differs throughout Sweden, depending on local conditions and requirements. The planning, control and organisation of the work also differ throughout Sweden. This gives rise to certain problems with respect to coordinated reporting at the national level. The NBHW has drawn up a unified reporting system for regional and local work. The system will involve the annual collection of the following information starting in 2008:

- systems for planning, monitoring and coordination
- regional and local studies and evaluations
- information initiatives and their directions
- work carried out with the support of government funding, and the relationship of this work to national goals.

This annual information will be supplemented by follow-up visits. It is planned that all county councils and large urban municipalities are to be visited during a three-year period, starting in October 2007.

## Best practices

Three examples have been selected to illustrate important initiatives in Sweden to prevent the spread of HIV. "The HIV School" has been selected as an example because it is an important project for a group that is vulnerable with respect to information and support, namely HIV-infected children. The other two examples show methods of reaching a large number of people with important information about sexuality and HIV/STIs. "Sexaktuellt.se" is a website with information directed primarily to persons newly arrived in Sweden and to asylum-seekers. "The Main Thread" is a manual of methods in sexuality and relationships directed at young people.

### The HIV School

Just over 100 children and teenagers under 18 years are currently living with HIV infection in Sweden. Just over half of these live in Stockholm and the others live throughout Sweden. The number of children infected with HIV is so small in most county councils that it has proved difficult to build up resources to meet all the needs of every child in all parts of Sweden. Medical matters are handled either by the Child Health Services or by health services for infectious diseases. All of these children and young people need information, support and counselling that is appropriate for their age. Older children and teenagers also require education and information about sexuality and preventing the spread of infection, such that they can live a full life without exposing others to risk. These children and young people often end up in limbo in the health care system, since methods that are suitable for their age are often lacking, as are adequate resources and knowledge to meet the needs of this group.

The HIV School has been run nationwide since 1999, with activities based at the Karolinska University Hospital in Stockholm. The activities include annual educational opportunities in the form of extended weekend camps at which children infected with HIV aged 10-16 years from all over Sweden can take part. A similar course and HIV conference is arranged each year for older teenagers and young adults aged 17-26 years. This conference is also nation-wide and is arranged as a residential conference lasting four days. The programme includes team-building exercises, lectures, yoga and time to just be together.

The aim of The HIV School is to provide information about HIV and prevention of transmission of HIV to others that is suitable for their ages. A further aim is to relieve the feeling of loneliness and self-stigma of the individual child. Participation in the HIV School provides children an extended network of peers who know that they are HIV-positive and who live in the same situation. The meetings provide the children and teenagers with information about medication, and information about the body and how it develops during puberty. Various teaching methods are used to give the children and the teenagers the possibility to share experiences, both in groups and individually, various issues related to puberty, emotional life, sexuality and HIV. The individual child or teenager gains strength by sharing their individual experiences with others. It is important to show that it is possible to live a normal life without exposing others to the risk of infection. At each educational session, one young HIV-infected person is invited to act as an example and to inform the others how life in Sweden with respect to education, partners, preventing infection, partners and children, can work out for a young person with HIV infection.

### **Comments from participants at The HIV School aged 10-16 years:**

- *It felt good to meet other children with HIV, now I know that I am not alone with it.*
- *Talking about HIV felt strange, but a good feeling. I'm just not used to it.*
- *It's good to make what is a pretty big thing actually quite normal. Here, for example, you don't have to lie about why you're taking medicines, and you don't feel that you have to be careful. Not only that, it's fun as well, and it's not always that you get the chance to "open up" as you do here.*
- *I had already learnt about HIV in Eritrea, but now I've learnt a lot more, such as what the medicines are called.*

### **Comments from participants at The HIV Conference for young adults, 17-26 years old:**

#### ***What did you think was good about the conference?***

- *-Meeting new friends and getting answers to my questions.*
- *Finding out about how others live and finding out how people have told others about their infection*
- *I got to meet a lot of new people who don't have secrets from each other ... people that I can trust.*
- *The patience of the leaders. Great people. I'm not as scared as I was about starting medication.*
- *The lectures were good and educational, they have given me hope.*

## **www.sexaktuell.se**

One half of those who are registered in Sweden as infected with HIV have their origin in other countries. Sweden accepts large numbers of refugees and immigrant relatives. Many of the newly arrived may find it difficult to understand information in Swedish. Hence, information on HIV is presented in various languages.

Studies have shown that those with more global contacts use the Internet more frequently. People who are often in contact with other countries through their work, through newspapers or through visits use the Internet to a greater extent than people who are not so often in contact with other countries. Overall, Internet-use among immigrants is approximately as great as it is among the general population, while it is higher than the use among, for example, people who vote for the Social Democratic Party or for the Centre Party.<sup>10</sup>

Immigrants to Sweden thus find information evermore frequently through the Internet: many, for example, read newspapers and other information in their mother tongue in this way. That means that this channel is particularly suitable as a means to reach immigrants with information in the field of HIV and AIDS, sexuality and relationships. Publishing on the Internet also allows easier and more continuous updating in several languages, something that is significantly more expensive when using printed material.

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<sup>10</sup> Torsten Österman i Mediesverige 1997, Nordicom-Sweden.

A further advantage when using the Internet is that it is possible to be completely anonymous when collecting information. It is not even necessary to disclose one's voice, as is necessary when calling a telephone helpline. Thus the Internet offers new opportunities particularly for people – who may be more prevalent in certain immigrant groups – who find it awkward and embarrassing to pose questions about sexuality and sexually related diseases.

The website [www.sexaktuellt.se](http://www.sexaktuellt.se) was started by the Swedish National Institute of Public Health in 1999, and has been under continuous development since then. It is now possible to read at "sexaktuellt" brief facts about abortion, contraception, sexually transmitted infections and HIV/AIDS in 13 languages. The starting page is available in Swedish and in English. It is also possible to order material, make contact with immigrant organisations that work with issues of HIV and AIDS in Sweden, make contact with other NGOs, find a calendar of events, read brief notes in Swedish and English, and links to other sites. Statistics show that the site receives approximately 40,000 unique visitors every month.

Enquiries carried out by health care personnel have shown that the website has been of major significance for health care personnel who meet newly arrived migrants. Antenatal clinics, contraception counselling services, STI clinics, youth centres, primary health clinics and clinics of infectious diseases all have links to the website and can rapidly print out information sheets from PDF-files.

Responsibility for planning, coordinating and monitoring the work to prevent the spread of HIV and other STIs was taken over by the National Board of Health and Welfare one year ago. The update of the website was interrupted for a period as a result of this. A comprehensive review is currently under way of the complete field of communication. The Sexaktuellt website will undergo evaluation in the near future and its development will then continue.

<b>www.sexaktuellt.se</b> <b>is available in the following languages:</b>		
Albanian	Finnish	Somalian
Arabic	French	Spanish
Croatian	Persian	Thai
English	Russian	Turkish

## **The Main Thread – a handbook on sexuality and personal relationships among young people**

“The Main Thread – a handbook on sexuality and personal relationships among young people” is targeted at those who work with sexuality and personal relationships among young people in the age range 13-19 years. The Main Thread has been produced by LAFA, the Stockholm County Aids Prevention Programme. The aims of LAFA are to promote sexual health, to prevent the spread of HIV and other STIs, and to prevent unplanned pregnancies in Stockholm County. The idea of creating a handbook arose at the beginning of the 1990s, when LAFA discovered that many participants of informative training in issues of HIV/STIs and unplanned pregnancies did not know *how* they were to carry out health promotion work or other preventive work in practice. The aim of The Main Thread is foster knowledge through dialog involving sexuality and health using a method based on value judgement, support and further education. The Main Thread provides methods for communicators and peer-educators.

Most of the methods used in The Main Thread have been obtained from schools and youth clubs in Stockholm County, meaning that they are firmly anchored in practice. Practical exercises alternate throughout the book with theoretical sections. The handbook, The Main Thread, has a perspective that creates well-being and promotes health. The perspective involved with creating well-being involves texts and methods that are based on sexuality as a possible factor of healthy living, the assumption that sexuality is a positive force in the life of young people, and the belief that sexuality is something that most young people desire and choose to experience. A health-promoting perspective involves sexuality as a factor for health as long as one’s own experiences of influence and self-determination are allowed to be expressed. A further theoretical basis of the texts and methods presented by The Main Thread are social constructivism. This involves sexuality being considered as culturally determined and historically specific. Sexuality changes and is recreated in a never-ending interplay between the individual, the group, and society.

The Main Thread has been published in the form of a folder that is easy to update. Each chapter is introduced by a text explaining the theory and theme of that chapter and teaching methods that can be used when working with young people. The Main Thread contains the following chapters: Introduction, Planning work with sexuality, Self-esteem, Relationships, Value clarification exercises, Sexuality and contraceptives, Ethics, The downside of sexuality, Further methods, Texts for in-depth study, and Further literature.

The Main Thread can be bought at a subsidised price. Purchasers subsequently receive a subscription to continuous updates of the texts and methods. A person who purchases The Main Thread for a workplace will then become focal point at the

workplace. All focal points are invited to four seminars or sessions of advanced training every year.

The Main Thread is one component of the LAFA model, which is a model for the support and further education of people working with HIV prevention. The LAFA model includes a wealth of courses, seminars, information material, methods material, knowledge-based reports, the magazine "Insikt", and the website lafa.nu. LAFA also runs the websites kondom.nu and p-guiden.nu, which deal with issues of sexuality and contraception, targeting young people. Furthermore, LAFA provides approximately 1 million condoms each year, which are primarily distributed through schools and youth clinics. The Main Thread, together with these other components, has been a didactic tool in the work of LAFA to promote health and prevent ill-health for more than 10 years. The Main Thread is now used at 537 schools, 69 youth centres, 38 youth clubs, 46 NGOs, 54 local council administrations and 49 clinics within the health and medical care system. The Main Thread has been ordered by a total of 821 purchasers. The use and the spread of The Main Thread must also be seen against the background of Sweden's history of compulsory education in sexuality and relationships in schools stretching back more than 50 years.

The Main Thread was evaluated in 2001, through a survey with questionnaires and interviews. The evaluation showed that 75% of respondents had used one or more of the methods presented, 82% had used the in-depth texts when preparing, and 87% considered that The Main Thread had been a support in their education in sexuality and relationships. The evaluation concluded that the texts, methods and lists of material used by The Main Thread, and the context of the LAFA courses, seminars and points of contact, were experienced by those who work with young people, sexuality and health as a support. The positive results of The Main Thread in practice have stimulated LAFA to further develop its work with material that presents methods for communicators and peer-educators. A handbook in methods is now available for those working with sexuality and personal relationships among 10-13 year-olds and a further handbook of facts and methods for those working with persons whose mother tongue is not Swedish. The latter material is intended for those working with newly arrived refugees and immigrants.

LAFA receives each year study visits from 100-150 persons who work with HIV prevention throughout the world. The Main Thread was translated into English in 2004, and has since then been ordered by 265 NGOs and institutions all over the world. The handbook of methods was translated into Russian in 2006, financed by the Swedish International Development Agency, SIDA, and 1,700 books have since then been distributed in Russian and Russian-speaking areas. LAFA's work with The Main Thread has thus in this way developed and reached an international audience. The contents of the handbook have not been modified in the English and Russian translations in order to suit other cultures and societies: the book is presented as an example of LAFA's work with preventing the spread of HIV and AIDS among young people, and promoting their health. The idea has been that those who use the handbook will adapt the level and the focus as required by their own situation, and it has been concluded that there are more issues that are common across cultures and societies than issues that divide, when working with preventing the spread of HIV and AIDS among young people.

[www.lafa.nu](http://www.lafa.nu)

## **Sweden in the international work against HIV/AIDS**

A salient feature of Sweden's international work on HIV and AIDS and the efforts to contribute to the implementation of UNGASS declarations is found in Sweden's international development cooperation. One of the few donor countries that reaches the 1 % target of GDI for ODA, Sweden devotes considerable financial resources in supporting affected countries to fight HIV and AIDS, a work that has had a very high political priority in the national budget since 2003.

Thus, Sweden's total direct allocations to the work against HIV and AIDS have increased threefold during 2003-07, from SEK 478 million to SEK 1 482 millions. The main reason is the fivefold increase of Sweden's multilateral support, from SEK 166 million to SEK 942 million.

This is, however, gives only a partial picture. Much of Sweden's large international development cooperation contributes in an indirect way to the fight against HIV and AIDS, through, for instance, support to health systems, to education and schools, to the furthering of human rights etc. These allocations are not specifically targeted against HIV and AIDS but contribute nonetheless to the overall work against the pandemic.

A second characteristic of Sweden's international commitment is the focus on the complexity of HIV and AIDS and the readiness to discuss and act on also difficult questions. These deal i.a. with gender and the lack of power for women and girls, human rights, stigma and discrimination, leadership. The fight against HIV and AIDS will not be won by simplifying complex issues.

Thirdly, Sweden's work against HIV and AIDS is firmly situated in the context of the broad development agenda. Since HIV and AIDS affects virtually every single sector in the countries that are hardest hit, the work against the pandemic must be seen in this development perspective, both in countries' own priority setting and development processes and for donors in their decisions on allocation of budgets.