Mika Salminen (editor)

UNGASS HIV/AIDS COUNTRY PROGRESS REPORT FINLAND

January 2006–December 2007

Kansanterveyslaitoksen julkaisuja B 4/2008
Publications of the National Public Health Institute

”The beauty and significance of this Declaration of Commitment is in its pragmatic and straight-forward approach. By adopting the Declaration, the world has made a commitment to scale up efforts with specific targets and time frames in all critical areas including prevention, care, treatment and support.

The Declaration is a call for leadership and commitment at all levels in all countries; it is a frame-work for broad partnerships, and a tool for specific strategies, involving communities, young people and people living with HIV/AIDS, to turn the tide of the epidemic.”

Quote from the Closing Statement by H.E. Mr. Harri Holkeri, President of the General Assembly at the conclusion of the United Nations General Assembly special session on HIV/Aids, 27 June 2001

Kansanterveyslaitos
Folkhälsoinstitutet
National Public Health

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Reporting period: January 2006–December 2007

KTL - National Public Health Institute, Finland
Department of Infectious Disease Epidemiology and Control
HIV- Unit
-
Kansanterveyslaitos
Infektioepidemiologian ja -torjunnan osasto
HIV-yksikkö
-
Folkhälsoinstitutet
Avdelningen för infektionsepidemiologi och smittskydd
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National Public Health Institute (KTL)
Mannerheimintie 166
FIN-00300 Helsinki, Finland
Telephone +358 9 474 41, telefax +358 9 4744 8408

Kansanterveyslaitos
Mannerheimintie 166
00300 Helsinki
Puh. vaihde (09) 474 41, telefax (09) 4744 8408

Folkhälsoinstitutet
Mannerheimvägen 166
00300 Helsingfors
Tel. växel (09) 474 41, telefax (09) 4744 8408

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Cover graphic - kannen kuva – pärmbild: UN General Assembly High Level UNGASS follow-up meeting 2006. © Mika Salminen

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ABSTRACT

On June 25-27, 2001 the UN General Assembly Special Session (UNGASS) on HIV/Aids was held in New York. During the session and the multilateral negotiations accompanying it, the UN addressed HIV/Aids at the General Assembly level for the first time as a single issue. The Special Session was chaired by Mr Harri Holkeri, Councillor of State from Finland.

At the HIV/Aids Special Session, State Parties agreed on measures and targets to stop the HIV-epidemic by 2015. The General Assembly adopted the Declaration of Commitment on HIV/Aids "Global Crisis – Global Action", which defines the priority areas of enhanced action to fight the HIV/Aids epidemic. The UN follows the implementation of the Declaration of Commitment through regular indicator reporting. Additionally, in 2006, a high level review meeting was held New York to follow the progress achieved. The next such review meeting will again be held at UN headquarters June 10-11, 2008.

This report outlines the cross-sectorial HIV/Aids work done in Finland in 2006-2007. The report has been compiled under the guidance of the Ministry of Social Affairs and Health in cooperation with the Ministry for Foreign Affairs and the Civil Society/NGO sector. The National Public Health Institute HIV-unit has been responsible for data collection, analysis and report collation, drafting and coordination.

All relevant branches of government have been consulted and encouraged to submit their input during the report preparation.

In a global comparison and even compared to its EU-peers, HIV/Aids prevention, treatment care and support has been successful in Finland. Similar to many EU-countries, Finland fulfils and even exceeds most of the UNGASS Declaration of Commitment goals, even on the indicator level.

However, despite the relatively favorable HIV/Aids-situation, sexually transmitted HIV-infections have clearly increased in Finland during recent years. The reporting brought forward relevant future risks and need for improvement especially concerning long-term prevention work. Second generation behavioral surveillance among adult population would need to be further developed.

National cross-sectorial coordination would probably require strengthening to prevent a future deterioration of the epidemiological situation. The findings of the UNGASS-reporting process will be utilized in the development of future HIV/Aids action plans during 2008.

Keywords: HIV, Aids, Finland, Incidence, Prevalence, Country Report, UNGASS

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TIIVISTELMÄ

Vuonna 2001 (Kesäkuu 25-27) järjestettiin YK:n yleiskokouksen 26. erityisistunto teemanaan HIV/Aids (United Nations General Assembly Special Session on HIV/Aids; UNGASS) New Yorkissa. Istunnon ja sen aikaisten monenvälisten neuvottelukierrosten aikana YK käsitteli ensimmäistä kertaa HIV/Aids:ia kaikkien jäsenmaiden yhteisenä asiana yleiskokouksen tasolla. Yleiskokouksen puheenjohtajana toimi valtioneuvos Harri Holkeri Suomesta.

HIV/Aids- erityisistunnossa YK:n jäsenmaat sitoutuivat pysäyttämään HIV-epidemian etenemisen vuoteen 2015 mennessä. Istunnon loppuasiakirjassa (Declaration of Commitment on HIV/Aids ”Global Crisis – Global Commitment”), määritellään prioriteetit, joilla epidemian vastaisia toimia on tehostettava. YK seuraa loppuasiakirjan tavoitteiden toimeenpanoa tasaisin välein toimitettavan indikaattoriraportoinnin kautta. Lisäksi tavoitteiden saavuttamista tarkistetaan yleiskokouksen seurantakokouksissa, joista edellinen pidettiin vuonna 2006. Seuraava seurantakokous pidetään kesäkuussa 2008.

Tässä raportissa käsitellään vuosina 2006-2007 Suomessa tehty poikkihallinnollinen HIV/Aids-työ. Raportti on koottu Sosiaali- ja terveysministerion johdolla, tiiviissä yhteistyössä Ulkoministeriön ja kansalaisjärjestökentän kanssa. Tiedot on koonnut, tulkinnut ja koonnut raporttimuotoon Kansanterveyslaitoksen HIV-yksikkö.

Raportti on valmisteluvaiheessa käynyt useassa vaiheessa lausuntokierroksilla kaikkien oleellisten hallintosektoreiden ministeriöillä ja laitoksilla sekä laajalla järjestökierroksella. Myös kuntasektorille varattiin mahdollisuus lausuntojen antamiseen.

HIV/Aids-epidemian hallinnassa Suomi on onnistunut sekä kansainvälisessä että EU-tason vertailussa erinomaisesti. Kuten monet muutkin EU-maat, Suomi täyttää ja useassa tapauksessa ylittää lähes kaikki UNGASS HIV/Aids deklaraation epidemian ehkäisyn tavoitteet, myös indikaattoritasolla.

Vaikka HIV/Aids-tilanne Suomessa on hyvä monien mittareiden tasolla, seksivälitteiset tartunnat ovat viimeisten vuosien aikana selvästi lisääntyneet. Raportointi toikin esiin merkittäviä riskejä ja parantamisen tarvetta erityisesti ehkäisevän työn alueeella. Myös käyttäytymiseen liittyvää riskikäsitys- ja terveysseurantaa aikuisväestöllä tulisi kehittää.

HIV/Aids-työn kansallinen poikkihallinnollinen koordinaatio vaatisi vahvistamista mikäli hyvä epidemiologinen tilanne halutaan tulevaisuudessa säilyttää. UNGASS-raportoinnin kautta esiin nousseita asioita onkin tarkoitus hyödyntää HIV/Aids-toimintaohjelman uudistamisprosessissa vuonna 2008.

Asiasanat: HIV, Aids, Suomi, Ilmaantuvuus, Esiintyvyys, Maaraportti, UNGASS

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SAMMANDRAG

Den 25-27 Juni, 2001, höll FN:s generalförsamling en specialsession om HIV/Aids (United Nations General Assembly Special Session on HIV/Aids; UNGASS) i New York. Under specialsessionen och därtillhörande multilaterala konsultationer behandlade FN:s generalförsamling för första gången HIV/Aids som en separat gemensam fråga. Ordförande för specialsessionen var statsråd Harri Holkeri från Finland.

Under specialsessionen förband sig FN:s medlemsländer att stoppa HIV-epidemin före år 2015. Sessionen slutade med antagandet av en deklaration, Declaration of Commitment on HIV/Aids ”Global Crisis – Global Commitment” där medlemsländerna förbinder sig till specifika prioriteter för handling mot detta mål. FN följer upp deklarationen genom återkommande indikator-rapportering. Därtill följs målsättningarna genom uppföljningsmöten på hög nivå. Detta gjordes först år 2006, och följande möte kommer att anordnas i New York i Juni 2008.

I rapporten beskrivs multisektorialt HIV/Aids-arbete i Finland 2006-2007. Rapporten är utformad under vägledning av Social- och hälsovårdsministeriet samt i samarbete med Utrikesministeriet och medborgarorganisationer. Materialet är samlat, tolkat och producerat till rapportform av Folkhälsoinstitutets (KTL) HIV-enhet.

Under rapportens produktionsperiod har alla relevanta administrativa sektorer (inklusive kommunsektorn) samt ett stort antal medborgarorganisationer hörts i flera skeden och getts tillfälle att kommentera rapporten.

I bekämpandet av HIV/Aids-epidemin har Finland lyckats väl både i internationell jämförelse och i relation till andra EU-länder. Liksom ett flertal andra EU-länder, uppfyller och i ett flertal avseende även överträffar Finland UNGASS HIV/Aids deklarationens målsättningar, även på indikatornivå.

Även om situationen ser ut att vara under relativt god kontoll, finns det dock risker och hotbilder som borde åtgärdas. Antalet sexuellt överförda HIV-fall i Finland har ökat klart under de senaste åren. Rapporteringen påvisade speciellt resursbrister i preventivt HIV/Aids arbete, samt behov för förbättring av riskuppfattnings- och sexualhälso-uppföljningsstudier bland vuxenbefolkningen.

Den nationella koordinationen av preventivt HIV/Aids arbete skulle också kräva förstärkning och utveckling ifall det goda epidemiologiska läget skall kunna upprätthållas i framtiden. Dessa frågor kommer att uppmärksammas under utformningen av ett nytt nationellt HIV/Aids verksamhetsprogram under år 2008.

Ämnesord: HIV, Aids, Finland, Insidens, Prevalens, Landrapport, UNGASS

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List of abbreviations

MoSAH	Ministry of Social Affairs and Health
MFA	Ministry for Foreign Affairs
KTL	National Public Health Institute
STAKES	National Research and Development Centre for Welfare and Health
LTHSC	Low Threshold Health Service Center
PLWHA	People living with HIV/AIDS
NIDR	National Infectious Disease Register (main infectious disease passive surveillance system)
MSM	Men who have sex with men
IDU	Injecting drug user/use
MTCT	Mother to child transmission
GCW	Global coalition for women
NAC	National AIDS Committee
DALY	Disability Adjusted Life Years lost
YLD	Years Living with a Disability
YLL	Years Lost due to Disability

1. Status at a glance

1.1. Inclusiveness of the stakeholders in the report writing process

The report writing process was initiated in the spring of 2007, by a letter of consultation sent by the Ministry for Foreign Affairs (MFA) to the National Public Health Institute – (KTL) through the Ministry of Social Affairs and Health. This letter was prompted by the request of the Director of UNAIDS, Dr. Peter Piot for UNGASS reporting 2008. Following this, a coordination meeting of the abovementioned main governmental actors was commenced at the MFA on June 8, 2007. At this meeting, the main responsibilities of the actors were discussed and divided.

As vice-chair (KTL) and chair (MoSAH) of the NAC, KTL and the MoSAH were assigned the main work of collection and analysis of indicator data. In the process, they would consult all significant stakeholders both at the data collection, report drafting and prior to final submission stages. It was decided, that the HIV-unit of KTL will assume the main coordinating and drafting responsibility in the report writing process, supported as needed by the MoSAH.

In addition, KTL assumed responsibility for data collection and collation of the of the National Composite Policy Index (NCPI) questionnaires part A:

I. Strategic Plan
II. Political Support,
III. Prevention,
IV. Treatment, care and support and V. Monitoring and evaluation).

The MFA assumed responsibility for delivery of the final report and collection and collation of Global Commitment and Action indicators.

An important role of Civil Society NGO actors in the reporting process was recognized at the June 8 coordination meeting. It was decided to involve civil society not only as respondents at the report data collection stage, but also through two specific consultation and coordination activities.

For the collation of the National Composite Policy Index (NCPI) questionnaires part B

I. Human rights,
II. II. Civil society participation,
III. III. Prevention,
IV. IV and Treatment, care and support),

the Finnish HIV-network (a network of Finnish national and multilateral NGO/Civil Society actors; see attached list in section 11.2.6) was asked to act as the coordinator for responding to this part**.**

After completion of a first draft of the report, it was submitted to the NGO-actors and a hearing session of one half day was organized on November 19th. Feedback from the

NGO/Civil society actors was incorporated into a new draft, which was sent for final review on the 4th of December, 2007 to additional relevant NGO, civil society and governmental stakeholders.

Finally, the feedback of the review was incorporated into the report after which it was submitted to UNAIDS in January 2008.

1.2. Status of the epidemic

In 2007, 184 new HIV cases were reported in Finland. Cumulatively 2258 HIV-cases had been reported in Finland (as reported by 2.1.2008). Of these 492 had developed AIDS, of which 281 had died. For the year 2006 the corresponding figures were 2089 (HIV-infection), 459 (AIDS) and 273 (AIDS death).

1.2.1. Surveillance of HIV/AIDS

HIV-infection, AIDS and AIDS death are reportable diseases/conditions in Finland. Reporting and case linking is performed through comprehensive use of national personal social security insurance identity numbers, given at birth or at entry for legal long term immigration. The European Case definitions for HIV and Aids are followed in reporting.

Access to free-of-charge HIV-testing is through publicly funded municipal health care centers (main primary care providers). If requested, testing can be performed anonymously. Anonymous testing is also available through several different NGO settings and the private sector.

By law, both diagnostic laboratories and treating physicians report cases to the Finnish National Public Health Institute (KTL), which maintains the National Infectious Disease Registry (NIDR) for passive surveillance purposes. The system records major transmission groups and has been in use without major changes since the mid-1980s.

Voluntary targeted unlinked-anonymous studies are used as additional data sources to address prevalence in vulnerable groups. Blood and organ donations are universally screened for HIV and all expecting mothers are offered voluntary HIV-testing (opt-out regimen in place since 1998).

1.2.2. The HIV epidemic

The HIV/AIDS epidemic reached Finland in the mid-1980s. The epidemic has followed a western-European type of evolution with a consistently low annual incidence and prevalence rate of both HIV-infection and AIDS. Initially, the epidemic affected mostly men having sex with men (MSM), so that for many years, the majority of cases were in this transmission group. During the first 10-15 years of the epidemic HIV incidence and prevalence in Finland was among the lowest in a comparison of western European countries. By 2006-2007, the incidence rate has risen close to that of other Nordic Countries, but is still lower than in most old EU member states.

A feature of the Finnish HIV epidemic is that almost no IDU-associated HIV cases were recoded during the 1980s and the beginning of the 1990s. This is in sharp contrast to almost all other western European countries, including Sweden, Norway and Denmark, where large-scale outbreaks occurred in the 1980s. However, in 1998 the situation changed, when an outbreak was recorded among IDU mainly in the capital area. A strong prevention effort to counteract the outbreak was put in place, centering on development of Low Threshold Health Service Centers for IDU, providing health advice, referrals, small-scale care, vaccinations, rapid testing and injection equipment exchange. These efforts seem to have had an effect, since the outbreak has subsided and the prevalence never rose above 5 % within the subgroup.

During the late 1990s and especially after the year 2000, more and more cases of heterosexual transmission have been annually reported, and heterosexual transmission has for several years in a row been the largest transmission group. Approximately one third to one half of cases in this transmission category are reported among immigrants.

In 2006, reported cases of sexual transmission increased approximately 30 % compared to the year before. In 2007, preliminary surveillance data indicates that this increase seems to have been sustained.

1.2.3. AIDS and AIDS death

AIDS and AIDS-deaths peaked in Finland in 1994 and 1995, at 43 cases and 31 deaths, respectively. Since then, cases have declined, especially AIDS deaths. In 2007, 8 AIDS deaths were reported and only 3 in 2007. The reduction in AIDS deaths despite an increase in HIV-cases corresponds to the comprehensive access to care and ARV-treatment. After an initial sharp decline in reported AIDS-cases after start of widespread access to ARV-triple therapy in 1997, AIDS-cases have increased again since the turn of the century to approximately 25 cases annually. Most of these cases are diagnosed simultaneously as, or close to HIV-infection.

1.2.4. Current HIV prevalence and incidence estimates:

Population HIV prevalence rate of approximately 2 / 10.000 population*
Population HIV incidence rate of approximately 35 / million population*

HIV prevalence among vulnerable groups.

Estimated HIV prevalence among MSM: 4.5 % (2.6 - 7.3 %, CI 95 %) **
Estimated HIV prevalence among IDU: 1.4 % (0.5 – 3.2 %, CI 95 %) **

* based on passive reporting surveillance data (2007)
** based on cross-sectional unlinked-anonymous sampling data (2006 and 2005)

Figure 1 HIV Prevalence and Incidence

1.3. Policy and programmatic response

1.3.1. Main objectives of the Finnish HIV/AIDS prevention policy

Prevention of new infections is the key target of policy measures. For those who become infected, there is guaranteed free access to medically indicated treatment and care.

Support for full social empowerment of persons who have been infected to reduce their vulnerability is an essential part of prevention policies. Prevention activities are managed through national coordination and a multidisciplinary public/private partnership approach.

1.3.2. Main target groups of national HIV/AIDS prevention policy

- Youth are the most important target group, including the MSM group which must also be reached
- Prevention of infection risks and drug use among injecting drug users are equally important.
- Special attention needs to be directed to prisons, socially marginalised group, immigrants and sex workers
- Prevention of Mother to child transmission MTCT must be comprehensive
- Transmission within the healthcare sector must be completely eliminated, while simultaneously ensuring equal access to services for those living with HIV/AIDS

1.3.3. Main approaches to HIV/AIDS prevention

- HIV/AIDS prevention, treatment and care are integrated in a cross cutting way into multi-sectorial public health, social welfare and education programs on municipal, regional and national levels
- Health education and promotion are the main modes of influencing the development of the future epidemic
- Impact trough schools: health education as a standard compulsory subject for primary grades 7-9 as well as secondary grades I - II and includes sexual health and STD risk education
- Effective treatment and support measures are an integral part of prevention
- Support for full social empowerment of persons who have been infected to reduce their vulnerability is essential.
- HIV testing practices and epidemiological surveillance systems generate relevant information for intervention planning

- The level of competence of social and healthcare professionals must be a maintained and expanded by continuous primary and work associated education and training

- Legislation will respond with changes as needed if the HIV/AIDS situation changes

- Management of the situation through coordination and a multidisciplinary action

1.3.4. Political documents that exist with regard to HIV/AIDS prevention

1. The Health 2015 Public Health Programme. Government resolution, Helsinki 2001. 36 p. (Publications of the Ministry of Social Affairs and Health, ISSN 1236- 2050: 2001:6) ISBN 952-00-0982-5.

2. National HIV/AIDS policy for 2002-2006. Published in Helsinki, March 5, 2002. HIV Expert Group, Ministry of Social Affairs and Health.

3. National HIV/AIDS prevention strategy for 2008-2012 (draft 2007, to be completed by 1.6.2008). HIV Expert Group, Ministry of Social Affairs and Health.

4. Drug policy action programme 2004-2007. Government decision 2004.

5. Promotion of sexual and reproductive health. Action programme 2007–2011. Helsinki 2007. 200 pp. (Publications of the Ministry of Social Affairs and Health, Finland. ISSN 1236-2050, 2007:17). ISBN 978-952-00-2376-8 (paperback), ISBN 978-952-00-2377-5 (PDF)

6. National Tuberculosis Control Programme 2006. Helsinki 2006. 144pp. (Publications of the Ministry of Social Affairs and Health, Finland, ISSN 1236-2050, 2006:21) ISBN 952-00-2120-5 (paperback), ISBN 952-00-2121-3 (PDF)

1.3.5. Funding for HIV/AIDS prevention, treatment, care and support

The public financial resources allocated to HIV/AIDS prevention are divided between multiple actors and sectors. In many cases HIV/AIDS-prevention activities are linked to general health prevention and education activities. There is no specific budget line for the purpose and a comprehensive estimation of the resources used for HIV/AIDS has not been made. Prevention of health problems is according to the Law on Public Health (Kansanterveyslaki) the responsibility of the municipal government. Therefore, the responsibility for prevention, treatment and care lies within the municipally managed public national social services and health system providers.

HIV/AIDS prevention, care and support are mainly integrated into the public healthcare social care/welfare and education activities on state, regional and municipal levels. No specific publicly budget line earmark funded HIV/AIDS-specific governmental organizations exists.

On a municipal level, responsible authorities are the municipal social welfare and health boards and the municipal health centers (publicly funded primary healthcare providers). For primary education the municipal school boards and the primary and secondary education system (Comprehensive school and High school system) has the main responsibility for health promotion and sexual health education, including HIV/AIDS prevention education in schools.

Several national NGO and Civil Society organizations are actively involved in HIV/AIDS prevention and health education work. These are frequently partly or entirely funded through public/private partnerships with municipal and/or national funding agencies.

1.4. UNGASS indicator data: overview table

1.4.1. National indicators

Commitment and Action

Indicator	Description	Value
1	Domestic and international AIDS spending by categories and financing sources	Estimate not available
2	National Composite Policy Index (Areas covered: gender, workplace programs, stigma and discrimination, prevention, care and support, human rights, civil society involvement, and monitoring and evaluation)	Supplied in Annex 2

National Programs

Indicator	Description	Value
3	Percentage of donated blood units screened for HIV in a quality assured manner[1]	100%
4	Percentage of adults and children with advanced HIV infection receiving Antiretroviral treatment[2]	> 90 %
5	Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission[2]	> 95 %
6	Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV[2]	> 90 %
7	Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results[3]	> 95 %
8	Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results[4]	> 95 %
9	Percentage of most-at-risk populations reached with HIV prevention programs	Not known
10	Percentage of orphaned and vulnerable children aged 0–17 whose households received free basic external support in caring for the child[5]	> 99 %
11	Percentage of schools that provided life skills-based HIV education in the last academic year[6]	> 95 %

Data sources:

[1] Finnish Red Cross transfusion services
[2] Hospital Districts, MoSAH
[3] Primary healthcare providers
[4] Primary healthcare providers, Low threshold health service center sentinel surveillance network (KTL)
[5] MoSAH
[6] National Board of Education

Knowledge and Behavior

Indicator	Description	Value
12	Current school attendance among orphans and among non-orphans aged 10–14*[7]	> 99 %
13	Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*[8]	> 85 %
14	Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Not known
15	Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15[9]	Girls aged 14: 15 % Boys aged 14: 15 %
16	Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	Not known
17	Percentage of women and men aged 15–49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse*	Not known
18	Percentage of female and male sex workers reporting the use of a condom with their most recent client	Not known
19	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Not known
20	Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse[10]	39-67 %
21	Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected[11]	80-84 %

[7] MoSAH, National Board of Education
[8] Eurobarometer survey 2006
[9] School Health Survey 2006 and 2007
[10] "Risk"-study, Partanen et al. (2006) Publication series of the A-clinic foundation 52
[11] "Risk"-study, Partanen et al. (2006) Publication series of the A-clinic foundation 52, Low threshold health service center sentinel surveillance network (KTL)

Impact

Indicator	Description	Value
22	Percentage of young women and men aged 15–24 who are HIV infected[12]	0.03 %
23	Percentage of most-at-risk populations who are HIV infected[13]	IDU: 1.4 % MSM: 4.5 %
24	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy[14]	> 90 %
25	Percentage of infants born to HIV-infected mothers who are infected[15]	0 %

1.4.2. Global Indicators

Indicator	Description	Value
1	Amount of bilateral and multilateral financial flows (commitments and disbursements) for the benefit of low- and middle-income countries[16]	20,5 M€
2	Amount of public funds for research and development of preventive HIV vaccines and microbicides[17]	Vaccines 2006: 1.3 M€ 2005: 2.6 M€ Long term investment 6.6 M€
3	Percentage of transnational companies that are present in developing countries and that have workplace HIV policies and programs	To be supplied by UNAIDS
4	Percentage of international organizations that have workplace HIV policies and programs	To be supplied by UNAIDS

[12] National infectious disease surveillance system
[13] MSM survey and prevalence study 2006, IDU LTHSC visitor prevalence studies
[14] Hospital Districts
[15] National infectious disease surveillance system
[16] Ministry for Foreign Affairs
[17] TEKES and SITRA

2. Overview of the HIV/AIDS epidemic in Finland in 2006-2007

The HIV/AIDS epidemic reached Finland in the mid-1980s. The epidemic has followed a western-European type of evolution with a consistently low annual incidence and prevalence rate of both HIV-infection and AIDS. Initially, the epidemic affected mostly men having sex with men (MSM), so that for many years, the majority of cases were in this transmission group. During the first 10-15 years of the epidemic HIV incidence and prevalence in Finland was among the lowest in a comparison of western European countries. By 2006-2007, the incidence rate has risen close to that of other Nordic Countries, but is still lower than in most old EU member states. In 2006, 193 new HIV cases were reported, and in 2007 the same figure was 184 cases (per 2.1.2008).

A feature of the Finnish HIV epidemic is that almost no IDU-associated HIV cases were recoded during the 1980s and the beginning of the 1990s. This is in sharp contrast to almost all other western European countries, including Sweden, Norway and Denmark, where large-scale outbreaks occurred in the 1980s. However, in 1998 the situation changed, when an outbreak was recorded among IDU mainly in the capital area. A strong prevention effort to counteract the outbreak was put in place, centering on development of Low Threshold Health Service Centers for IDU, providing health advice, referrals, small-scale care, vaccinations, rapid testing and injection equipment exchange. These efforts seem to have had an effect, since the outbreak has subsided and the prevalence never rose above 5 % within the subgroup.

During the late 1990s and especially after the year 2000, more and more cases of heterosexual transmission have been annually reported, and heterosexual transmission has for several years in a row been the largest transmission group. Approximately one third to one half of cases in this transmission category are reported among immigrants.

In 2006, reported cases of sexual transmission increased approximately 30 % compared to the year before. In 2007, preliminary surveillance data indicates that this increase seems to have been sustained.

2.1. Access to VCT

Access to free-of-charge HIV-VCT is provided through publicly funded municipal health care centers (main primary care providers). In Finland, the majority of the outpatient primary care services are within the public sector, as are >95 % of the hospitals. More than 400 municipalities are served by approximately 250 municipal primary health care centers, which all offer free-of-charge HIV-testing services for municipal residents. If requested, testing can be performed anonymously. Testing is performed by licensed clinical micro-biological and immunological laboratories which have to follow set quality control and monitoring schemes according to internationally agreed standards.

Anonymous testing is also available through several different NGO settings. Injecting drug users are offered referral based and/or rapid point-of-care testing at IDU Low Threshold Health Service Centers (LTHSC). Similarly, there are NGO-based anonymous VCT services available using rapid testing schemes, provided by the Finnish AIDS Council. The Finnish Red Cross also provides free of charge HIV-testing.

HIV testing is available in correctional facilities under similar VCT conditions as in the civil sector.

Private healthcare services offering HIV VCT are also available.

2.2. HIV screening

No risk-group based screening or routine population HIV-testing is employed in Finland. However, to ensure the safety of blood and organ transplantations and to prevent mother-to-child HIV transmission, all blood and organ donations are universally screened for HIV-infection (using antibody, antigen and NAT-technology) and all expecting mothers are offered HIV-testing (opt-out regimen in place since 1997). In both cases, results are confidential.

Under existing law HIV-testing is not allowed as a prerequisite for employment, studies or for serving in military or paramilitary forces. Neither is involuntary screening performed in correctional facilities or for immigrant populations. Both are, however, offered as part of preventive medical care.

2.3. Surveillance schemes: passive surveillance for incidence estimation and prevalence back-calculation

HIV-infection, AIDS and AIDS death are reportable diseases/conditions in Finland.

Reporting and case linking is performed through comprehensive use of national personal social security insurance identity numbers, given at birth or at entry for legal long term immigration. Many other infectious diseases follow the same reporting scheme as HIV, but more information on disease status is collected.

By law (Law on infectious diseases and associated decree[18]), both diagnostic laboratories and treating physicians report cases to the Finnish National Public Health Institute (KTL), which maintains the National Infectious Disease Registry (NIDR[19]) for passive surveillance purposes.

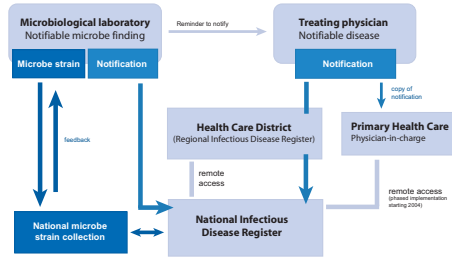


Figure 2: National Infectious Disease Notification System – NIDR

Data submission follows the schematic described in the figure. The system records major transmission groups and has been in use without major changes since the mid-1980s.

2.4. Surveillance schemes II: sampling-based studies for prevalence estimation in specific groups

Voluntary targeted unlinked-anonymous studies are used as additional data sources to address prevalence in vulnerable groups. They have been used to estimate HIV prevalence among IDU: s at an approximately bi-annual rate and more recently also been applied to prevalence estimation among MSM.

[18] Law on infectious diseases 25.7.1986/583 and associated decree 31.10.1986/786

[19] National Infectious Disease Registry (NIDR): www.ktl.fi/ttr

2.5. HIV/AIDS in major and minor transmission groups in 2006-2007

By the end of 2007 (data as reported by 2.1.2008), cumulatively 2258 HIV-cases had been reported in Finland. Of these 492 had developed AIDS, of which 281 had died. For the year 2006 the corresponding figures were 2089 (HIV-infection), 459 (AIDS) and 273 (AIDS death). For HIV and AIDS reporting, Finland follows the European case definitions for AIDS and HIV-infection from 1993. http://www.ktl.fi/portal/4792

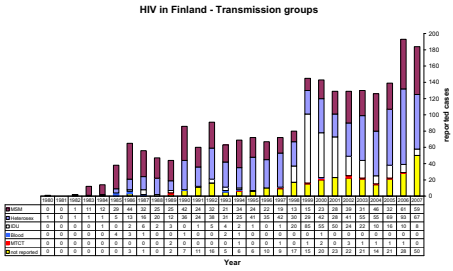


Figure 3: Annually reported HIV by Transmission Category

Annually reported HIV infections have steadily increased in Finland since the beginning of the epidemic in the 1980s. The first known HIV-case in Finland stems from 1980 (retrospectively identified).

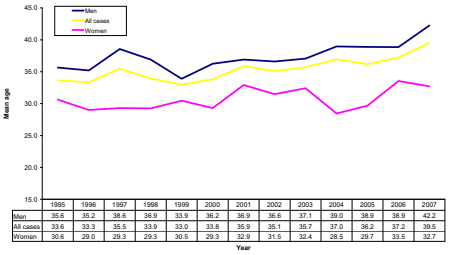
In the beginning years of the epidemic, HIV-infection was very much associated with MSM and few cases in other transmission groups were recorded. In the 1990s more heterosexually transmitted cases appeared, both among migrants coming from high-endemic areas but also among native Finns. By the late 1990s, the epidemic seemed to have stabilized at approximately 60-80 cases reported annually.

A particular feature of the Finnish epidemic is the absence of an IDU-associated epidemic during the 1980s. While all other Nordic countries experienced large outbreaks in this group during this time period, very few cases appeared in Finland, despite active case-finding and even screening efforts among some vulnerable groups (notably prison inmates).

In the late 1990s, however, this changed: in a few years beginning in 1998 more than 300 new cases were reported among IDU. Since then, strong prevention efforts seem to have been able to limit the outbreak and prevent the establishment of high prevalence and permanent endemicity in the group (se below chapter 2.5.2 for further details).

During the period of 2000 to current times, a clear trend of increased cases in the sexual transmission group is seen, both in the MSM and heterosexual transmission categories.

In 2006, cases in the sexual transmission increased by approximately 30 % compared to the previous year, raising concerns of the need to improve prevention efforts for this transmission category. The same trend seems to continue in 2007.

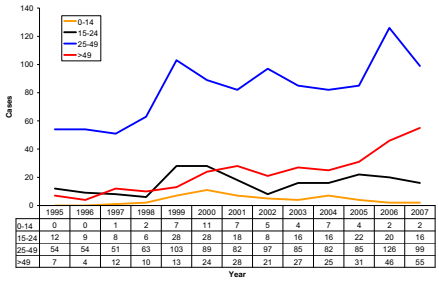


	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Man	35.6	35.2	38.6	36.9	33.9	36.2	36.9	36.6	37.1	39.0	38.9	38.9	42.2
All cases	33.6	33.3	35.5	33.9	33.0	33.8	35.9	35.1	35.7	37.0	36.2	37.2	39.5
Women	30.6	29.0	29.3	29.3	30.5	29.3	32.9	31.5	32.4	28.5	29.7	33.5	32.7

Figure 4: Mean Age at HIV Diagnosis

The age distribution among HIV cases on diagnosis has remained relatively high over the years. The mean age has risen from approximately 34 years to 40 since 1995. Especially among men, the rise in mean age is significant.

Cases among women are on average 5 years younger than men at HIV diagnosis.



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
0-14	0	0	1	2	7	11	7	5	4	7	4	2	2
15-24	12	9	8	6	28	28	18	8	16	16	22	20	16
25-49	54	54	51	63	103	89	82	97	85	82	85	126	99
>49	7	4	12	10	13	24	28	21	27	25	31	46	55

Figure 5: Age Group Distribution at Diagnosis

As seen by the age group chart, the increase in mean age is particularly due to the increase in the oldest age group, but partly also the group of 25-49 year old, where a strong increase was seen in 2006 compared to previous years.

The peak among youth (15-24 year old) seen in the years 1999 to 2001 is largely due to an outbreak among IDU during those years.

AIDS in Finland follows the general epidemiology of other western highly developed countries. After a substantial lag compared to HIV-infection, the incidence of AIDS rose to its maximum level in 1994-1995, when 44 and 43 cases, respectively, were reported.

After 1996 and 1997 combination antiretroviral therapy including protease inhibitors became widely available in Finland and AIDS diagnoses dropped markedly. The lowest level was recorded in 1999, when only 11 cases were notified to the NIDR.

Currently, approximately 25 AIDS cases are annually reported. Of these, over half are discovered simultaneously or within 1 month of their HIV-diagnosis, and therefore probably largely represent long-term, previously undetected infections.

The level of underreporting of AIDS cases has not been formally estimated, but is not likely to be very high due to the few numbers of cases. It is known to be higher among immigrant populations, partly due to loss-to-follow-up due to further migration. There is no evidence of higher in AIDS incidence among permanent residents with immigrant background compared to native Finns.

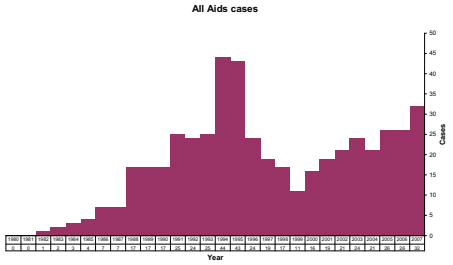


Figure 6: Annual Newly Reported AIDS-Cases in Finland

Deaths are followed two ways for reported HIV cases. Deaths due to AIDS are reported to the NIDR similarly to AIDS and HIV-infection. In addition, cases are regularly (weekly) linked to death reports in the national Population Register, which records all causes of death among residents in Finland.

Therefore, deaths due to AIDS and due to other causes can be distinguished.

Mortality surveillance shows, that during the period of up to 1998, most deaths among HIV-infected were due to AIDS. Since then, however, the majority of deaths occur due to other reasons. In 2006, only 3 AIDS-related deaths occurred, representing only 10% of all deaths among HIV cases. A large part of the reduction in AIDS-related death is probably due to wide coverage and good compliance of ARV-treatment.

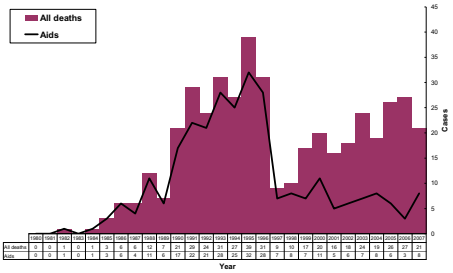


Figure 7: Annual newly reported deaths among HIV-infected in Finland

Non-AIDS related deaths in the group of HIV cases are overrepresented in the IDU-transmission category, which may currently underestimate the proportion of AIDS-related
deaths. The proportion may change in the future.

2.5.1. HIV infection: Sexual transmission

Sexual transmission has increased its share and numbers among annually reported HIV cases in Finland. This trend is seen both in the transmission group of men who have sex with men (MSM) and among cases in the heterosexual group.

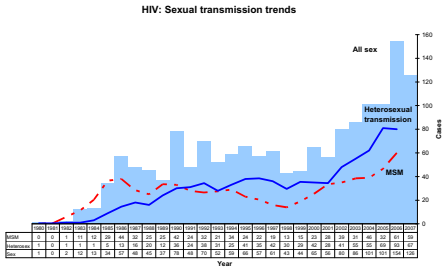


Figure 8: HIV Infection - Sexual Transmission Trends

2.5.1.1. Men who have sex with men (MSM)

Among MSM the reversed trend is clearly visible, as cases diminished during the whole period of the 1990s, but have again slowly started rising in the present century (red trend line).

The main crossing point of the trend was seen in 1998, when reported cases among MSM reached their lowest point of only 13 cases. Since then annual figures have risen slowly but constantly, so that in 2006 an all-time-high of 61 cases were reported in this group.

Most cases in the MSM group are among individuals who are Finnish citizens at the time of diagnosis.

The prevalence of HIV-infection among MSM was empirically estimated for the first time in 2006 using an anonymous survey and linked testing oral fluid mail-in testing scheme. Among the approximately 400 study participants, HIV prevalence was found to be 4.5 % (CI 95, 3 – 7%). The estimate is biased by higher socioeconomic status, age and regional representativeness, but does provide evidence of significant prevalence at least in a part of the vulnerable subpopulation.

2.5.1.2. Heterosexual transmission

Similar to the MSM group, the trend of heterosexual transmission shows a strong rise in annually reported cases during the latest century. In 2006 a record number of 94 cases were reported in this transmission category.

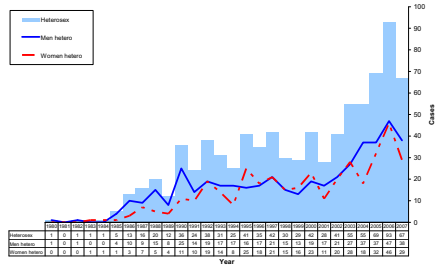


Figure 9: Heterosexual Transmission

Approximately 63 % (n = 59) of cases reported in this category in 2006 were

among individuals with Finnish citizenship at diagnosis. This is slightly higher, but consistent with the proportion seen in previous years. 2007 figures are not adjusted for reporting delay.

2.5.1.2.1. Men

A slight majority of cases in the heterosexually transmitted category are seen among men. The sex ratio among the cases is 1:1.2. Among Finnish nationals at diagnosis, the ratio is on average higher, approximately 1:1.6.

Among immigrant populations, the sex ratio is reversed, approximately 0.8:1.

In 2006, 47 cases of HIV infection among men were recorded in the heterosexual transmission category.

2.5.1.2.2. Women

Women represent on average approximately 45 % of annually reported cases in the heterosexual transmission category. The growth in annually reported numbers for heterosexual transmission is also seen among women, but the trend is slightly less pronounced that that seen among men, especially if only Finnish citizens at date of diagnosis are considered.

2.5.2. HIV infection: Injecting drug use

Finland experienced its first domestic outbreak of HIV-infection among IDU only in the late 1990s, more than 10 years later than most western European countries. Even the countries closest benchmarks, the other Nordic countries of Sweden, Norway and Denmark experienced severe HIV epidemics among IDU in the mid- and late 1980: s.

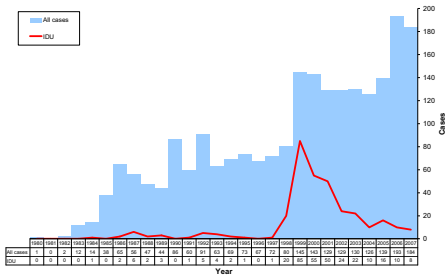


Figure 10: Injecting Drug Use

Prior to 1998, few IDU associated cases were reported, and most of them were reliably associated with likely transmission abroad. However, in 1998 a rapid increase in cases in this category was recorded. Since then, a total of 325 cases (by November 9, 2007) in this category have been reported, most of which are linked to the original epidemic.

In the last few years, however, the number of annually reported cases has strongly diminished, so that in 2006 only 9 cases and in 2007 only 6 (by November 9, 2007) cases were reported.

Additional data from anonymous sampling based surveillance shows that the prevalence has remained low in the group, despite continuously high Hepatitis C prevalence. A prevalence study was last performed in 2005 and late 2007. The 2005 data indicates a prevalence of approximately 1.4 % HIV infection among IDU. Preliminary analysis of 2007 data suggests that prevalence has remained low.

2.5.3. Mother-to-child transmission - MTCT

The total number of cases reported to be due to MTCT since start of surveillance in 1980 is 14 cases. All but one of these cases have occurred prior to arrival to Finland.

Table 1: HIV-testing among Pregnant women in Finland 1998-2006

	1998	***1999***	***2000***	***2001***	***2002***	***2003***	***2004***	***2005***	2006
Tested	60055	58670	59112	57427	59112	60300	60060	59343	59659
HIV + cases	5	7	8	13	12	13	8	16	13

All expecting mothers in Finland who participate in maternity care services (>> 99 % of pregnancies) are offered HIV-testing. Annually approximately 60.000 pregnant women are tested. Approximately 40 % of the women have had their first HIV diagnosis through the MTCT testing system.

Since the start of the screening programme (1998) and associated efficient MTCT prophylaxis for both the mother and child, no children have been infected with HIV in Finland through this transmission route, when HIV infection has been diagnosed prior to delivery. In a follow-up study between 1993 and 2007 in the largest maternity ward in Finland, 96 healthy children without HIV-infection had been born to HIV infected women by November 2007[20]. Only one child was infected during this period, and in this case the mother's infection was only diagnosed after delivery.

2.5.4. Blood and organ donations

The total number of HIV infections due to blood or tissue products or due to organ transplants reported in Finland since 1980 is 14.

Table 2: HIV testing among blood donations in Finland

	1998	*1999*	*2000*	*2001*	*2002*	*2003*	*2004*	*2005*	*2006*
Donated units tested	349120	335751	330635	322357	312455	297292	285794	274870	278220
HIV+	0	0	0	0	2	2	0.0	1	2
/100 000	0.00	0.00	0.00	0.00	0.64	0.67	0.00	0.36	0.72

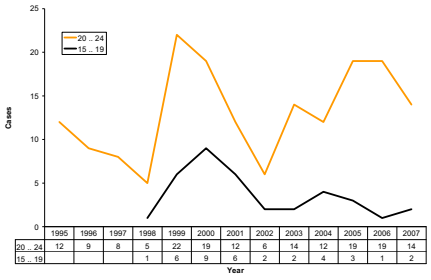
However, no cases of HIV infection due to domestic blood transfusions or blood products have been reported to have taken place in Finland after 1985.

[20] Päivi Lehtovirta, 2007. Obstetric and Gynecological Aspects of HIV-infection in Finland. 79 p. University of Helsinki, Faculty of Medicine, Doctoral Thesis. Yliopistopaino, Helsinki. ISBN 978-952-92-2757-0.

2.5.5. Special considerations and vulnerable groups

2.5.5.1. Youth

Among youth aged 15-24 years old, HIV-infection is relatively rare. Totally, 304 cases have been reported, 46 in the ages of 15-19 and 258 in the age group of 20-24 years old. The prevalence in the age-group is approximately 0.03 % based on a population of 260.000[21] and taking into account deaths.



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
20 .. 24	12	9	8	5	22	19	12	6	14	12	19	19	14
15 .. 19				1	6	9	6	2	2	4	3	1	2

Figure 11: HIV-infection among youth

Cases in these age groups occur mainly in the IDU (30.5 %), Heterosexual transmission (35.5 %) and MSM (13 %) categories. In the younger (15 – 19 year old) age group, 54 % (n = 25) of the cases are among migrants, many of which may have been infected through MTCT. The peak of 1999-2001 was clearly associated with an outbreak among IDU.

Surrogate markers

Chlamydia and Hepatitis C virus infection among youth can be considered surrogate markers of sexual and injecting drug use associated HIV-risks among youth and are followed as indicators of risk changes.

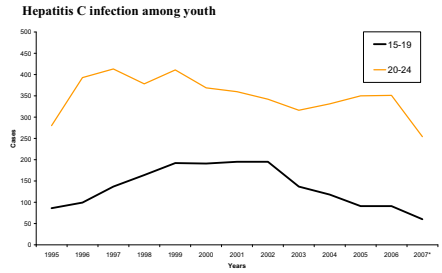


Figure 12: Hepatitis C infection among youth. * adjusted for reporting delay

In the age-groups of youth, HCV-infection has declined during the last 6-8 years, indicating less risk associated with IDU (see later chapters for prevention programme).

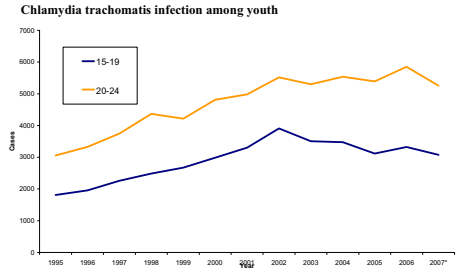


Figure 13: Chlamydia trachomatis infection among youth. * adjusted for reporting delay

In contrast to Hepatitis C infection, Chlamydia infection is common among youth and shows no sign of clear decline, suggesting common risk for sexual transmission. Therefore, general STI prevention efforts are particularly targeted to youth and adolescents.

2.5.5.2. Migrants

HIV cases according to citizenship at diagnosis

A significant proportion of HIV cases in Finland are seen among immigrant populations, as defined by citizenship status at the time of reporting. Of the total number of reported cases in Finland, 28.5 % has been among immigrants.

[21] National Population register, 2006

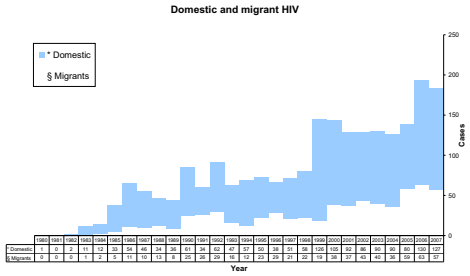


Figure 14: Domestic and Migrant HIV infection. * Finnish Citizenship, § Foreign citizenship

While these cases do affect disease burden, the effect on the evolution of domestic epidemiology is less significant since the reported cases represent the epidemiology of the originating country.

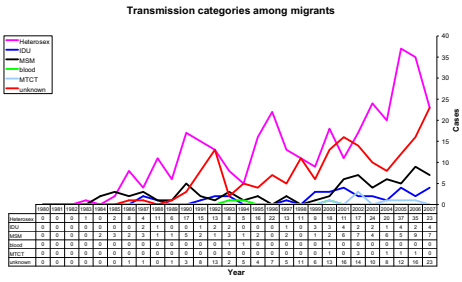


Figure 15: Migrant HIV-cases and Transmission Category

The most common transmission category among migrants is heterosexual transmission. The proportion of cases for which there is no reported transmission category is high, probably due both to re-migration before physician reporting and/or due to inability to identify the most likely way of transmission.

The proportion of MSM cases among migrants has somewhat increased since the turn of the millennium.

2.5.5.3. Travelers

A significant proportion HIV cases have a travel association. Of cases among Finnish citizens, 38 % have been reported to be travel-associated (390 cases by 2006). The absolute majority belongs to the sexual transmission group.

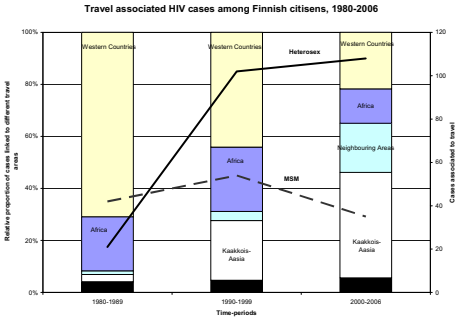


Figure 16: Travel Associated HIV-cases among Finnish Citisens, 1980 - 2006

Travel associated cases are clearly linked to areas to which Finns travel frequently. General areas where cases have been reported to occur have changed somewhat over time, as shown by the below figure.

The largest numbers of travel-associated cases in recent years are linked to travel to South-East Asia.

2.5.5.4. Neighboring areas

HIV-cases linked to neighboring areas with recently expanding epidemics have slowly increased, both due to travel and migration. In total, 32 cases linked to eastern European neighboring areas have been reported.

2.5.5.5. Correctional facilities

VCT applying rapid testing is offered as part of regular health care services in correctional facilities. Cases are reported using the same reporting system as the for the general public health service and are not identified separately, but separate monitoring of positive results collected in a cooperation between KTL and the prison health services.

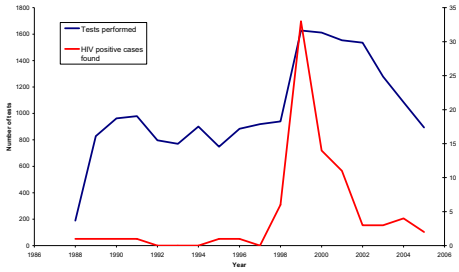


Figure 17: HIV in Correctional Facilities

2.5.5.6. Sex workers

There is no specific information on the incidence or prevalence of HIV infection among sex workers in Finland. This group is not included in routine reporting in the regular passive surveillance system, although the association is sometimes reported. However, rapid HIV testing offered in low threshold services by NGO service providers does not indicate that prevalence would be especially high.

However, due to high-prevalence epidemics in neighboring areas where a significant proportion of sex worker temporarily working in Finland originate from, there is a potential for high prevalence in this group in the future.

3. National cost estimates for HIV/Aids

As HIV/Aids prevention, treatment, care and support activities are to a large extent integrated into general primary, secondary and tertiary health care, the total spending or resources allocated cannot be reliably estimated without a major effort.

Even direct costs and the disease burden are challenging to estimate reliably over any longer time-periods. Recently, the European Center for Disease Prevention and Control (ECDC) commissioned a joint pilot study[22,23] to perform a rough estimate on disease burden due to a number of important infectious diseases in Europe. One of the diseases covered was HIV-infection and Aids.

While the ECDC study was a pilot with several limitations, especially in comparability across countries and years, it applied a standard composite methodology to estimate disease burden (Disability Adjusted Life Years), which could be used to make national estimates.

Assessments of disease burden are often based on singular health metrics, such as incidence, prevalence or mortality data alone. However, as diseases and their consequences are heterogeneous in terms of morbidity and mortality it is difficult to get an overall estimate of disease burden. Composite health measures attempt to overcome this by combining mortality, incidence (and/or prevalence) and the sequelae associated with a disease. The Disability Adjusted Life Years (DALYs) is such a composite measure that can be helpful in estimating disease burden.

In addition to composite measures, direct current costs of an epidemic and future predictions can be estimated using average standard estimates of costs/case.

While both methods are relatively crude and contain significant uncertainty and/or bias in several regards, they do provide some guidance on the scale of current and future disease burden and costs.

National resource allocation for HIV/Aids prevention, treatment, and care and support activities can be estimated only for a small minority of activities. These mainly consider very targeted activities which have a separately distinguishable budget. The majority of HIV/Aids prevention, treatment, care and support activities in Finland are too integrated into other activities to allow for direct resource allocation estimation.

3.1. *Disease burden associated with HIV/Aids*

The method used in this report is based on the above mentioned report, which in turn is an application of the methodology first described by Murray and co-workers in the Global Burden of Disease (GBD) project[24,25]

[22] van Lier E, Havelaar A, Nanda A, . The burden of infectious diseases in Europe: a pilot study. Euro Surveill 2007;12(12)[Epub ahead of print]. Available online: http://www.eurosurveillance.org/em/v12n12/1212-222.asp

[23] van Lier E, Havelaar A. The burden of infectious diseases in Europe: a pilot study. (Printed matter) RIVM report 215011001/2007. RIVM, P.O. Box 1, 3720 BA Bilthoven. Available online: http://rivm.nl/bibliotheek/rapporten/215011001.html

[24] Murray CJ, Acharya AK. Understanding DALYs (disability-adjusted life years). J Health Econ 1997; 16(6):703-30.Murray CJ, Lopez AD.

[25] Global mortality, disability, and the contribution of risk factors: Global Burden of Disease Study. Lancet 1997; 349(9063):1436-42.

3.1.1. Disability Adjusted Life Year (DALY) estimates

Estimating Disability Adjusted Life Years lost was done using the following equation:

DALY = YLL + YLD

YLL is the number of years of life lost due to mortality and YLD is the number of years lived with a disability, weighted with a factor between 0 and 1 for the severity of the disability. The YLL due to a specific disease in a specified population is calculated by summation of all fatal cases (d) due to the health outcomes (l) of a specific disease, each case multiplied by the expected individual life span (e) at the age of death:

$$YLL = \sum_{l} d_l \text{ x } e_l$$

Figure 18: YLL formula

YLD is calculated by the product of the duration of the illness (t) and the severity weight (w) of a specific disease, accumulated over all cases (n) and all health outcomes (l):

$$YLD = \sum_{l} n_l \text{ x } t_l \text{ x } w_l$$

Figure 19: YLD Formula

Applying the DALY methodology involves making several choices on details of the analysis, which should reflect value choices that are relevant to the decision-maker.

Value choices, such as disability weighting, age-weighting and discounting, imply that life years are assigned different value depending on the age and the health state they are in.

Disability weighting means that each outcome of a disease is assigned a different value (severity weight) on a scale from 0 (perfect health) to 1 (death), (see original pilot study for some examples).

For this report, the following (value) choices were made in as in the pilot study:

- to use incidence rather than prevalence data;
- to use HIV-infection, Aids and Aids death as outcomes;
- not to apply discounting and age-weighting;

For this report, the following differences were applied compared to the pilot study

- use of the historical yearly average lifetime in Finland to calculate life expectancy and YLD rather than the life expectancy of a standard life table;
- use of the historical yearly average lifetime of Aids death cases for the calculation of YLD
- to estimate annual disease burden since 1980
- Different duration of illness and severity weights for HIV-infection and Aids during the time-periods of 1980 – 1996 and 1997 – 2006 depending on the scenario applied (see below).

For DALY based burden of disease estimations, two different scenarios were applied:

> **Scenario 1.** Disease burden under the assumption of equal access to HAART (ARV treatment) since 1997

Scenario 2. Disease burden under the assumption of no access to HAART (ARV treatment)

Since effective ARV treatment has been practically universally available in Finland since 1997, a longer time of living with disease but a lower severity weight was used in scenario 1 in the estimations compared to the original pilot report. The factors used were the following:

Table 3: Scenario 1, Equal Access to HAART

Scenario 1	1980-1996		1997-	
	Avg duration (y)	severity	Avg duration (y)	severity
*YLD factors used (HIV):	10	0.136	17.2	0.2
** YLD factors used (Aids):	2	0.505	5.36	0.38

To simulate for scenario 2 the real incidences (as annual cases reported) of Aids and Aids death were replaced with modeled figures between 1997 and 2007. YLD factors used for this scenario were the same throughout the period and similar to the time-period of 1980-1996 in scenario 1.

In the model of scenario 2, Aids cases were estimated based on the average of the prior 4 years of the relative ratio of HIV of and Aids cases. Aids death cases were similarly weighted to be based on reported HIV cases. In the model this resulted in an annual HIV/Aids ratio of 0.47-0.52 and an HIV/Aids death ratio of 0.41-0.42.

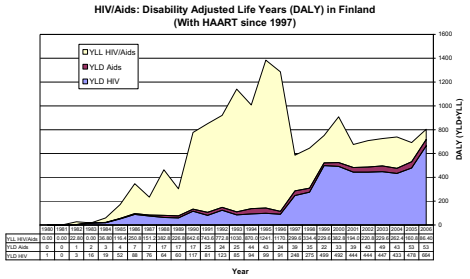


Figure 20: Disease Burden under scenario 1 (real data)

While the model is very simple, it incorporates a possibility to compare the impact of ARV-treatment on a relatively conservative estimate of the evolution of the epidemic in case treatment had not been available or applied.

Calculations using real reported data collected through the passive reporting system show that the cumulative disease burden over the entire epidemic in Finland until 2006 adds up to 16221 Disability Adjusted Years of Life (DALY) lost due to HIV/Aids.

This is not the only conclusion that can be drawn from the DALY estimates. Examining the changes that occur when effective ARV-treatment became available shows the clear saving in terms of life lost that treatment brings. Even though the value of the YLD measure (Years Living with Disability) increases due to longer estimated life after diagnosis, the YLL measure (Years Lost due to Death) strongly decrease, leading to a much reduced total DALY.

The result would suggest that treatment is highly cost-effective in terms of reducing the loss of productive life, although estimating the magnitude would require availability of a parallel matched cohort who did not receive treatment. As this is not available, modeling was applied to get some idea on DALY savings (see below).

It should be noted that the estimates include several factors of uncertainty.

Especially the estimates of average duration of disease and the severity factor are uncertain, particularly for the time-period where effective ARV-treatment has been widely available.
The representation of the DALY-estimate as an annually calculated value is also not necessarily the best way and should be interpreted with a degree of caution. It does, however, reflect an objective estimate of the DALY for reported cases.

A further uncertainty stems the fact that the model applies no discounting for future years lost.

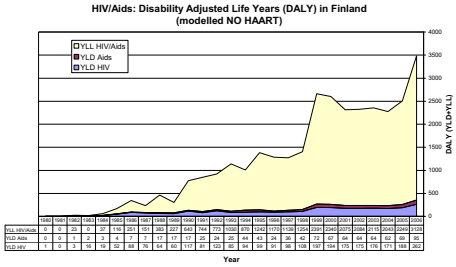


Figure 21: Disease Burden under scenario 2 (data modeled for 1997-2006)

Disease burden was also modeled for a situation where ARV would not have become widely available in 1997. This was primarily done as a thought experiment and should be interpreted with due caution. In the model several of the data are relatively crudely estimated, which may bias the interpretation significantly.

However, assumptions made on annual incidence of Aids and Aids death in no-ARV scenario during 1997-2006 were conservative and based on the assumption that neither rate weighted to HIV-incidence increases (or decreases) significantly. Some conclusion may therefore be drawn, bearing in mind the limitations of the scenario analysis.

Comparison of disease burden with and without ARV

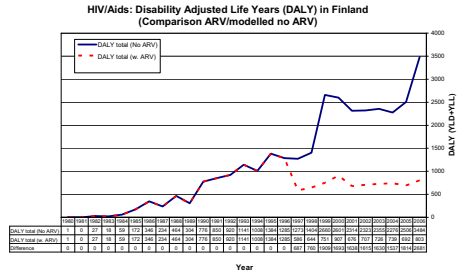


Figure 22: DALY in Finland ARV and No ARV Scenarios

Comparing the no-ARV model with the estimate of disease burden based on real data clearly shows how large the effect of treatment is: compared to the no-ARV model, application of efficient ARV was estimated to have saved close to 16.000 DALY in the last 10 years (table and figure), which is as much as the total of the epidemic disease burden calculated based on reported HIV, Aids and Aids death incidence.

Table 4: Comparison Disease Burden with and without ARV

Comparison DALY	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	total
ARV Available	586	644	751	907	676	707	726	739	692	803	16221
No ARV model	1273	1404	2660	2601	2314	2323	2355	2276	2506	3484	32185
Difference (DALY Saved)	687	760	1909	1693	1638	1615	1630	1537	1814	2681	15964

A more detailed examination of the no-ARV model reveals that treatment availability increases the HIV YLD estimate, but this is clearly compensated by the large reduction in the Aids YLD and Aids death YLL estimate, as

demonstrated in the table below. Positive values represent savings compared to no ARV availability.

Table 5: DALY savings due to ARV

Comparison difference	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	total
ΔYLD HIV	-150	-167	-302	-298	-269	-269	-271	-263	-290	-402	-2680
ΔYLD Aids	-3	7	49	35	25	21	15	19	16	42	227
ΔYLL Aids	839	920	2162	1957	1881	1863	1886	1781	2088	3041	18418
ΔDALY	687	760	1909	1693	1638	1615	1630	1537	1814	2681	15964

The scenario analysis suggests that using a DALY indicator, effective ARV treatment is highly cost-effective in Finland compared with no ARV treatment.

3.1.2. Direct cost estimates

Due to the integration of HIV/Aids care into the regular public health care system, estimations of direct costs incurred per case and year are close to impossible to produce. Such an exercise would require an in-depth analysis throughout the country, since the resources used for HIV/Aids public health care in different regions of the country vary so widely.

To gain some sort of estimate of current and projected costs due to HIV/Aids care, standard monthly, annual and total published costs per case can be used. If different case costs, different assumptions on the development of incidence and variable lifetime estimates are used for such modeling, realistic total estimates can be made to illustrate the cost effects changes in epidemiology can have over long time periods.

Such scenario building is particularly useful to demonstrate potential savings that could be achieved by diminishing incidence or increased costs associated with increasing incidence.

3.1.2.1. Parameters, assumptions and limitations of the cost modeling

For this report a conservative direct healthcare cost model using the following parameters for the epidemic and its future development were used:

Table 6: Parameters, Assumptions and Limitations of the Direct Cost Modeling

Parameter	*Values modeled*	*Properties*
Annual average cost per case	10.000 €	Single approximate estimate, based on published values[26,27]
Lifetime for a case	mean 13 years, stdv +/- 10 years	Single-sidedly cut normal distribution according to model
Annual incidence scenarios (HIV cases)	Scenario 1: 100 cases/year Scenario 2: 200 cases/year Scenario 3. 500 cases/year	Diminished (prevention effect), Current and Growth scenario

[26] Hutchinson AB; Farnham PG; Dean HD; Ekwueme DU; del Rio C; Kamimoto L; Kellerman SE. The economic burden of HIV in the United States in the era of highly active antiretroviral therapy: evidence of continuing racial and ethnic differences. J Acquir Immune Defic Syndr. 2006; 43(4):451-7

[27] Valenti WM. Costs of HIV care: evolution and update. AIDS Reader. 2007;17:242-244.

For the scenarios, equal access to treatment and care was assumed for all cases. Cost estimated are only direct health care costs, and do not include social welfare costs or loss of productivity and other indirect societal costs or losses associated with HIV/Aids.

A fixed average annual direct health care cost-per-case of 10.000 €/case/y was used to keep the model as simple as possible. This is a gross simplification, since true per-case costs will vary according to disease stage, the size of the epidemic and the development of treatments, their outcome predictions and unit prices for medications and services. However, the figure is based on relatively recent estimates in a western setting.

Lifetime of cases was modeled to follow a partly one-sided normal distribution over a 50 year period, with an average lifetime of 13 years and a standard deviation of 10 years. However, the normal distribution was modified to include a biased proportion of 10 % cases which die of Aids within 1 year of HIV diagnosis (figure). This is a conservative estimate which is heavily dependent on the proportion of late diagnoses.

The mean lifetime of 13 years may be an underestimate under current ARV-treatment access. It was chosen as a conservative estimate, and does reflect the fact that a substantial proportion of cases (10% annually) in Finland indeed are diagnosed late.

To reflect the large variation in post-HIV diagnosis lifetime, a wide variability reflected by a standard deviation of +/- 10 years was included in the model.

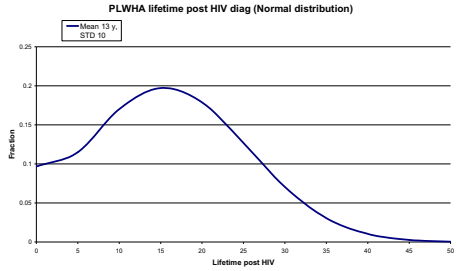


Figure 23: PLWHA Lifetime post HIV diagnosis

Costs were modeled for annual and cumulative epidemic costs under three non-variable HIV incidence scenarios: an annual incidence of 100, 200 and 500 cases over a time period of approximately 40 years. To keep the model simple, the incidence was kept fixed over time in all three scenarios.

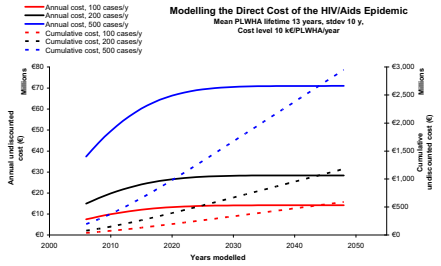


Figure 24: Modeling the Direct Cost of the HIV/Aids Epidemic

In the scenarios, costs of cases from previous years were cumulatively included in accordance to the lifetime normal distribution model. Under this model, annual costs slowly increase as the size of the PLWHA population grows. Eventually a steady-state is achieved, when annual deaths equal annual incidence. For the purpose of this report, the model is set to start from the year 2006 adjusted to a level of 1474 PLWHA under the annual incidence of 200 cases (scenario 2). This point was chosen as it closely resembles the actual estimated levels recorded that year and the current incidence level.

From this point, the epidemic and its costs were annually modeled until the year 2048 under the three fixed incidence scenarios.

It is clear that the model carries several simplifications which are unrealistic. Especially the use of a set annual incidence simplifies the model greatly. Nevertheless, the 3 different incidence scenarios do allow a comparison to be drawn between outcomes in situations where:

A, Scenario 1) a situation where prevention would cut incidence to half the current level;

B, Scenario 2) the epidemic would evolve further in Finland at the current level (approximately 200 cases annually); and

C, Scenario 3) there would be a strong increase in incidence.

The incidence levels were chosen to be conservative but different enough to demonstrate significant differences in both annual and cumulative costs.

3.1.2.2. Comparison of costs modeled under different epidemic scenarios

The following comparison of the scenarios allows drawing some conclusions on the consequences of changes in HIV/Aids epidemiology and could therefore be helpful for policy guidance.

Table 7: Health care costs (undiscounted) and size of steady-state PLWHA population under different scenarios

	Annual health care cost 2006 (M€)	Annual cost 2015 (M€)	Annual cost 2040 (steady state; M€)	Total costs 2006-2040 (M€)	PLWHA population at steady-state
Scenario 1 (100 cases/year)	7.5	12	14.2	476	1400
Scenario 2 (200 cases/year)	15	24	28.4	952	2800
Scenario 3 (500 cases/year)	37.5	60	71	2,381	7000

The comparison shows, that even a relatively moderate increase in annual incidence can have a very large cost-impact even in annual costs. In the Finnish setting, an evolution approximating that from scenario 1 to scenario 2 has taken place between 1998 and 2007. This translates to a more than doubling of the estimated direct health care costs.

Scenario 3 is not unrealistic either, and especially its long-term costs are very high.

An issue which was not modeled at all in the estimation of costs, is the indirect impact of HIV/Aids as loss of productivity due to disability caused by the disease.

Loss-of-productivity costs have been estimated in the literature, and have been as high as 4 times the cost of treatment by Hutchinson et al.[28]. In this study, lifetime

[28] Hutchinson AB; Farnham PG; Dean HD; Ekwueme DU; del Rio C; Kamimoto L; Kellerman SE. The economic burden of HIV in the United States in the era of highly active

direct medical cost per case was 180900 USD whereas the productivity losses were 662100 USD.

Considering the still high disease burden and the high direct health care and indirect productivity loss costs of HIV/Aids, strongly suggests that even relatively expensive prevention interventions, if effective, are highly cost-effective.

The burden of disease- and cost modeling strongly suggest that strengthening of those prevention activities which are known to be effective is well advised and will lead to significant savings over time.

In the models above, burden of disease and costs were only crudely modeled for all cases, but the models could be easily extended to subcategories. This would, for example, allow an estimation of the cost-effectiveness of targeted interventions, such as among IDU.

antiretroviral therapy: evidence of continuing racial and ethnic differences. J Acquir Immune Defic Syndr. 2006; 43(4):451-7

4. National response to the HIV/AIDS epidemic

The national response to the HIV/AIDS epidemic is outlined in several policy documents of which the most important is the National HIV policy. This was given as a non-binding guidance document issued by the HIV-expert group of the MoSAH in 2002 and ran through 2006. Currently a new policy framework document is under development, and is scheduled to be issued during 2008.

The policy outlined 8 key action areas as the following:

I. Prevention of new infections is the cornerstone of preventive measures
II. Effectiveness of treatment and support measures is an integral part of prevention
III. It is essential to support the full social empowerment of persons who have been infected and to reduce their vulnerability
IV. HIV tests and epidemiological follow-up systems generate information to be used in the planning of future measures
V. International cooperation is a prerequisite for conquering the HIV epidemic
VI. The education of professional staff must be expanded and the level of competence must be maintained
VII. Legislative reform may become necessary as the HIV situation changes
VIII. Management of the situation calls for improved coordination and a multidisciplinary approach.

4.1. Prevention

Prevention of new infections is the first key action area and objective of the current HIV policy document.

According to the Law on Public Health (Kansanterveyslaki), prevention of health problems and health promotion is the responsibility of the municipal governments and is funded by municipal taxation. Therefore, the responsibility for HIIV/AIDS prevention, treatment and care also lies within the municipally managed public national social services and health system providers.

HIV/AIDS prevention, care and support are mainly integrated into the public healthcare social care/welfare and education activities on state, regional and municipal levels. No specific publicly budget line earmark funded HIV/AIDS-specific governmental organizations exists.

On a municipal level, responsible authorities are the municipal social welfare and health boards and the municipal health centers (publicly funded primary healthcare providers). For specialized HIV care and treatment, municipalities usually purchase services fro their residents from regional and university hospitals organized into Hospital Districts.
For primary education the municipal school boards and the primary and secondary education system (primary and secondary school system) have the main responsibility for health promotion and sexual health education, including HIV/AIDS prevention education in schools.

In the Finnish system, cooperation between governmental and NGO/Civil society actors is actively pursued, especially for prevention activities. While NGOs and Civil Society are independent

in their activities, a large part of their funding comes from governmental or other public national sources. A particularly large funding agency is the national Slot Machine Association (Raha-automaattiyhdistys; RAY), which is a government monopoly on gambling. All of the proceedings are used for publicly beneficial purposes, such as sports and exercise, culture and public health.

The different ministries (such as the MoSAH and the MFA) also have their own project funding available for tendered or proposal based prevention projects. In addition, various forms of public-private partnerships are common, where a municipal or regional agency purchases a certain service or parts of it from an NGO or Civil society actor.

Untargeted awareness campaigns and direct prevention activities directed toward the general population have not been seen as a priority area of HIV/AIDS prevention and especially not for achieving behavior change in the general public. Instead, targeting youth and building of a solid sexual health knowledge base at an early age among youth is seen as the main approach to achieving low risks at adult age. The main tool for achieving this is through health education in schools.

In addition, targeted prevention efforts are applied to reach vulnerable groups such as MSM, IDU, sex workers and Immigrants.

In the following, the main approaches and key targets groups of HIV prevention are described (as specified by the Key objectives of the HIV policy document).

Key objectives: 1: *The incidence of new HIV-infections, other STI and viral hepatitis infections will decline in all risk categories,* **2:** *Knowledge and understanding of HIV transmission risks improves and attitudes do not declines among youth* **and 3:** *Programs and projects aiming at HIV-prevention will be evaluated through studies.*

4.1.1. Youth

Health education and promotion are the main tools of influencing the development of the future epidemic. The target of the activities is to ensure that all residents in Finland are aware of and understand true transmission risks and can take these into account in their behavior. Similarly important is ensuring that false beliefs and common misconceptions towards HIV risks and HIV-infected do not prevail.

Under the prevention policies currently applied, HIV/AIDS risks are not dealt with in a vacuum, but need to be integrated in general activities such as dealing with sexual health, sexuality education, reproductive health and reduction of drug related harm. HIV/AIDS prevention activities are seen as a part of health promotion activities and are integrated in cross-cutting health education work.

In specific activities, youth are the most important target group and MSM groups must also be reached. The best long-term impact is achieved through schools, as they reach almost the entire population in a comprehensive way.

In Finland, health education was introduced as a standardized compulsory subject in 2005 for grades 7-9 in the primary level (ages 13-15) and grades 1-3 of secondary level (ages 16-18) school system. The subject covers a standardized comprehensive health and healthy lifestyle curriculum and includes reproductive and sexual health, sexuality education (including non-judgmental dealing of homosexuality and other

sexual minorities) and STI risks, including HIV/AIDS risks. Prior to 2004, sexuality education and reproductive health was part of the school curriculum, but incorporated into other subjects. Schools also had more freedom in choosing how to implement the subject which led to wide variation in its content.

For the currently applied sexual health and HIV/AIDS prevention policy model concerning youth, sexuality and reproductive health education start early, prior to puberty. This is to ensure that youth have the knowledge and tools they need at the age when issues of sexuality become timely due to their natural sexual development. Since there is large natural variation in the age when youth reach puberty and mature sexually, as well as between the development of girls and boys, it is important to ensure that sexuality and reproductive health education are available and repeated right before and throughout the period of adolescent puberty.

According to the currently applied sexual health promotion approach, birth-control and STI prevention tools must be made available for youth through low threshold sexual heath services, i.e. youth clinics and school health services. Birth-control advice is offered to youth both through schools and the regular primary healthcare system. In a number of municipalities throughout the country, specialized youth clinics are also available.

In 2006, the government issued a Sexual and Reproductive Health Action Programme[29].

Several NGO organizations organize and maintain regular youth outreach activities and specialized service forms[30]. These services are most often either organized in cooperation with municipal healthcare actors or directly funded by municipal governments through service contracts[31].For some services, central governmental support is also available.

Among civil society actors, an important recent development has been the engagement of the Evangelical Lutheran Church of Finland youth sector. In 2006, the church youth association and the AIDS council together produced a guide called “A Miracle in the Eyes of God – on Sexuality, Physicality and Gender” targeted to confirmation trainees. The confirmation is a part of the process of accepting the message of the church and confirming ones membership of the parish.

Approximately 90 % of fifteen-year-old youth (annually close to 24.000) participate in confirmation training organized by the local parishes. This is the highest rate of participation in any Lutheran Country, despite Finland otherwise being a very secularized society. Studies show that participation is part of youth culture and training camps are very popular among the youngsters.

The “Miracle” training manual is targeted to youth leaders of the training camps, and they are themselves in the ages of 16-18 year old. The “Miracle” encourages open, positive and respectful discussions of sexuality, physicality and gender issues.

[29] Promotion of sexual and reproductive health. Action programme 2007–2011. Helsinki 2007. 200 pp. (Ministry of Social Affairs and Health, Finland. ISSN 1236-2050, 2007:17). ISBN 978-952-00-2376-8 (paperpack), ISBN 978-952-00-2377-5 (PDF)

[30] Väestöliitto, AIDS-tukikeskus http://www.aidstukikeskus.fi , Diakonissalaitos, Suomen HIV/Aids hoitaja-yhdistys, EVL Kirkko

[31] Esim. Helsingin kaupunki ja Väestöliitto, A-klinikkasäätiö ja Diakonissalaitos

4.1.2. Sexual minorities

Among sexual minorities in Finland, MSM are the most relevant group needing special attention and targeted prevention messaging and support. In a recent study, HIV prevalence in at least a subset of this group was estimated to be close to 4.5 %, the highest recorded in any identifiable vulnerable subpopulation ever recorded in Finland.

At the start of the HIV epidemic in the 1980:ies NGO:s, such as the organization for sexual equality (SETA), have been actively involved in HIV/AIDS work, mainly through the establishment of the HIV-foundation (HIV-säätiö) which runs the Finnish AIDS Council (Aids-tukikeskus).

Nowadays, the AIDS-council is an independent NGO dedicated to HIV/AIDS prevention, service provision, training and advocacy work independently of SETA. It also has a broader scope covering several areas of sexual health and prevention of HIV-infection and addresses both mainstream and vulnerable groups.

The Finnish AIDS Council is run by the HIV Foundation. It aims to:

- Prevent HIV infections.
- Enhance the competence of social and health care professionals in handling HIV questions.
- Support people with HIV infection, their families and friends, and those concerned about HIV.

The services of the Finnish AIDS Council have been available since 1986. The organization is ideologically and religiously independent.

The AIDS council has an active role in safe sex promotion among MSM. Its "safely among men" line of work has been well received and accepted among the MSM. However, the resources allocated to this work are relatively small compared to the estimated size of the target group.

4.1.3. Travelers

Travelers for leisure and business have recently been recognized as an important target group for enhanced prevention of especially sexual transmission. In 2007, a few training workshops mainly targeted for professionals in the travel and travel medicine field have been held, and a project for enhanced prevention in the group has started and will run through 2008.

Travelers are specifically mentioned as a target group in the drafts of the new HIV strategy document. The AIDS-council, the MoSAH, KTL and several other actors are planning a targeted awareness and prevention project with the aim of engaging travel agencies and workplace health providers in the work.

4.1.4. Injecting drug use

For HIV/AIDS and other infections with a transmission route involving direct blood contact, prevention transmission among IDU is an equally important aspect of comprehensive HIV/AIDS prevention efforts. In Finland HIV infection among IDU was rare until the end of the 1990s, when the first outbreak in this group was recorded.

Finnish policy on dealing with drug use and the harm it induces is based on prevention of use and supply control of illicit drugs. However, it also pragmatically recognizes that blood-borne infection risks must be addressed at the heart of the problem and not simply ignored. In the face of an outbreak of

HIV infection among injecting drug users (IDU) that started in 1998, changes enhancing prevention of infection risks were implemented. These include, but are not limited to, health promotion strengthening, vaccination coverage enhancement for hepatitis viruses, enhanced access to VCT for HIV, Hepatitis B (HBV) and Hepatitis C (HCV) as well as free injection equipment exchange.

Figure 25: Excerpt from statute 786/1986, Communicable Diseases Decree

During the period of 1998 to 2007 a new concept combining social and health services was developed to tackle the HIV outbreak and drug use associated harm. Building on strong public–private partnerships, governmental and municipal actors have joined forces with NGOs/Civil Society actors to make an impact.

A network of low threshold health promotion and service centers (LTHSC) now extends to close to 30 of the largest cities and municipalities.

Excerpt from statute 786/1986 Communicable Diseases Decree

Section 6 (30.12.2003/1383)
As duties referred to in the Communicable Diseases Act, ***the municipal body responsible for the prevention of communicable diseases and the health centre physician in charge of communicable diseases*** working under the body shall for their part, in addition to the duties laid down in the said Act:

1) ***be responsible for the combat of communicable diseases*** in the area of operation of the health centre, including dissemination of information on communicable diseases, health education and health counseling, ***also health advice to injecting drug users and exchange of injecting equipment*** as necessary for the prevention of communicable diseases;

The new measures were introduced with a model that aims at lowering the threshold of the target group to access the services. These changes were introduced in governmental strategy and policy action programs during the period of 1998 through 2007[32].

In 2004 injection equipment exchange was made explicitly legal and an obligation to provide such services was laid upon municipal health services.

The LTHSC model emphasizes trust-based voluntary participation and anonymous access. Services include small-scale health care provision, counseling and guidance to detoxification services, vaccinations, condom distribution, and exchange of injection equipment.

[32] Governmental Strategy Documents on drugs 1998 and 2000, Governmental Drug Policy Action Programme 2004–2007

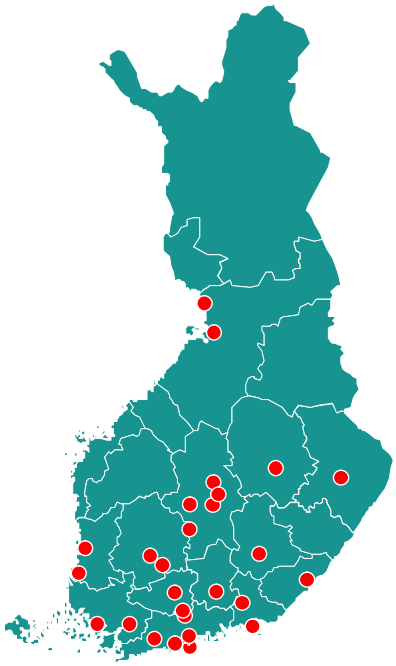


Figure 26: Network of LTHSC in Finland

In addition to the fixed LTHSC, services have evolved to include Mobile LTHSC units, peer-to-peer and outreach work.

In parallel to the primary prevention work, the response to the IDU HIV epidemic has benefited from the joint development of public – private sector partnership based specialized health services for HIV-positive IDUs. This includes combined antiretroviral therapy, a methadone maintenance program and social services.

In the capital region the specialized services for HIV-positive IDU are provided at a single integrated center, the Munkkisaari Service Center.

Examples of the funding and organization model used to provide services vary, so that in the capital city Helsinki services are provided by the A-Clinic Foundation and the Helsinki Deaconess Institute (HDL), but funding comes from both municipal and national government sources. On the other hand, in neighboring Espoo municipality, the stationary services are to mainly directly organised by the municipal health center, but mobile services are purchased from the Helsinki Deaconess Institute.

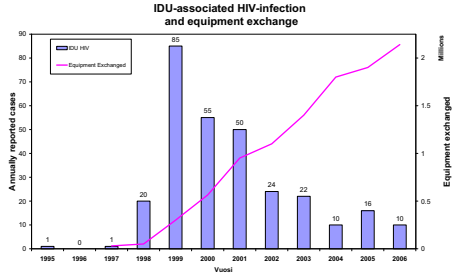


Figure 27: IDU associated HIV-infection and Injection Equipment Exchange

LTHSC and the other targeted service models provide a very important and efficient access point for reaching out to users with prevention messages. More than 10.000 different clients are reached annually.

In 2006, annual exchange of injection equipment exceeded 2 Million units.

The programme has been a success: surveillance data show, that the HIV outbreak was rapidly curbed. Annual incidence has decreased and prevalence among users has never exceeded 1–2 %. There is a clear correlation between the increase in service provision and decline in the incidence of HIV.

An evaluation of the effectiveness of the LTHSC model for prevention of IDU-associated blood born infections is currently ongoing and is estimated to be completed in early 2008.

4.1.5. Correctional Facilities

Prison health is the responsibility of the prisons health services, which fall under the authority of the Criminal Sanctions Agency (Rikosseuraamusvirasto) which

is an agency under the Ministry of Justice. However, the MoSAH can give advice and guidance to the prison health services, if necessary.

During imprisonment, prison health services offer services to inmates that to most parts equal those in the civil public health sector, but taking into account special needs of the inmates.

HIV testing in prisons is available using the VCT concept. Automatic screening is not done, neither on entry nor at exit. However, the threshold of offering testing is low, and rapid HIV-tests are offered at several correctional facilities.

ARV- and other HIV/AIDS treatment are available during imprisonment.

A large part of inmates in the correctional system have an addiction disorder. Using illicit drugs during imprisonment is not allowed. Studies show, however, that drugs are being used during imprisonment, including injecting drugs. On entry, each inmate is given a package containing disinfectant materials, instructions and containers for disinfection of injection equipment. Leaflets on blood born and STI risks and protection are also given. During the imprisonment, additional disinfectants and condoms can be obtained from the prison health services. Injection equipment exchange services are not available within the correctional facilities.

Addiction and detoxification health services are available in the Finnish correctional system. However, opiate maintenance or substitution therapy is available only if it has been started before imprisonment.

A key NGO, Kriminaalihuollon tukisäätiö - KRITS (Probation Foundation Finland)[33] is actively involved in development of harm reduction measures and social support for inmates and ex-inmates.

4.1.6. Sex workers

Sex workers are at increased risk for both social marginalization and STI: s, including HIV-infection. In addition, sex work may in a subset of the group be linked to IDU and therefore introduce additional risks of infection to this group.

Sex work is not explicitly illegal in Finland, but several regulations reduce the of sex workers possibilities to be open about their activities in contact with authorities, including social and health authorities. A part of sex work in Finland is tied to economic and/or organized crime migration, especially from the neighboring areas.

While permanent residents can access public health care services, non-residents cannot, and social barriers may create high barriers for access even for residents.

Therefore, special efforts have been put in place to ensure a lowering of the threshold for sex workers to access preventive social and health services. In many instances this means creating trust-based services outside the regular local or national governmental social welfare and health services. NGO-based actors can in this regard provide the best access and help for sex workers.

The main NGO providing such services in Finland is the Pro-Tukipiste[34], which has outlets in the cities of Helsinki (capital) and Tampere. Pro-Tukipiste is a registered non-profit organisation which supports and promotes the civil and

[33] http://www.krits.fi
[34] http://www.pro-tukipiste.fi

human rights of individuals involved in sex work. Pro-Tukipiste follows and takes part in national and international discussions concerning prostitution and sex work, and also makes statements concerning issues related to prostitution policies. The association follows the treatment and the legal status of sex workers in Finland.

Pro-Tukipiste maintains and runs professional social and health care service units and outreach units in Helsinki and Tampere.

4.1.7. Migrants

A significant proportion of HIV cases in Finland are seen among immigrant populations. While these cases do affect total disease burden, the effect on the evolution of domestic epidemiology is less significant since the reported cases reflect the epidemiology of the originating country.

Over a long term perspective, however, the effect on prevalence may become greater, and warrants targeted prevention and support for integration to prevent the formation of continuously high prevalence among immigrant- and immigrant descendant populations.

Migrants from high-endemic areas are therefore a group with special needs. People migrate to Finland for a variety of reasons including work, study, and family reasons, as well as refugees or asylum seekers.

Those gaining permanent or long-term residence in Finland are covered by the national public healthcare system and have access to prevention, treatment and care though it. There is no HIV-screening policy associated with study, work or family immigration.

The refugee and asylum seeker group is nowadays a minority group and has been estimated to account for less than 20 % of migration to Finland. The health of this group is under the responsibility of the Ministry of Interior immigration and refugee services.

Upon entry, migrants in this group are offered health checkup services, including testing for infectious diseases such as TB and HIV. HIV testing is offered on a voluntary, VCT basis, and access to translators is provided. Migrants in this group are offered medical services according to clinically determined need.

Due to cultural and societal reasons as well as language barriers, many migrants experience difficulties in accessing official health and social services in Finland, including HIV services. These barriers can sometimes be overcome or alleviated if help or services can be provided by NGO/Civil service actors.
The Finnish AIDS Council (Aids-tukikeskus)[35], an NGO dealing with various aspects of HIV prevention and support work, have a specific migrant support line of work, which provides both direct help and support groups for migrants, but also training and materials for health professionals to prepare them for working with migrants in HIV prevention and care.

4.1.8. Nosocomial transmission, including tissue and organ donations and assisted reproduction services

Key objective 4: *Nosocomial transmission and transmission through blood transfusion or blood products must be completely eliminated, while simultaneously ensuring equal access to*

[35] http://www.aidstukikeskus.fi

health services for those living with HIV/AIDS.

In the Finnish health system, patient-care personnel relation is based on trust. Therefore, while patients are actively encouraged to inform the care personnel, especially the treating physician, of all health conditions which affect health status and may influence care, there is no explicit legal obligation to inform health personnel about HIV status.

Evidence shows, that within the health sector universal blood precautions are sufficient to prevent nosocomial transmission and protect personnel from infections. Health care guidelines stipulate that universal blood protection measures have to be used in all invasive procedures or procedures that may result in blood or tissue exposure. Disinfection and sterilization guidelines and standards ensuring elimination of nosocomial transmission through multiuse instruments and equipment are in place.

For tissue and organ donations and assisted reproduction services, all performing units are responsible for ensuring prevention of nosocomial transmission in accordance to national standards. Prevention measures and the standards guiding their application are similar to all health care providers, including dental health providers and the entire private sector.

Healthcare provision is monitored by the Agency of Medicines and Medical Devices, the provincial health authorities and the National Authority on Medicolegal Affairs.

4.1.9. Blood donation and blood product mediated transmission

In Finland, blood, plasma and blood component donation and blood product production services are run exclusively by the Finnish Red Cross and donations are exclusively based on voluntary donors. No compensation is given to donators. As blood donation is entirely voluntary, donators are confidentially pre-selected through the use of a standardized questionnaire used at all donation events. Exclusion criteria are based on known risks for blood born infections.

In addition, all donations are screened prior to use for HIV and other blood born infectious using highly sensitive techniques. For HIV, both combined antibody/antigen detection and NAT-screening techniques are used.

Since the turn of the century, blood donation screening has revealed approximately 1 positive donation every second year, both among repeat and newly recruited donators. All positive donations are discarded prior to use.

Furthermore, blood product manufacturing processes (for production of clotting factors etc.) employ methods which have been shown to inactivate HIV.

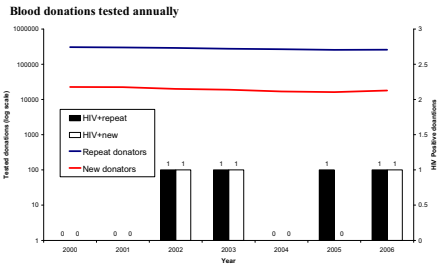


Figure 28: Blood Donations Tested Annually

4.1.10. Mother to child transmission

Key objective 5: *All expecting women must be offered HIV testing and if found positive, offered to be informed of their*

HIV-infection. All those who have been infected must be offered mother-to-child prevention measures through drug-prophylaxis and other measures available according to best medical knowledge.

Maternity and newborn child healthcare and health promotion is organized through a network of public municipally organized and funded maternity and child health centers. These centers offer specialist nurse, social support and welfare as well as physician services for the benefit of both the expecting mother and her child both during the pregnancy and after delivery. Almost all pregnant women utilize the services, which are available free of charge.

As one part of the services, the expecting mother is routinely offered certain infectious disease tests as part of a national programme for unborn child health. The tests are voluntary, and include tests for syphilis, the carrier status of Hepatitis B and HIV-infection. HIV test offering is based on an opt-out scheme. Out of an annual level of close to 60.000 pregnancies examined, only 0.4 % of pregnant mothers on average have refused testing.

Table 8: Testing and test refusals in maternity centers

	2000	*2001*	*2002*	*2003*	*2004*	*2005*	*2006*	*2007*
Tests	58881	57141	58864	60226	60003	59312	59639	58740
Refusals	132	287	84	73	57	31	20	17
HIV+	8	13	12	13	8	16	13	pending

Annually, 5-16 HIV-positive mothers have been identified through the screening programme, of which the majority are cases that have already earlier been identified.

All mothers with HIV-infection are offered mother to child transmission prophylaxis according to international best available praxis. Prophylaxis is also used for the newborn. A special training and instruction manual for maternity clinics is available for this purpose, also covering prevention of transmission through breast-feeding.

4.2. Treatment and care

In the Finnish HIV policy and strategic approach to tackle the epidemic, effective treatment and support measures are seen as an integral part of prevention. The assurance that access to the best existing treatment and care is available, and trust in a professional, compassionate, confidential and non-discriminating response within the health- and social care system, helps those who may fear that they have acquired HIV infection to seek testing and care.

In the long run, the trust in the response from the system and the help it provides will help to maintain a low proportion of people not knowing of their infection and who may unknowingly transmit it further.

A low number of unaware HIV-infected individuals is an important contributor to restricting the HIV epidemic. Therefore measures that actively encourage the seeking of care and testing are highly cost-effective.

Key objectives: 6. All *necessary clinically indicated care is guaranteed free of charge to those who have been infected. Access must be equally available throughout the country and covers all those who are eligible for social security benefits through national or European Union legislation or through multi- or bilateral international agreements,* **7:**

National resources for HIV prevention and interruption of chains of transmission will be strengthened, **8:** *The application of post exposure prophylaxis drug treatment is developed. National guidelines are developed by organizing a national expert meeting with PLWHA representation,* **13***: All health- and social care professionals and other professional groups dealing with PLWHA gain a level of understanding enabling them to meet PLWHA in a professional and egalitarian way through their primary and vocational professional training or continuous education.*

The public health system in Finland is funded mainly by municipal taxation and a national obligatory social insurance system run by Kansaneläkelaitos – KELA (The Social Insurance Institution of Finland), which is an agency governed directly by the parliament (the national assembly). The social insurance provides benefits and covers many areas of social support services and health costs, including partial compensation for private medical care. Social insurance coverage is not tied to employment but legal residence status.

A certain degree of co-payments still have to be provided for most primary, secondary and tertiary care, but various caps to these fees exist and the fees are also tied to economical status in a way that ensures that people with low economical resources are equally covered.

For HIV/AIDS there is a special provision in the Act on Customer Fees within the Social- and Healthcare system (3.8.1992/734) which explicitly stipulates that access to HIV/AIDS medical treatment and care is free of all charges for all legal residents. This covers primary and specialist care, laboratory diagnostics and medication (incl. ARV-drugs).

Prevention of health problems is according to the Law on Public Health (Kansanterveyslaki) the responsibility of the municipal government. Therefore, the responsibility for prevention, treatment and care lies within the municipally managed public national social services and health system providers. On a municipal level, responsible authorities are the municipal social welfare and health boards. HIV/AIDS treatment, care and support are mainly integrated into the public healthcare social care/welfare on state, regional and municipal levels.

Public health primary care in Finland is provided through publicly funded municipal health care centers. The majority of the outpatient primary care services are within the public sector, as are >95 % of the hospitals. More than 400 municipalities are served by approximately 250 municipal primary health care centers, which all offer primary health services to municipal residents. For HIV care, there are special provisions given by guidelines issued by the Ministry of Social Affairs and Health, which enable seeking care in a non-residential health center. These guidelines have been put in place to enable the maintaining of confidentiality for residents of small municipalities. However, the costs are referred back to the residential municipality. Clients of the municipal health services pay a relatively small annual co-payment for the use of the services. Children and certain social groups do not pay co-payments

HIV VCT services are provided free of charge by all municipal health centers. Laboratory services are either provided by local laboratories or purchased by the municipal health center from health district level laboratory centers or private laboratory service providers.

For specialist care, municipal health care centers in turn refer their patients to regional or University central hospitals belonging to regional health districts. There are 21 such secondary and tertiary health districts providing specialist services. Municipalities or municipal co-operations purchase specialist services as part of their public health service provision obligations. HIV-care is referred to the specialist care level due to the needed level of expertise.

HIV specialist care is provided by all regional health districts, but some of the larger health districts have more expertise available and may at some instances provide subcontracting services to other districts. However, there is no formal decision to centralize HIV care and treatment, and municipalities and health districts can make their own choices on how to provide the services under their obligations.

The largest center of the public health system providing specialist HIV/AIDS health services is the Helsinki and Uusimaa Hospital Districts (HUS) Aurora Hospital Infection Clinic. Some specialization is also available for infection dentistry and maternity care within the HUS area.

In addition to public health care, HIV/AIDS care can be received through private health care services, but costs of these are not compensated from the national health insurance system.

In the Helsinki area, the municipal health board and municipal health services have made a separate agreement with the Helsinki Deaconess Institute (a private health service provider) and the HUS Aurora Hospital Infection Clinic for provision of HIV/AIDS and addiction health services for HIV-infected injecting drug users.

The development of necessary competence for dealing with HIV/AIDS issues throughout the social and health service field is a recognized challenge. Due to the low prevalence of HIV in Finland and concentration into metropolitan areas, most social and health professionals outside the areas of higher prevalence are unfamiliar with HIV/AIDS issues and are therefore poorly prepared to meeting PLWHA.

Professional education curricula for health professionals (excluding infectious disease specialization) deal with general STI and blood borne infection issues, and HIV/AIDS is only dealt with as one of many conditions to consider.

To improve the educational level and practical skills of professionals who may meet PLWHA in their work, continuous education seminars and workshops have been organized throughout the years by the Helsinki University Palmenia Continuing Education Center[36] in cooperation with The National Public Health Institute - KTL, the MoSAH and several NGO and Civil Society actors.

The Finnish association of HIV/Aids nurses (SHAS), the Finnish AIDS Council and the HUS Aurora Infectious disease unit has published an “HIV-care handbook” in 2007 with financial support from the Slot Machine association and the MoSAH. The handbook is mainly targeted to nursing professionals, but immediately gained wide popularity among the whole healthcare field.

4.3. Support

Key objective 9*:* *Psychological and social support is available for all those PLWHA and their next of kin*

[36] Palmenia Centre for Continuing Education, http://www.helsinki.fi/palmenia/english/index.htm

Social and welfare support and psychological support due to health problems is provided by both the municipal social services and the municipal heath centers. These include support for accessing of sickness and disability benefits covered by the social insurance system, support for home care in case of need and access to crisis and long-term psychological support and mental care. Access to sickness and disability benefits (including the possibility to disability retirement benefits) and home care is nationwide.

For psychological support there is more variation in the coverage, especially on the level of expertise on dealing with HIV/AIDS issues.

Several national NGO and Civil Society organization are also actively involved in HIV/AIDS support work. These are frequently partly or entirely funded through public/private partnerships with municipal and/or national funding agencies or through direct purchasing agreements.

4.4. Knowledge

The starting point for the Finnish HIV/AIDS strategic approach is to ensure that all citizens and permanent residents have the knowledge and understanding needed to enable them selves to avoid exposure to true risks of HIV infection.

At the same time, the approach should ensure that a similar high level of knowledge and understanding can be achieved regarding common misbeliefs and groundless fears towards HIV/AIDS risks and those living with the infection.

The main means to achieve these goals is through a comprehensive coverage and high standard of the primary education system. Coverage of the Finnish primary and secondary educational system is very high, over 98 % of youth complete their compulsory education [12].

4.4.1. Finnish education system

This section is adapted from chapter 10 in the publication "Koulutuksen määrälliset indikaattorit 2006" published by the Finnish National Board of Education [37]

One of the basic premises of Finnish education policy is to guarantee everyone equal opportunities in education and training. This objective has required the formal education system to be clearly structured and all study tracks available in qualification-oriented education and training to be open from pre-primary education through to tertiary education. Education has always played a significant role for Finns in terms of guaranteeing upward social mobility. Finnish children start school in the year when they turn seven. Prior to this, each local authority (municipality) is obliged to provide 6-year-olds with pre-primary education. Pre-primary education may be provided either in connection with school or as part of day care. Even though pre-primary education is not compulsory for children, the participation rate is 100%.

Compulsory 9-year basic education is provided at comprehensive school, which is common for everyone and which is completed by virtually all Finnish children. In 2005, about 57,500 children started comprehensive school, while just below 63,800 students received their leaving certificates. Annually, only a few

[37] Finnish National Board of Education. International comparisons of some features of Finnish education and training, Chapter 10 in "Koulutuksen määrälliset indikaattorit 2006" edited by Timo Kumpulainen and Seija Saari. ISBN-13: 978-952-13-3092-6 (bound), ISBN-13: 978-952-13-3093-3 (PDF). http://www.oph.fi/pageLast.asp?path=1,438,5089,43978,44346

hundred fail to obtain the comprehensive school leaving certificate. Those young people who wish to improve their leaving certificate or otherwise supplement their skills and knowledge may participate in additional education lasting one extra school year. About 1,600 young people chose this option in 2005, which is about 2.5% of the whole age group.

Upon completion of basic education, upper secondary level provides two main alternatives: general upper secondary school or vocational education and training. Both alternatives last three years and completion of the studies provides eligibility to apply for higher education. Those completing basic education apply for these two types of education through the national joint application system. This centralized application system contributes to ensuring that almost all basic education leavers apply for upper secondary studies and also continue their studies immediately upon completion of basic education. In 2004, 54% and 38% of basic education leavers moved on to upper secondary school and vocational education and training, respectively. Another 3% continued their studies in additional education. About 5% of basic education leavers did not continue to the next level immediately after finishing comprehensive school.

At tertiary level, a new polytechnic system was created in Finland in the early 1990's to complement traditional university education. Using the OECD indicator covering tertiary graduates, where the number of completed degrees is set in proportion to the size of a typical age group graduating from tertiary education, about 50% of young people complete a tertiary degree. This ratio is clearly higher than the OECD average.

4.4.2. Long-term strategic approach

Untargeted awareness campaigns and direct prevention activities directed toward the general population have not been seen as a priority area of HIV/AIDS prevention and especially not for achieving behavior change in the general public.

Instead, targeting youth and building of a solid sexual health knowledge base at an early age among youth is seen as the main approach to achieving low risks at both young and adult age. The main tool for achieving this is through health- and sexual education in primary and secondary level schools.

The Finnish educational system achieves consistently outstanding marks in both national and international evaluations. The learning outcomes of Finnish basic education are among the best in the world. According to the OECD's PISA survey, 15-year-old Finns are among the best in terms of reading literacy, mathematics and sciences. A particular strength of Finnish basic education is the fact that the proportion of poorly performing students is low.

In the latest (the year 2006) PISA – The OECD Programme for International Student Assessment evaluation Finland scored as the number 1 ranked country for all OECD members and PISA partner countries. The theme of the evaluation was Science.

According to the 2003 PISA definition, this area of the evaluation covers the students':

"*Scientific knowledge and skills applied to real-life situations, as opposed to science linked to particular curricular components. Students are required to show a range of scientific skills, involving*

the recognition and explanation of scientific phenomena, the understanding of scientific investigation and the interpretation of scientific evidence. Tasks are set in a variety of contexts relevant to people's lives, related to life and health, technology and the Earth and environment.[38]"

In this regard the Finnish approach seems to give youth a solid ground for acquiring the necessary skills to make evidence informed choices in their daily lives and behavior, including sexual behavior.

4.4.3. School health- and sexual education

Sexual education has been part of school education in curriculum for 14-15 year-old pupils from the 1980s. Presently schools are obliged to implement a new national curriculum of health education including sexual education and prevention of sexually transmitted diseases. In addition to the curriculum on health education, sexual health issues are integrated into other school and study objects such as biology, media education and human development.

The focus on sexual education in Finland is moving from a biological perspective to a wider orientation that includes emotional and social aspects of sexual health. Sex education material for teachers and school public health nurses are available also via the Internet.

Adolescents' sexual knowledge and behavior is monitored every two years in connection with the national School Health Promotion Study. The data has been available since 1995 to evaluate the provision and effect of sexual education at national level.

There are active non-governmental organizations providing materials and services for sexual education of adolescents in Finland, e.g. the Family Federation of Finland (Väestöliitto) operates a Sexual Health Clinic - Open House Clinic for Adolescents, with active Internet service[39].

4.4.4. School health surveys

The National Research and Development Centre for Welfare and Health (STAKES) in cooperation with the University of Jyväskylä run the School Health Promotion Study, which is a large-scale population based health and health education survey for students at 8th and 9th grades at comprehensive schools (14–16-year-olds) and for 1st and 2nd grades in high school (16–18-year-olds).

Data collection

Data collection is performed in the end of April, in a biannual and geographically rotating fashion in the participating municipalities. The survey covers approximately 90 % of the Finnish municipalities. In even-numbered years the provinces of Southern Finland, Eastern Finland and Lapland are surveyed, whereas in odd-numbered years the survey covers the provinces of Western Finland, Oulu and Åland.

The survey, which is an anonymous classroom questionnaire of 12 pages was distributed to 164 000 respondents in 2005/2006. The response rate was 82 % in comprehensive school and 77 % in high school.

[38] http://www.pisa.oecd.org -> what PISA produces -> PISA 2003

[39] http://www.vaestoliitto.fi

Table 9: Participants in the School Health Survey

The School Health Promotion study 1995–2006					
Year	*Participating Municipalities*	*Comprehensive schools*	*High schools*	*Vocational schools*	*Respondents*
1995	25	58	10	8	10081
1996	96	255	155	77	53000
1997	117	193	122	79	46000
1998	136	285	159	78	59000
1999	179	324	186	95	82200
2000	156	334	200	88	79000
2001	173	244	161	3	59000
2002	150	416	219	-	82000
2003	219	352	205	-	71600
2004	145	432	222	-	84763
2005	212	398	207	-	73900
2006	148	431	228	-	88200

The questionnaire covers living conditions, school as working environment, health-related behavior (e.g. nutrition, smoking, use of alcohol and drugs, sexual behavior) and health (e.g. diseases and symptoms, depressive mood).

Among the subjects on sexual behavior and sexual health are questions on whether or not the respondent has had sexual intercourse, how many times ever and with how many partners one has had intercourse.

The study questionnaire also includes a question on use of birth control and which method is used.

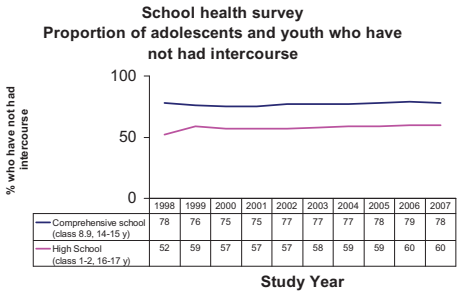


Figure 29: Adolescents and youth who have not had intercourse

Results from the school health survey indicate that adolescents are relatively well aware of HIV/AIDS related risks. However, a proportion of students do start their sexual activity early, at the age of 14-15.

The proportion of students who have not had their sexual debut (75-79 % have not had intercourse) has not changed significantly among comprehensive school classes 8-9 since 1997. It has increased in the older age groups of High school students in classes 1-2 (in 2007, 60 % had not had intercourse compared to only 52 % in 1997).

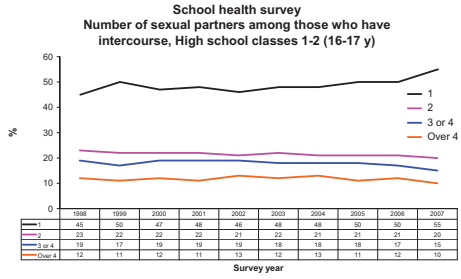


Figure 30: Sexual partners among 16-17 y old

Also, a larger number of students reported single sexual partners among High school respondents (44 % in 1997, 55 % in 2007).

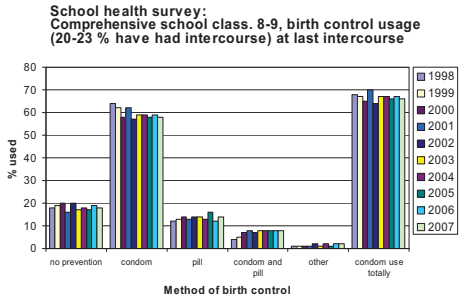


Figure 31: Birth Control Use in Comprehensive School

The main method of birth control both among 14-15 year old adolescents and among 16-17 year old youth is condom use. However, approximately 30-35 % of the younger group and over 40 % of the older group had not a condom at their last intercourse. Twenty and 10 % of the two groups, respectively, did not use any prevention at all. For the older group, the decline in the use of condoms correlates with a wider use of birth control pills.

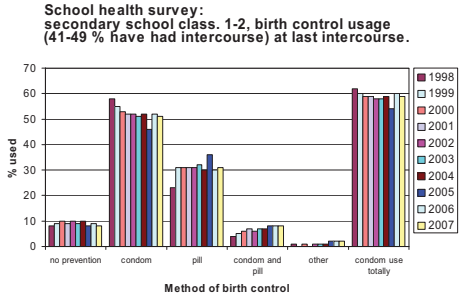


Figure 32: Birth Control Use in Secondary School

While the total proportion of those using birth control is high, it would be important to stress the importance of double protection by simultaneous use of condoms in the future.

4.5. Behavior change

There are few systematically conducted studies assessing sexual behavior and STI related risk taking among the general adult population. A few targeted studies among MSM and IDU have been conducted, but these are not necessarily even subpopulation wide, and are not always annually performed.

Several health monitoring surveys with a wide sampling base are conducted in Finland, but these mainly address nutrition, various chronic diseases, smoking, drug and alcohol use, mental health and functional capacity/physical activity issues (i.e. AVTK, FINRISKI and HEALTH 2000)[40].

However, none of the regularly conducted surveys cover sexual health issues, particularly not those that deal with sexual orientation, risk perception or risk taking. As a result, there are no adult population level data on key parameters such as sexual partner numbers or condom use, nor much any other risk indicator.
Therefore, it is difficult to know anything specific on trends of risky behavior in Finnish adult populations. Studies among adolescents show no great changes over the years, but after the completion of high school there is no specific data available for adult populations. Partly this is explained by the strategic approach of reaching youth and an effective STI disease surveillance system which will be able to pick up changes leading to increased incidence.

However, there is no guarantee that behavioral patterns and especially condom use frequencies recorded in school health surveys are permanently maintained in adult populations as the

[40] http://www.ktl.fi/portal/4152, http://www.ktl.fi/portal/11531

youth mature. On the contrary, there is anecdotal evidence for an increase in complacency towards safe sex.

Also, disease surveillance systems pick up only on hard outcome endpoints, i.e. only when risks have been realized and led to increased incidence. At this point, increased disease burden already leads to higher costs and suffering, which could have been avoided by recording increased risk behavior and putting in place effective interventions.

Therefore, it is quite clear that a stronger emphasis has to be put on developing effective ways for risk behavior surveys in the very near future.

4.6. *Impact alleviation*

Impact alleviation consists of all measures that reduce the societal and personal burden of HIV/Aids. To ensure that this will be realized, the regulatory and legislative framework must support the objective. The HIV policy contains as a goal that legislation will respond with changes as needed if the HIV/Aids situation changes.

4.6.1. Current legal framework for HIV/Aids

There is no specific HIV/AIDS legislation, but several pieces of legislation cover issues that concern HIV/AIDS prevention. These include the following main statutes[41].

Constitution 11.6.1999/731

Protection against discrimination due to gender, race, minority status, sexual orientation, social and health status

Act on the Status and Rights of Patients 17.8.1992/785

Protection against medical mismanagement and right to self-determination within the healthcare system

Primary Health Care Act 28.1.1972/66

Free access to prevention and primary care for all legal residents

Act on Specialized Medical Care 1.12.1989/1062

HIV and AIDS care is not specifically allocated to be dealt with within the specialized medical care system. In many municipalities care is however implemented this way to ensure necessary expertise.

Act on Customer Fees within the Social- and Healthcare system 3.8.1992/734

Free of charge access to HIV treatment and care for all legal residents
Covers care, laboratory diagnostics and medicines (incl. ARV-drugs)

Personal Data Act and Personal Data File Decree 22.4.1999/523

Identity protection

Communicable Disease Act and associated decree 25.7.1986/583

Surveillance and reporting of HIV and Aids cases, special protections against HIV status disclosure

Act on Employee Contracts 26.1.2005/55, Act on the Protection of Privacy in Working Life 13.8.2004/759

Protection against disclosure, discrimination due to health status

[41] http://www.finlex.fi

The employer may not exercise any unjustified discrimination against employees on the basis of age, health, disability, national or ethnic origin, nationality, sexual orientation, language, religion, opinion, belief, family ties, trade union activity, political activity or any other comparable circumstance.

Penal Code 19.12.1889/39

Knowingly transmitting HIV to another person or exposing another person to the risk of transmission of HIV is not specifically mentioned in the penal code as a felony. However, judicial practice has established these acts to be comparable to the offence of causing grave bodily harm. Under this interpretation a person can therefore be charged and sentenced.

5. National resource and funding estimates

As is described in many subsections of this report, HIV/Aids prevention, treatment, care and support are integrated in many regular activities in society, rather than falling under separate programmes. Therefore direct resources allocated are close to impossible to identify by any level of accuracy.

There are some targeted activities for which the resources allocated or used can be estimated. These, however, represent only a small fraction of the cumulative factual spending on HIV/Aids prevention, treatment care and support, and therefore cannot be used to make any meaningful comparisons with other health issues or between countries.

5.1. Government

Within the central government, the Ministry of Social affairs and Health (MoSAH) has a few budget lines for project- or programme based activities in the health field. In addition, the National Slot Machine Association, which is governmental monopoly, issues funding targeted for NGO health and social affairs activities.

5.1.1. Central Government

Of the national governmental funding appropriations issued by the MoSAH, there are two project budget lines which are relevant, the appropriations for "Prevention and control of infectious diseases" and the budget line for "Health Promotion". In addition, the as the National Public Health Institute - KTL operates under the MoSAH, its HIV-units budget is derived from the governmental Social Affairs and Health budget.

In addition to the identified funding, many appropriations under the MoSAH budget line indirectly support HIV/Aids work.

Table 10: Examples of readily available government funding for national HIV/Aids issues*

MoSAH budget lines	*2006*	*2007*	**Project activity areas**
Prevention of infectious diseases (total: 1360 k€)	nk	538 k€	STI and HIV/Aids prevention
Health promotion (total: 9300 k€)	1171 k€	1294 k€	Sexual health, health promotion among IDU
National Public Health Institute – KTL (HIV-unit budget)	298 k€	317 k€	Surveillance, prevention, expert functions, co-ordination, research and international cooperation

***NOTE:** these figures only serve as examples and should not be used as estimates of total NGO/Civil society spending levels on HIV/Aids, which have not been reliably estimated

Funding by the National Slot Machine Association for HIV/Aids prevention activities is spread under various activities and cannot be reliably estimated.

5.1.2. Municipal and Regional Government

Although the regional and (especially) the municipal governments are largely responsible for both prevention and care and therefore also appropriate the bulk of the resources spent on HIV/Aids, their direct contribution is impossible to directly measure.

The estimation of health care resources spent would require a detailed cost analysis, which would have to be done both on a municipal and hospital district level.

In addition, the role of the educational system, especially the primary prevention activity in the form of health education and school health system which is provided by the municipal comprehensive school system is essential for the HIV/Aids prevention work.

As for the health care system, the resources for HIV/Aids prevention within the educational system cannot be easily estimated.

5.2. NGO: s and Civil Society

Non-governmental Organisations (NGOs) and Civil Society working in the field of HIV/Aids are funded to a large extent by both governmental appropriations and/or by tendering contracts issued by municipal health authorities. National spending by the NGO/Civil society sector is as difficult as the government sector to estimate, but some published data or otherwise available can be shown as examples.

Table 11: Examples of available data of NGO/Civil Society spending on HIV/Aids issues*

Organisation	*Annual budget*	*Activity area*	**Main funding sources**
National Aids Council	1400 k€	HIV/Aids prevention, Service and Support	MoSAH, Slot Machine Association
Pro-tukipiste**	1100 k€	Support and help for sex workers	MoSAH, Slot Machine Association, City of Helsinki
Helsinki Vinkki IDU LTHSC***	800 k€	Health promotion and prevention of infectious diseases for Injecting Drug Users	A-Clinic Foundation, MoSAH, Slot Machine Association, City of Helsinki

***NOTE:** these figures only serve as examples and should not be used as estimates of total NGO/Civil society spending levels on HIV/Aids, which have not been reliably estimated
** Unofficial figure; 2008 budget estimate
*** Unofficial figure; 2005 funding

6. Best practices

6.1. Integration of HIV and AIDS prevention, treatment and care into regular primary, secondary and tertiary level healthcare

The integration of HIV/AIDS as a cross-cutting issue in regular healthcare with as little specific actions as possible is in many ways a successful practice. As HIV/AIDS is more or less a health issue among others, there is no question on who has responsibility for tackling the problem, as it follows regular divisions of labor within society.

According to the Law on Public Health, the responsibility to primary prevention, public health preventive medicine and testing services lies with the municipal level of government. The health services are typically provided by the municipal health centers.

The Law on specialized care regulates the organisation and duties of the health care districts which run the regional and university central hospitals. According to the regulation, the provision of public health specialized care is the responsibilty of the hospital districts, and the municipalities purchase these services for their residents. PLWHA are generally referred to the specialist level for their care.

This approach also lays a solid foundation for comprehensive coverage of HIV/AIDS services, as municipal health providers cannot point to some other, possibly unavailable national actor for picking up the responsibility or costs.

6.2. Voluntary testing and counseling with a low threshold

Voluntary testing and counseling is provided by all municipal health centers free of charge. This ensures that there is no cost limitation towards HIV-test seeking and that regional coverage is adequate.

6.3. Efficient surveillance system enabling rapid response in changing situations

The system in place for HIV/AIDS surveillance in Finland is one of the best performing passive reporting systems even using an international yardstick. The use of a double reporting system (lab and physician reporting), multiple reporting time-points (infection, AIDS, AIDS-death), confidential and secure use of personal identifiers enabling report linking and case counting and the collection of a rather wide array of transmission group data ensures that epidemiological changes can be rapidly detected and responded on.

An example of this was the outbreak among IDUs in 1998 which was identified within a few months of the first cases and almost immediately led to rapid prevention responses.

Other tools which are useful for surveillance are the use of rapid HIV screening tests in diagnostic testing. This enables a good contact to those seeking testing and enables counseling to be performed while tests are developing. It has also significantly increased test uptake upon vulnerable groups, especially IDUs.

In addition to passive surveillance, sampling based studies among IDU and MSM populations are conducted to monitor trends in prevalence among vulnerable groups. Here the application of novel and innovative, oral fluid sampling devices for HIV-testing with integration into anonymous population surveys has provided valuable data on specific otherwise hard to reach populations.

6.4. Integration of HIV/AIDS prevention into school health and sexual health education

Health education, including sexual health, sexuality education, drug and alcohol use, STI and HIV/Aids issues reach close to 100 % of all adolescent through the compulsory school subject of ages 13-18.

6.5. Targeted prevention services for highly vulnerable groups

Special targeted services (Low Threshold Health Service Centers – LTHSC) for IDUs include health promotion and advice, vaccinations, counseling, sexual and reproductive health services, small scale medical services, referrals, testing and injection equipment exchange services. Such services are provided at close to 30 sites across the country in a multitude of collaborative public-private co-operations. The A-clinic foundation and the Helsinki Deaconess Institute the largest service providers.

Targeted low threshold services for sex workers are provided in two large cities (Helsinki and Tampere). The services are provided by an NGO actor, Pro-Tukipiste ry and funded by governmental and municipal actors.

The Finnish AIDS Council provides preventive, training and support services targeted both to vulnerable groups such as MSM but also to youth, health professionals and PLWHA and their next of kin

6.6. Involvement, private-public partnership and direct governmental and municipal financing of civil society and NGO: s in prevention and support

Most HIV prevention activities in Finland which are not directly run by the governmental or municipal health care or educational systems actively engage civil society and NGO: s. The National HIV Expert group has permanent representation from Civil Society and NGO members have been engaged in UNGASS and the EU Think Tank Civil society forum.

Importantly, NGO: s and governmental actors have a good and working cooperation in substance work including day to day dialogue. Finnish HIV/AIDS NGOs are mainly directly funded by national funding agencies.

In addition, several NGO: s have long- and short-term contract for special service provision with municipal bodies responsible for health issues. As an example, the IDU-LTHSCs in Helsinki are entirely run by two NGOs, the A-Clinic Foundation and the Helsinki Deaconess Institute based on a service contract with the municipal health services in Helsinki, who provide the funding. In addition, the MoSAH provides national funding for certain development and monitoring activities.

6.7. Training and self-help manual production

The Finnish association of HIV/Aids nurses (SHAS), the Finnish AIDS Council and the HUS Aurora Infectious disease unit has published an "HIV-care handbook" in 2007 with financial support from the Slot Machine association and the MoSAH. The handbook is mainly targeted to nursing professionals, but immediately gained wide popularity among the whole medical field, including physicians.

The role of nurses in HIV/AIDS work, especially in testing, counseling and positive prevention among PLWHA is very important in Finland.

The Finnish Body Positive association has produced an "HIV self-help manual"

6.8. A miracle in the Eyes of God – on Sexuality, Physicality and Gender: a guide for confirmation training of the Lutheran Evangelical Church

The Finnish Aids Council in co-operation with the Evangelical Lutheran Association for Youth in Finland (NK) published January 18th 2007 a book called "A Miracle in the Eyes of God - On Sexuality, Physicality and Gender". The book is targeted at group leaders of confirmation trainings.

It was considered essential by the publishers to produce the book since its message could reach the majority of Finland's fifteen-year-olds. The publishers intended the book to provide support for those responsible for practical youth work in local parishes. In addition, the book complements the Evangelical Lutheran Church of Finland's theme for youth work during years 2006-2007. The theme "Beautiful in the Eyes of God" focuses on growing up as a boy or as a girl, including also sexuality as one of the aspects. The Church Council had requested that NGOs, including NK, produce material for the Church's various themes. The Church Council is not directly responsible for the materials produced by NGO: s, such materials are to be used as background in youth work.

"A Miracle in The Eyes of God" encourages open, positive and respectful discussion of sexuality, physicality and gender issues. The book does not hesitate to touch upon difficult topics and does not offer any strict rules for the reader. When it comes to love, affection and their limits, this book challenges adolescents to reconsider their own responsibilities. The book offers a lot of concrete support and information for recognizing and dealing with emotions, accepting oneself, understanding sexuality, dating, and respecting our own bodies and the bodies and the physical and mental integrity of others. The book contains a lot of practical exercises, which help young people to face their own thoughts concerning sexuality, physicality and gender issues.

The Finnish Aids Council produced the book in collaboration with experts from the Evangelical Lutheran Church of Finland. The book was published in Finnish in a run of 25,000 copies. Local parishes can order the book from NK free of charge. Furthermore, the book can be downloaded from the Finnish Aids

Council's website. The Finnish Aids Council is a national NGO which was established 20 years ago. The Council provides support and psychosocial help to those who are already infected, their close friends and to those who suspect they could have been infected. In addition to support services the Council provides education and prevention services. HIV/AIDS material is produced and education services are especially provided to professionals working in the social and health care section. Additional target groups served in prevention are: 1) the migrant population, 2) men who have sex with men and 3) young people.

NK (Nuorten Keskus) is a nationwide Christian service organization engaged in youth work. The foundation of its work is grounded in the teachings of the Evangelical Lutheran church. The aim of the organization is to strengthen a young person in his faith in God; to help him grow up into a physically and mentally well-balanced person and to motivate him to be active in the Church and society. Member organizations of the NK include Lutheran local parishes and Christian youth associations. The NK serves people between the ages of 15 to 29.

Background: The Finnish System of Confirmation Training: A Unique National Custom

In practice the goal of confirmation training is to lead young people in the direction of congregational fellowship and to help them to grow as Christians. During the period of confirmation training, young people's questions about life are discussed and answered in accordance with the frame of reference provided by the Christian faith.

Surveys show, that confirmation training is a part of Finnish youth culture. From a young person's perspective it is not viewed as something which labels a person as religious. It is regarded as a natural part of going through one's teenage years.
The confirmation training offered by the Evangelical Lutheran Church of Finland is remarkable in having the highest rate of participation in any Lutheran country.

Organization of Confirmation Training

The Evangelical Lutheran Church of Finland comprises about 560 local parishes. Local parishes are responsible for conducting confirmation training. Approximately 90 % of Finland's fifteen-year-olds attend confirmation training - about 58,000 youngsters each year. Confirmation training lasts at least six months.
The average confirmation class size is 25 youngsters, three workers (a priest, a diaconal worker and a youth worker), and about five to seven group leaders. The mainstream trend in confirmation training is to conduct most of it in a camp. The length of the camp stay ranges from five to twelve days. In addition to the camp, confirmation training includes activities which aim to introduce the youngsters to the everyday life and the fellowship in the congregation.

The Role of Group Leaders in Confirmation Training

The training of group leaders for confirmation camps has become the core of youth work in many parishes. In 2006, approximately 24,000 young people took part in this training. The group leaders, aged 16 to 18, have a central role in confirmation training: as volunteers they run the confirmation camps together with workers from local parishes. Group leaders also work as volunteers in other forms of confirmation training. They act for an average of two to three years as group leaders.

6.9. International development policy and development cooperation

Development policy means the principles and policies according to which Finland acts to improve the circumstances of developing countries and the living conditions of their inhabitants. Development policy is part of Finland's foreign policy, but not only that: development policy also involves activities within Finland itself.

As a responsible member of the international community, Finland promotes development and a more equitable division of the benefits of globalisation. This is our responsibility, but in this way we also construct the security, economic growth and the fundamental well-being of our own society.

The main goal of Finland's development policy is to contribute to the eradication of extreme poverty from the world.

Development cooperation is a key instrument of development policy. It can be used to promote the strengthening of an environment conducive to development in the poorest countries in order to improve the premises for investments and trade and to achieve economic growth.

Finland's development policy is steered by the government resolution on development policy from October 2007.[42]

The fight against HIV/AIDS has been included as one of the cross-cutting themes in the new Development Policy of the Government of Finland (approved by the Cabinet in 18 October 2007). HIV and AIDS are seen not only as a health problem but a broad social issue that affects the society as a whole.

HIV and AIDS have been implemented as a mainstreaming issue for NGO's[43] development cooperation since 2004. During the year 2006 proximately 12 percent of the total funds of MFA were channeled through specialized NGOs. Special attention has been directed to Children. Finland has approved the framework for the protection, care and support of orphans and vulnerable children living in a world with HIV and AIDS.

There is number of highly specialized Finnish development cooperation and humanitarian aid NGOs[44]. Larger ones take actively and regularly part to build awareness on global HIV and AIDS trends towards Finnish civil society. Part of the budgets of NGOs is directed to awareness campaigns. In addition to this NGOs are involved in Advocacy work on HIV and AIDS related issues. HIV and AIDS was included as one of the cross-cutting themes in the new Development Policy of the Government of Finland partly due to the advocacy given by development cooperation NGOs.

[42] http://www.formin.fi

[43] Some development cooperation NGOs, World Vision Finland etc. have chosen HIV and AIDS as a special theme to be implemented

[44] Examples: Fida International, Finn Church Aid, Save the Children, Plan Suomi Säätiö, Suomen lähetysseura, World Vision Finland

7. Major challenges and remedial actions

7.1. Progress made on key challenges reported in the 2005 UNGASS Country Progress Report

Finland has achieved most of the UNGASS national targets set in 2001. The main changes since the 2005 report have to do with improved surveillance among MSM and IDU low threshold services.

The main goals of equal and comprehensive access to prevention, treatment and care are to a large extent fulfilled, although regional differences have not been completely eliminated. Nevertheless, there are still challenges that need to be addressed as well as uncertainties that the current surveillance system cannot address. These still need further responses and development.

7.2. Challenges faced throughout the reporting period of 2006-2007 that hindered the national response and the progress towards achieving the UNGASS targets

The main challenges with achieving all UNGASS targets have to do with the following issues:

7.2.1. UNGASS Indicators

There are several indicators for which the information was not possible to collect during the reporting year:

9: Percentage of most-at-risk populations reached with HIV prevention programs

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

16: Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months

17: Percentage of women and men aged 15–49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse

18: Percentage of female and male sex workers reporting the use of a condom with their most recent partner

19: Percentage of men reporting the use of a condom the last time they had anal sex with a male partner

These data are missing because these are no direct studies of sexual behavior, risk perception and risk taking among the general adult populations. The only data available in any more or less consistent fashion is that of youth attending schools, certain vulnerable groups and sentinel data from STI clinics. However, not all of this data is completely compatible with the UNGASS indicators, either.

A similar missing feature is that studies or surveys monitoring the societal attitudes towards HIV, AIDS and PLWHA are not regularly performed. The few available data are spotty and inconsistently gathered.

Monitoring of behavioral and attitude indicators needs to be strengthened in the future to be able to respond and target misconceptions and risk taking.

7.2.2. Division of work and responsibility between government and NGO actors

7.2.2.1. Integrated HIV/AIDS work

A guiding principle for the Finnish AIDS policy and the strategic approach toward prevention, treatment and care is the integration of the activities into regular social health care, with as little special measures put in place as possible. There are no "AIDS-centers", "AIDS-clinics" or "HIV/AIDS wards" in Finland that would segregate and separate HIV-cases from other patients. Municipal public social and health provider have a clear legal obligation to see to the needs of their residents in any health issue, including HIV/AIDS.

While this approach has many benefits, it is not without problems either. When the approach works best, it provides equal access and nondiscriminatory HIV/AIDS care compared to any other medical condition. It also sets clear boundaries to where responsibilities lie within the various levels of social welfare and health care actors.

In a worst case scenario, however, the integration may lead to integration on paper only and factual negligence of HIV/AIDS specific issues that would have to be taken into consideration for proper organization of actions. This may happen for many reasons, but mainly because one of the following reasons:

1) Perceived or real rarity of the issue at hand (HIV/AIDS); which may lead to:
2) Prioritizing other social and health issues
3) Therefore: lack of resources
4) Therefore: lack of knowledge and understanding

If a situation like the one that is described above develops, which may well be the case in the smaller municipalities in Finland; it may mean that if faced with a need for service provision for an HIV positive resident, the system may not be ready for the task.

This may lead to an inappropriate, or in the worst case even judgmental response towards the person, or to a referring to the lack of resources for the provision of especially supportive social services. While those accessing the public health system may press forward and demand their legal right to service, this places a too high burden on the individual to be acceptable.

A big part of the problem above is the large number of municipalities and the small size of many of them. It is clear that a municipality as small as 2-3000 inhabitants and with the corresponding tax base cannot provide the same level of services as one of 500.000 inhabitants. In addition, Finland is a large country with long distances in the rural areas, which puts additional challenges to ensuring equal access for all. This creates great challenges for creating and managing functional cooperative models between many small municipalities.

As the small municipality size leads to several problems, a process of creating larger units of an average of 20.000 has started. This is expected to improve access to services in the future.

An additional challenge is that some of the groups vulnerable to HIV infection, especially the IDU, sex workers and sometimes even MSM, may be perceived

as marginal or "difficult to face" groups within the public social welfare and health system. For some of them who act on the boundaries of the legal and judicial system (especially migrant sex workers or illegal immigrants), there may be no legal access to services.

This raises the threshold for access to services, frequently both among the providers and the clients, which in many ways has a negative long term public health effect.

7.2.2.2. Engaging the 3rd sector actors

One solution that has been frequently used to try to solve some of the above challenges is the engagement of and co-operation of NGO and Civil Society actors together with government (local and national) actors. NGOs working for a certain defined cause frequently have better possibilities to develop expertise which can be utilized for the benefit of both the individuals in need and the community.

NGOs also often have a better possibility to reach out and connect to vulnerable groups and may be perceived among the target groups as more trustworthy because of the lack of a direct "governmental" role.

For these reasons, there is both a tradition and good practice of outsourcing of parts of the social and health services to the so called 3rd sector, i.e. different NGOs and non-profit civil society actors (1st sector is the public sector, 2nd is the private sector). While this approach has the many obvious benefits and at its best leads to excellent results, it is not without challenges.

A main challenge for the NGO engagement is long term funding. Most of the actors receive their operational funding trough a mixture of short term contracts. These come from many different sources, which can be self-initiated applications to a certain broad funding-program (national or international, EU-funding is often used) or tendered, i.e. competition based. The latter is most frequent when municipal actors outsource part of their activities. Municipal actors are public agencies and are required to follow competition legislation in their outsourcing work. Especially important in this regard is the Act on Public Contracts, 348/2007, which specifies the rules under which a public agency must operate their purchasing of goods and services.

The constant need for re-applying for external funding leads to a diminished longevity for the work at hand. In practice the funding available may be mostly for short term projects and less for maintenance of long-term activities, which can severely counteract the actual goal of the program at hand.

A special emerging challenge can be seen in evolving rules for tendering processes: within certain types of public funding agencies, the question of freely competed tenders has been raised in areas where typically more or less targeted funding has been utilized in the past. This means, that due to stricter EU community competition rules and national legislation (see above), some non-profit NGOs which have a long established and recognized expertise within a field, may be faced with having to compete on equal terms with for-profit civil society actors for a certain activity.

This approach incorporates a great risk of losing the expertise if a new actor comes in with an aggressive bidding to gain a foothold in the field. Such a situation may for example develop if packaging of many different services is performed to be able to gain a strong position towards the tendering party. Especially in

situations where municipalities more and more outsource some of their public social and health care duties to privately owned and operated actors, this may very well happen. This puts a hard burden on the expertise of the outsourcing agency as well as on the bidding service provider to be able to produce and judge competitive bids.

It will be important to make sure that it is even in the future possible to ensure that tendering processes adequately take into account and judge the best expertise and experience available in competitive tendering processes, so that these factors can overrule the cost of the services in provider selection when there is a clear difference between bidders.

7.2.2.3. Division of responsibilities

Another challenge of outsourcing or NGO engagement is that over time the responsibilities laid down in the laws and regulations may become blurred. While the law on public health is clear on where the responsibility leis (i.e. within the municipal government), the perception among those who may fund the services may become such that they have fulfilled their legal duty by such funding, even if it would be inadequate.

Therefore, external monitoring of the fulfillment of the legal responsibilities by municipal social and health actors would need to be strengthened. During the mid 1990:s recession the National Board of Social Affairs and Health, which used to be responsible for monitoring of social and health service provision was decommissioned entirely.

While the tasks of the former board were divided among other actors, such as the MoSAH, STAKES and the regional governments, the development of detailed common standards was largely abandoned and more freedom given to the local actors in decision making and standard setting according to local needs. There is a need to evaluate whether some clearer guideline setting would be needed in the future.

7.2.3. Need for strengthened nationwide activity

Certain areas of especially preventive, but to a certain degree also healthcare HIV/AIDS work would benefit from a nationwide approach. Currently the challenge in this regard is how to identify the correct actor which would have both the mandate and resources available for such activities. Since preventive health and social work is the responsibility of municipal governments, it is difficult to identify a single actor who could take on a nationwide common program. In the current governmental structure only the MoSAH, regional governments or municipal co-operation bodies[45], advised and assisted by KTL and STAKES could take the lead in these activities.

7.2.3.1. HIV/Aids expertise within the public health care

The integration of HIV/Aids into regular primary, secondary and tertiary health care is not without problems. In practice, the existence of adequate HIV/Aids expertise in health care becomes questionable especially in those regional health districts where the prevalence and number of PLWHA is low, because HIV/Aids constitutes such a minor section of a health care providers workload.

Even in the health districts with the highest number of PLWHA in the country, the allocation of human resources for maintenance of HIV/Aids expertise has great difficulties to hold its own against more established fields of medicine.

[45] Lääninhallitukset, Kuntayhtymät, Kuntaliitto

7.2.3.2. Social marketing and awareness campaigns

A major issue in this regard is how to identify an appropriate actor which could be responsible for awareness campaigns. While there is little evidence of true behavior change through such social marketing, there is good evidence of its supportive role for maintenance of existing safe practices and as an attitude modifier. Currently no actor is self evident in co-ordination or funding of campaigning or social marketing activities. Again, a possibly could lie in the municipal co-operation bodies. However, relatively large resources would be needed to achieve this.

7.2.3.3. Stigma and discrimination

Issues of stigma (and to a certain degree discrimination) due to fears and false beliefs have not been entirely removed from the societal response to HIV/AIDS in Finland. Although little data is available on the public attitudes towards HIV-infected, anecdotal reports and isolated events point to the existence of negative attitudes especially towards questions on transmission of HIV/AIDS.

A recent case of an individual who had sexually transmitted HIV to several other persons despite knowledge of his/her own infection received a lot of media coverage. In the Finnish legal system interpretation, such knowing exposure of others has been deemed as falling under criminal prosecution.

Media coverage of the case resulted in a partial backlash in attitudes and has the problem of emphasizing the responsibility of the positive person and de-emphasizing the need of the other parties for self-protection.

It is clear that there is a need to study the questions of HIV related attitudes and stigma. Also, it would be important to estimate the public health and societal effects of the current judicial practice.

7.2.3.4. MSM work

Men having sex with men are clearly among the most vulnerable groups for HIV/AIDS in Finland. The estimated prevalence (4.5 %) in this group is the highest of all subpopulations in the country.

Despite this there are only little prevention resources available for targeted MSM work. The MoSAH and some other funding bodies have provided resources for some NGO: s (The AIDS council and the Pro-Tukipiste) for preventive MSM work, but the coverage and extent is far from sufficient to reach the whole population even in the capital area.

Preventive work through these organizations should be vigorously supported to extend their coverage. In addition, other relevant organisations, both governmental and NGO/Civil society, could include risk reduction and safe sex promotion, including targeted non-heteronormative messaging, on their agendas. However, this would require a clear increase in available funding and making STD prevention a priority area.

International estimates would suggest that approximately 2-7 % of the male population belong to this group, making it the single largest vulnerable group. In this regard there would probably be a demand for targeted health services for MSM. In some countries, health clinic specializing in this group exist and act as a natural route for health promotion and HIV/AIDS prevention work.

STI clinics have their own role in MSM health promotion and certainly STI prevention work, but they may not be

able to fulfill the whole spectrum of MSM specific health issues.

7.2.3.5. Strengthened youth work, including non-hetero-normative health education and prevention

Thanks to the school health survey, there is relatively good data available on both the knowledge level and the STI risks among adolescents and youth in comprehensive schools and high schools. However, after this level, data is much spottier, and only exists from small-scale studies. In addition, the data is currently missing completely for those youth who choose vocational schools after the comprehensive school level. This deficit has been clearly addressed in the MoSAH "Promotion of sexual and reproductive health action programme" of 2006. Data from university level students is almost completely missing, although it could be collected through university health services.

While the addition of Health education as a standardized compulsory subject in schools is a positive development and has probably improved the level of knowledge among youth significantly, there is little knowledge on how the knowledge turns into preventive action especially after the age of 18. Chlamydia and Papillomavirus infections are common among youth, especially after the age of 19.

Resources for school student health services have been significantly reduced in the last 10 years, and in most schools access to a school nurse is only available certain days of the week, and access to a school physician only once a month.

There are few youth health clinics that would offer sexual health and STI prevention advice targeted specifically to youth. The services are in principle available through regular municipal health centers, but the "youth-friendliness" varies greatly between municipalities. Few, if any health centers provide free access to condoms. Access to condoms and other birth control tools is widespread, but prices are relatively high, especially for condoms and may therefore represent a barrier for use.

The establishment of much wider network of municipal free youth sexual health clinics should be considered as an alternative to current practices. There is an urgent need to try to influence sexual behavior in way that would reduce current levels of risk among youth.

Another important issue which would need further emphasis in youth health education and promotion would be to develop the school health education curriculum further, so that more attention could be paid to young men who are having, or might have, sex with men.

The health education materials and curiculums should be critically examined and renewed to more strongly also include a non-heteronormative angle to ensure that the information on transmission and safe sex practices will also be addressed to young MSM and non-heterosexual women.

7.2.3.6. Positive prevention

Sexual prevention among PLWHA is mainly conducted by peer organizations such as the Finnish Body Positive association and by specialized infection clinic staff (mainly nurses and social workers). Low threshold health service centers for IDU also have a role in this.

However, little is known about the actual impact of positive prevention messaging or even on how it is practiced. There is a need for developing the concept further, maybe by much more concrete

collaboration between the PLWHA organizations and the health care actors to develop more standardized tools and methodology.

7.2.3.7. Migrants

Migration as an issue is going through major changes in Finland. The population of migrants grows continuously, and the number of residents with a migrant background increases. Prevention work among migrant populations needs own approaches which also must be adapted to the specific and differing needs of the diverse migrant populations.

The successful integration of these services into the homogenous social and health services in Finland represent a tremendous future challenge, especially as there is a real need to increase migration due to a shrinking workforce in Finland.

An additional and highly vulnerable group is formed of illegal and/or trafficked migrants whose needs easily become overrun by legal barriers. The needs of this group need to be addressed foremost from a human rights framework.

7.2.4. Neighbourhood area cooperation

The neighboring areas of Finland in the East and the South have experienced some of the most rapidly expanding HIV-epidemics during the last 10 years. A lot of cross-border exchange to these areas (the Russian Federation and the Baltic States) occurs and is expected to grow extensively in the future.

The widespread HIV-epidemics coupled to a still significant economic gradient between the areas represent a major challenge for HIV prevention in the area.

Finland has a long tradition of Neighboring Area collaboration with the Russian Federation in the field of Health, and this should be further extended and supported in the future to ensure a beneficial outcome for the years to come.

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

Plans to enhance behavioral surveillance, through the incorporation of questions on sexual behavior and risk taking in national health surveys exist. Currently negotiations are under way to enable this to be achieved.

Similarly, the d School health study is planned to be extended to vocational schools to reach a higher proportion of the youth population.

Many of the other challenges will be addressed through the new National HIV Policy document which hopefully will be able to suggest solutions to at least part of the challenges.

8. Support from the country's development partners

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

9. Support for Global Commitments

9.1. UN and bilateral development co-operation

Finland strongly supports UNAID in its work and financial contributions in the past years have been as follows

Table 12: Contributions to UNAIDS by Finland

Year	*Amount*	*Comment*
2005	7 M€	Incl. 1 M€ for GCW
2006	8 M€	Incl. 1 M€ for GCW
2007	8 M€	

Finland also contributes for HIV/AIDS work indirectly through non-earmarked donations to several UN agencies, as well for bilateral development cooperation work, for example with Mozambique.

9.2. Global fund

Finland joined the Global fund against AIDS, Tuberculosis and Malaria in 2006 and has contributed (and pledged to contribute) as follows:

Table 13: Contributions and Pledges to the Global Fund by Finland

Year	*Amount*	Comment
2006	3 M€	
2007	2.5 M€	
2008	2.5 M€	pledged
2009	2.5 M€	pledged

9.3. Regional activities

In addition to the above development cooperation support, Finland has a longstanding tradition of various forms of neighboring area co-operation. Work is especially done in collaboration with Nordic countries and the Russian Federation in the field of HIV and AIDS prevention, control and treatment. In addition, regional co-operation extends to the Baltic States of the European Union and to larger networks international regional networks with a Northern Dimension.

This work cannot be categorized as bilateral financial flow from a DAC member country (Finland) to a low- and middle income country. It however contributes to the improvement of the HIV and AIDS situation in the co-operating countries and their regions. Highlights of the regional co-operations can be found in projects in the Murmansk and Leningrad regions, the Republic of Karelia and the city of St. Petersburg.

Regional collaboration work is especially done in the format of two larger co-operation frameworks.

9.3.1. Northern Dimension Partnership in Public Health and Social Well-being (NDPHS)

Web address: http://www.ndphs.org/

Partnership in Public Health and Social Well-being

Finland in 2002 took the initiative to establish a regional partnership pro-gramme. The Northern Dimension Partnership in Public Health and Social Well-being (NDPHS) is a cooperative effort of thirteen governments, the European Commission and eight intergovernmental

organisations. The NDPHS provides a forum for concerted action to tackle challenges to health and social well-being in the Northern Dimension area and foremost in north-west Russia.

Founded on 27 October 2003 at a Ministerial-level meeting in Oslo, Norway, the Partnership works according to the provisions spelled out in the Declaration concerning the establishment of a NDPHS (the Oslo Declaration). This Declaration lays the foundation for the Partnership's objectives, structure, role and practical functions, main priorities, financing methods and guidelines for future development. Being multinational and multi-stakeholder in its composition, the membership of the NDPHS is comprised of numerous Partner Countries and Partner Organizations (the Oslo Declaration also includes a definition of a Special Participant).

The NDPHS is one of two existing Partnerships within the Northern Dimension (ND) policy that began in 2000 with the European Council's adoption of the 1st Northern Dimension Action Plan. From its beginning, when the ND policy was the main external, cross-border framework for the European Union's relations with North-west Russia and the Baltic Sea and Artic regions, this policy has aimed at addressing the special regional development challenges of Northern Europe.

In accordance with the Political Declaration on the Northern Dimension Policy and the Northern Dimension Policy Framework Document– both endorsed at the ND Summit in November 2006 – from the beginning of 2007 the Northern Dimension policy changed its character to a joint endeavor of four partners, namely that of the European Union, Iceland, Norway and Russia.

The mission of the NDPHS is to promote the sustainable development of the Northern Dimension area by improving peoples' health and social well-being. The Partnership aims to contribute to this process by intensifying cooperation, assisting the Partners and Participants in capacity building, and by enhancing the extent of coordination between international activities within the Northern Dimension area.

In working to achieve these objectives, the Partners focus on increasing political and administrative coherence between the countries in the Northern Dimension area, narrowing their social and economic disparities, and improving peoples' overall quality of life.

The Partnership has two main priority fields in which it aims to support cooperation and coordination.

The first priority is to reduce the spread of major communicable diseases and prevent life-style related non-communicable diseases. These diseases include HIV/AIDS, tuberculosis, sexually transmitted infections, cardiovascular diseases, resistance to antibiotics, as well as other major public health problems that arise from the use of illicit drugs and socially distressing conditions.

The second priority is to enhance peoples' levels of social well-being and to promote socially rewarding lifestyles. Here, an emphasis is placed on encouraging proper nutrition, physical exercise, safe sexual behavior, ensuring good social and work environments, as well as supporting alcohol, drug and smoke-free leisure activities. Within this priority field, special attention is placed on youth as the primary target group.

Across both priorities, gender and children's perspectives are taken into account. Equity and social inclusion are

treated as central elements in achieving the Partnership's objectives, for which reason a strong interaction between the health and social sectors is promoted. People with disabilities and indigenous peoples are also recognized as vulnerable groups that have particular needs and therefore require special attention.

Among the principal approaches taken, the Partnership supports the reorientation of and greater efficiency within the health and social care systems. Potentials to improve community-based social care and preventive social services are at the forefront of capacity building efforts in this respect.

9.3.2. Health cooperation in the Barents Region

Web address:
http://www.barentshealth.org/

The Barents Health Co-operation Programme was launched in March 1999 and marked new emphasis on health and medical-related issues in the Barents Euro-Arctic Region. In 2003, a new Barents Health and Social Programme was adopted. In 2005, a unique Barents HIV Programme was adopted.

The official health cooperation in the Barents Region is developed by regional and national/federal health authorities in four countries, Norway, Sweden, Finland and Russia. A Working Group on Health and Social-relating Issues (WGHS) meets regularly to follow up the programme. The WGHS is operating in conjunction with the Barents Regional Council and the Barents Euro Arctic Council, as well as other international structures in the region, among them the Northern Dimension Partnership in Public Health and Social Well-being.

In October 2003, a new and enhanced health and social programme for the years 2004-2007 was adopted by the Barents Euro Arctic Council (BEAC). The Cooperation Programme on Health and Related Social Issues in the Barents Euro-Arctic Region 2004-2007 has a stronger emphasis on social aspects, multilateral action and coordination than the first programme. Special attention will be paid to gender mainstreaming, children and young people, and to vulnerable groups in the population.

Priority areas in the programme are defined as:

1. Prevention and combat of communicable diseases
2. Prevention of lifestyle related health and social problems and promotion of healthy lifestyles
3. Development and integration of primary health care and social services

The Cooperation Programme on Health and Related Social Issues in the Barents Euro-Arctic Region 2004-2007 has been developed with the Second Northern Dimension Action Plan and the Northern Dimension Partnership in Health and Social Wellbeing in mind, and is intended to constitute a key component of the Partnership.

In February 2005, the Barents Working Group on Health and Social-related Issues (WGHS) adopted the Barents HIV/AIDS Programme. The new programme will help coordinate and strengthen international efforts in the fight against HIV and AIDS in the region.

9.3.3. Neighboring area cooperation funding mechanism

Finland provides funding for regional bilateral HIV/AIDS prevention through its Neighboring area cooperation funding mechanism (grants provided though the MFA).

Web address:
http://www.formin.fi/public/default.aspx?nodeid=34823&contentlan=2&culture=en-US

As examples of the activities of governmental (MFA, MoSAH, STAKES, KTL, regional governments), NGO: s and regional collaborators (financed by the MFA) the following could be highlighted:

- Coordination of the HIV/AIDS in the Barents and EU Northern Dimension programme, 2005-2007
- Pilot project of the Barents HIV/AIDS programme in Murmansk to establish a Low Threshold Health Service Centre, 2005-2007
- Technical assistance to the HIV/AIDS Expert Group of the EU Northern Dimension partnership, 2005-2007
- Prevention of HIV infection in the Republic of Karelia, 2007-2009
- Psychological and social support to HIV infected women in Leningrad Oblast, 2007-2009.
- Technical assistance to health professionals in the Baltic States based on the WHO/ILO guidelines on health services and HIV/Aids (ILO Geneva 2005) provided by Tehy ry, the Union of Health and Social Care Professionals and PSI.

9.4. Support for HIV vaccine development and microbicide development

Finland has supported HIV vaccine development nationally, providing both long-term investment support and specific project support for an SME drug/vaccine biotech startup company (FIT-Biotech LTD, Tampere). FIT-Biotech develops DNA-vector vaccines, including candidate HIV-vaccines. Finland does not financially support IAVI or the International Microbicide Initiative.

Long term investment support has been given by SITRA[46] (the Finnish Innovation Fund) and short-term project support by TEKES[47] (Finnish Funding Agency for Technology Innovation). Both are national government supported independent funding agencies. The annual and long term contributions for FIT-Biotech for vaccine development are as follows:

Table 14: Vaccine and Microbicide Support

Agency/year	***Amount***	Comment
SITRA	6.58 M€	Long-term investment
TEKES		
Year		
2006	1.26 M€	General vaccine development
2005	2.58 M€	General vaccine development
2003	2.89 M€	HIV-vaccine
2002	2.16 M€	HIV-vaccine
2001	0.19 M€	HIV-vaccine

[46] http://www.sitra.fi
[47] http://www.tekes.fi

10. Monitoring and evaluation environment

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

Monitoring and evaluation is performed in a multi sectorial fashion, where each responsible authority performs M&E activities as part of their annual business cycle. In addition, there are National level M&E activities for HIV/AIDS within the MoSAH, the National Public Health Institute and STAKES.

The main monitoring instrument is outcome monitoring, i.e. surveillance of new HIV-infections, AIDS and AIDS deaths (see chapter 2, especially points 2.1-2.3). In addition, STI and blood-borne infection surveillance data is used as surrogate markers. The numbers of performed HIV tests are surveyed annually.

For IDU prevention, a separate action and service provision monitoring system is in place, collecting annual indicator data in low threshold service centers, such as visits, client numbers, equipment exchange numbers, vaccinations, test numbers, regional coverage etc. The above functions are mainly the responsibility of the National Public Health Institute – KTL and its sister institute, STAKES, together with a network of LTHSC sites.

Some monitoring of behavioral aspects of prevention is in place. These are targeted mainly towards youth, where STAKES performs an annual school health survey in age groups 13-18 year olds. In this survey, standard questions on HIV-associated issues are used, and are employed for monitoring issues such as age of sexual debut and condom use, as well as partner numbers.

HIV/AIDS health care service provision monitoring is mainly performed regionally or locally and few HIV-specific data are available nationally.

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

The main challenge of the current monitoring and evaluation system is that while there are relatively comprehensive local and regional systems in place, they are general in nature. Another challenge is the highly autonomous organization of health care, which makes it difficult to impose national reporting and monitoring responsibilities for regional actors.

An important challenge for compliance with UNGASS reporting is the poor suitability of certain indicators for countries with a well developed and established comprehensive public health system. This means that certain currently collected indicator data are less relevant for national actors and this provides a challenge for their accurate estimation.

It is especially difficult is to estimate the proportion and actual figures of funds spent on HIV/AIDS prevention and treatment, since many of the activities are part of established functions which are not HIV-specific.

A clear missing part of a comprehensive monitoring and evaluation system in Finland is the lack surveillance and direct studies of sexual behavior, risk perception and risk taking among general adult populations. The only data available in any more or less consistent fashion is

that of certain vulnerable groups and sentinel data from STI clinics.

A similar missing feature is that studies or surveys monitoring the societal attitudes towards HIV, AIDS and PLWHA are not regularly performed. The few available data are spotty and inconsistently gathered.

Monitoring of behavioral and attitude indicators needs to be strengthened in the future to be able to respond and target misconceptions and risk taking.

10.3. Remedial actions planned to overcome the challenges

At the moment there is no national remedial funding or direct programmatic actions planned on a national level. However, there are plans to enhance existing structures towards more systematic behavioral and attitude data gathering and analysis.

In the new HIV strategy under development, a clearer coordination and monitoring and evaluation role is proposed to be given to the MoSAH appointed NAC, i.e. the HIV expert group.

However, this is subject to political decision and has not been decided on yet.

10.4. The need for M&E technical assistance and capacity building

There is a clear need for additional indicator development for applicability in European settings. The leading role for this should perhaps be given to the European Center for Diseace Control and Prevention (ECDC) in cooperation with WHO-Euro and possibly UNAIDS.

11. Contributors to the report

11.1. Main Government Contributors

The contributors listed in this section are nationally responsible for data collection, analysis, co-ordination and reporting to UNAIDS.

11.1.1. Ministry of Social Affairs and Health

MINISTRY OF SOCIAL AFFAIRS AND HEALTH

Web address: www.stm.fi

The Ministry of Social Affairs and Health aims to provide the population with a healthy environment, good health and functional capacity, and adequate income and social protection in different life situations.

The Ministry directs and guides the development and policies of social protection, social welfare and health care. It defines the main course of social and health policy, prepares legislation and key reforms and steers their implementation, and handles the necessary links with the political decision-making process.

The general aims of social welfare and health care and the measures that will be taken in order to fulfil these aims are adopted in a Target and Action Plan for Social Welfare and Health Care that is drawn up for the whole period of office of each government. Thus the development of social welfare and health services is a part of the political decision-making. The Plan is a kind of co-operation contract between the local authorities (municipalities) and the state. The preparation, execution and follow-up of the Plan are the responsibility of a steering group composed of the representatives of, among others, the Association of Finnish Local and Regional Authorities, the Ministry of Social Affairs and Health and related authorities, and non-governmental organizations in its sector.

There are five provinces in continental Finland plus the autonomous Province of Åland Islands. The State Provincial Offices are regional government authorities of the state. They guide and supervise social welfare and health care in the provinces, while the country's 431 municipalities are responsible for the actual provision of services. At the end of 2005 the Finnish population was about 5.2 million.

11.1.2. Ministry for Foreign Affairs

Web address: www.formin.fi

FORMIN.FINLAND.FI

MINISTRY FOR FOREIGN AFFAIRS OF FINLAND

The Ministry for Foreign Affairs promotes the security and welfare of Finland and the Finns, and works for a secure and fair world.

The Ministry for Foreign Affairs concentrates on foreign and security policy, trade policy and development policy as well as on significant foreign policy issues and international relations in general. The Ministry also assists other branches of government in the coordination of international affairs.

The Finnish Foreign Service – the Ministry and approximately one hundred

diplomatic and consular missions – focuses on serving Finns, the Finnish economy and society at large, the country's political leadership and Parliament.

Finland's welfare is increasingly based on knowledge, creativity and innovation. The relatively small domestic market offers limited possibilities for success. It is therefore of the utmost importance to work more effectively at an international level.

Finns also travel more than ever, for both business and pleasure. This creates growing challenges for Finnish diplomatic and consular missions abroad.

11.1.3. National Public Health Institute - KTL

Web address: www.ktl.fi

KTL protects and promotes the health of Finnish people

Kansanterveyslaitos
Folkhälsoinstitutet
National Public
Health Institute

The National Public Health Institute – KTL is a research and expert institute under the Ministry of Social Affairs and Health of Finland. KTL provides public decision makers, other stakeholders and the general public with reliable information on public health.

The institute's core functions are public health research and expert functions. KTL also operates functions for health monitoring and public health services, including the development, assessment and performing of laboratory research. The Institute participates in the dissemination of health information and health education through education and training activities.

The eleven departments at the institute cover all aspects of public health from safe drinking water and vaccinations to genetics and mental health. KTL is responsible for the control of infectious diseases and for the prevention of chronic diseases in collaboration with the health care system. It has an important role in shaping Finnish public health work and health policies. KTL is very actively involved in numerous international collaborations.

KTL is the only governmental institution with a unit within its organisation dedicated to HIV/Aids affairs. The HIV unit at the Department of Infectious Disease Epidemiology and Control is in responsible for national surveillance, expert advice, research and co-ordination under the guidance of the MoSAH. The unit has collated the UNGASS report and will publish it within the publication series of the institute.

11.1.4. National Research and Development Centre for Welfare and Health – STAKES

Web address: www.stakes.fi

STAKES is a sector research institute under the Ministry of Social Affairs and Health of Finland. Its core functions are research, development and information production. STAKES assesses changes affecting welfare and health, evaluates the outcomes of welfare policy and brings forth new alternatives.

STAKES monitors and evaluates the functions and development in health care and social welfare, carries out health care and social welfare research, produces,

acquires and distributes information and know-how from national and international sources. It produces information and expertise for policymakers and other stakeholders and acts also as a statistical authority in the field of social welfare and health care. Statistics are compiled concerning various topics, e.g. social and health services (including reproductive health), alcohol and drugs, and social and health expenditure.

The different divisions in STAKES work with issues such as evaluation of outcomes and equity of the service system, advanced client-centered services, facilitation of decision-making in the social services and health care, support to the preventive work, health care statistics and registers, information technology development and harmonisation. STAKES also includes the Finnish Office for Health Technology Assessment (Finohta) that promotes the use of good, evidence-based technologies in health care and develops the efficiency and effectiveness of health care.

STAKES has a unit of International Development Co-operation (IDC) which has a strong role in especially neighboring area collaboration within the HIV/Aids sector.

11.2. Main NGO/Civil society sector contributors

The Contributors listed in this section have involved themselves actively in the data collection, evaluation and drafting during all steps of the reporting process. They are important players within the Finnish HIV/Aids field.

11.2.1. The Finnish AIDS Council

Web address: www.aidstukikeskus.fi

HIV Foundation / Finnish AIDS Council

The services of the Finnish AIDS Council have been available since 1986. The organization is ideologically and religiously independent. The Finnish AIDS Council is run by the HIV Foundation. It aims to:

- Prevent HIV infections.
- Enhance the competence of social and health care professionals in handling HIV questions.
- Support people with HIV infection, their families and friends, and those concerned about HIV.

The Finnish AIDS Council is a national expert and service organization run by the HIV Foundation. Its work is in line with the Government Resolution on the Health 2015 Public Health Program, according to which public health organizations are opinion leaders in health promotion, distributors of information, and providers and developers of services. The Finnish AIDS Council's guidelines comply with the guidelines of the Finnish national HIV/AIDS strategy.

The Finnish AIDS Council's work is divided into two sectors: Services, and Prevention and Training.

11.2.2. The Finnish Body Positive Association (FBPA)

Web address: www.positiiviset.fi

The Finnish Body Positive Association (FBPA) was founded in 1989. FBPA is a peer organisation and the only association for people with HIV in Finland. The fundamental idea is by people with HIV for people with HIV.

The main purposes of Finnish Body Positive Association are:

- to promote the well being of its members and their families
- to increase the self esteem of its members
- to fight against discrimination of people with HIV and AIDS
- to participate in the forming of AIDS policies in Finland
- to offer correct and unprejudiced information about HIV and AIDS.

FBPA has its office and drop-in centre in downtown Helsinki open six days a week. Its Treatment Action Group informs about the development and availability of new treatments. The International Group is in charge of international connections and relationships.

The Women's Group has regular meetings centered on women's issues. Some members of FBPA give talks in schools, colleges and universities. FBPA is actively involved in community symposiums and seminars where HIV and AIDS are discussed.

FBPA works in companionship with other communities and authorities active in the field of HIV. The most important Finnish companions are Finnish Aids Councils, Finnish AIDS Foundation, Finnish Red Cross, Diaconal Projects of Helsinki Deaconesses' Institution and Finnish HIV/AIDS Nurses' Association.

Internationally FBPA is a member of NordPol, a coalition of Nordic organisations for people with HIV/AIDS. Some members of FBPA have been active in European Aids Treatment Group (EATG) and European Community Advisory Board (ECAB).

FBPA is funded mainly by Raha-automaattiyhdistys ry (Finnish Slot Machine Association) and the Ministry of Social Affairs and Health. FBPA also has its own fund raising activity.

11.2.3. Pro-Tukipiste

Web address: www.pro-tukipiste.fi

PRO·tukipiste

The main NGO providing services for sex workers in Finland is the Pro-Tukipiste, which has outlets in the cities of Helsinki (capital) and Tampere. Pro-Tukipiste is a registered non-profit organization which supports and promotes the civil and human rights of individuals involved in sex work. Pro-Tukipiste follows and takes part in national and international discussions concerning prostitution and sex work, and also makes statements concerning issues related to prostitution policies. The association follows and makes statements on the treatment and the legal status of sex workers in Finland.

Pro-Tukipiste also maintains and runs professional social and health care service units and outreach units in Helsinki and Tampere.

11.2.4. The A-Clinic Foundation

Web address: www.a-klinikka.fi

The A-Clinic Foundation is a non-profit, non-governmental organisation providing treatment services mainly through municipal public-private partnership. It is the leading substance abuse service provider in Finland with

- 19 outpatient and inpatient service units: youth clinics,
- Therapeutic communities
- Low Threshold Health Promotion Service Centres for injecting drug users
- Järvenpää Addiction Hospital
- Activities in the areas of prevention, training, research and information provision.
- Staff of 700

For the last ten years the A-Clinic Foundation has been an active developer of low threshold services. Health and social advice centers provide needle exchange, medical services, condoms, Hepatitis vaccinations, HIV and Hepatitis testing and counselling.

Working methods also include outreach and different peer work models.
A-Clinic Foundation actively engages in societal dialogue with the specific aim of improving the conditions for underprivileged groups, including

11.2.5. The Helsinki Deaconess Institute

Web address: www.hdl.fi

The Helsinki Deaconess Institute is the biggest private sector provider of social services in the capital area of Finland. It, for instance, provides special services for HIV-positive intravenous drug users.

The goal of the special services is to enhance the social wellbeing of the target group, increase their expected lifespan, make medical treatment available to everyone and hinder the spread of the HIV-epidemic in cooperation with other actors. The services consist of a Low Threshold Health Service Centre, Mobile Health Counselling Unit, short- and long-term accommodation services and homecare.

The creation and maintenance of a confidential relationship with the clientele is a precondition for the success of the special services. The essential operational principles are: keeping the threshold for entrance as low as possible, providing anonymous and comprehensive services.

11.2.6. The Finnish HIV-network

The Finnish HIV-network is an informal forum of NGOs and municipal actors for sharing information and promoting awareness on HIV and AIDS in Finland. The network is also actively participating in the current political discussion related to HIV and AIDS issues. The network was established in 2000. The following organizations are members of the network:

A-Clinic Foundation
Caritas
Church Council of the Evangelical Lutheran Church of Finland
Family Federation of Finland
FIDA International
FILHA
Finn Church Aid
Finnish AIDS-Council
Finnish Body Positive Association
Finnish Christian Medical Society
Finnish Evangelical Lutheran Mission
Finnish Medical Association
Finnish Red Cross
Finnish UN Association
Helsinki Deaconess Institute
Hospital District of Helsinki and Uusimaa
International Solidarity Foundation
Kehys ry.
Kepa, Service Centre for Development Cooperation
Kotimaa
National Public Health Institute
National Research and Development Centre for Welfare and Health
Plan Suomi ry.
Pro-tukikeskus
Save the Children
Social Services Department of the City of Helsinki
Stadia
Student Union of the University of Helsinki
Superliitto, Finnish Union of Practical Nurses
Suomen hiv- ja aids-hoitajien yhdistys
Taksvärkki
Tehy, Union of Health and Social Care Professionals
Trade Union Solidarity Centre of Finland
UFF
Unicef
Unifem
Union of Multicultural Families ry.
Vaasan kehitysmaaseura
World Vision
YouAct
YMCA Finland

11.3. Other contributors

These actors have given their separate direct individual feedback to the draft document. Most comments to substance have been incorporated, but with some necessary editing. Some comments were too broad or too specific to incorporate, or were discarded due to being outside the scope of the report.

The Ministry of Justice
World Vision
Tehy, Union of Health and Social Care Professionals
Helsinki City Health Center
HUS Aurora Infection Clinic
SETA
Church Council of the Evangelical Lutheran Church of Finland[48]

In addition, the following actors were given the opportunity to comment on the report, but either had no comments or did not give a response to the request.

The Ministry of Education
The Ministry of the Interior
The Ministry of Labour
The Association of Finnish Local and Regional Authorities

[48] the Church Council provided as their input a Declaration outlining their view, role and effort in Global HIV/Aids work. The strong input and effort by the Lutheran Church is acknowledged, but publishing of the declaration is outside the scope of the report. The declaration is available upon request.

12. Annexes

12.1. ANNEX 1: Consultation/preparation process for the country report on monitoring the progress towards the implementation of the Declaration of Commitment on HIV/AIDS

The report writing process was initiated in the spring of 2007, by a letter of consultation sent by the Ministry for Foreign Affairs (MFA) to the National Public Health Institute – (KTL) through the Ministry of Social Affairs and Health. This letter was prompted by the request of the Director of UNAIDS, Dr. Peter Piot for UNGASS reporting 2008. Following this, a coordination meeting of the abovementioned main Governmental actors was commenced at the MFA on June 8, 2007. At this meeting, the main responsibilities of the actors were discussed and divided.

As vice-chair (KTL) and chair (MoSAH) of the NAC, KTL and the MoSAH were assigned the main work of collection and analysis of indicator data. In the process, they would consult all significant stakeholders both at the data collection, report drafting and prior to final submission stages. It was decided, that the HIV-unit of KTL will assume the main coordinating and drafting responsibility in the report writing process, supported as needed by the MoSAH.

In addition, KTL assumed responsibility for collation of the of the National Composite Policy Index (NCPI) questionnaires part A:

V. Strategic Plan
VI. Political Support,
VII. Prevention,
VIII. Treatment, care and support and V. Monitoring and evaluation).

The MFA assumed responsibility for delivery of the final report and collection and collation of Global Commitment and Action indicators.

An important role of Civil Society NGO actors in the reporting process was recognized at the June 8 coordination meeting. It was decided to involve civil society not only as respondents at the report data collection stage, but also through two specific consultation and coordination activities.

For the collation of the National Composite Policy Index (NCPI) questionnaires part B

V. Human rights,
VI. II. Civil society participation,
VII. III. Prevention,
VIII. IV and Treatment, care and support),

The Finnish HIV-network (a network of Finnish national and multilateral NGO-actors; see attached list in chapter 11.2.6 The Finnish HIV-network) was asked to act as the coordinator for responding to this part.

After completion of a first draft of the report, it was submitted to the NGO-actors and a hearing session of one half day was organized on November 19th. Feedback from the NGO/Civil society actors was incorporated into a new draft, which was sent for final review on December 5, 2007 to additional relevant NGO, civil society and governmental stakeholders.

Finally, the feedback of the review was incorporated into the report after which it was submitted to UNAIDS in January 2008.

12.2. ANNEX 2: National Composite Policy Index questionnaire

Appendix 7. National Composite Policy Index (NCPI) 2007

COUNTRY: FINLAND

Name of the National AIDS Committee Officer in charge: Dr Merja Saarinen, Director, Health Promotion, Ministry of Social Affairs and Health

Signed:

Postal address: Ministry of Social Affairs and Health.PO Box 33.
00023 Government, FINLAND

Tel: +358-9-160 74030

Fax: +3598-9-160 74126

E-mail: merja.saarinen@stm.fi

Date of submission: 30.1.2008

Instructions

Background

The following instrument measures one of the National Commitment and Action indicators, the National Composite Policy Index (NCPI), designed to assess progress in the development and implementation of national AIDS policies and strategies. **It is an integral part of the list of core UNGASS indicators and is to be completed and submitted as part of the 2007 UNGASS Country Progress Report.**

This third version of the NCPI has been updated to reflect new AIDS programmatic guidance and to be consistent with new and agreed to policy and implementation measurement tools.[13]

NCPI data were also submitted in previous UNGASS reporting rounds in 2003 and 2005. Countries are strongly advised to conduct a trend analysis on the key questions and include a description of the findings in the 2007 Country Progress Report.[14]

STRUCTURE OF THE QUESTIONNAIRE

The NCPI is divided into two parts:

Part A to be administered to government officials.

Part A covers five areas:

1. Strategic plan
2. Political support
3. Prevention
4. Treatment, care and support
5. Monitoring and evaluation

Part B to be administered to representatives from nongovernmental organizations, bilateral agencies, and UN organizations.

Part B covers four areas:

1. Human rights
2. Civil society involvement
3. Prevention
4. Treatment, care and support

The overall responsibility for collating and submitting the information requested in the NCPI lies with the National Governments, through officials from the National AIDS Committee (NAC) (or equivalent) with support from UNAIDS and other partners.

PROPOSED STEPS FOR DATA GATHERING

1. **Designation of two technical coordinators for the study (one for part A; one for part B)**

   Technical coordinators should be given responsibility to undertake the desk review and carry out interviews to answer specific questions. Preferably, the technical coordinator for Part A should be from the NAC (or equivalent) and for Part B should be a person outside the government. These persons should ideally be familiar with the issues and have a monitoring and evaluation background, and may request the assistance of consultants with a similar background.

[13] Policy and Planning Effort Index or children orphaned and made vulnerable by HIV/AIDS, UNICEF 2005; Scaling up Towards Universal Access, UNAIDS 2006; Setting National Targets for Moving Towards Universal Access, UNAIDS 2006; Practical Guidelines for Intensifying HIV Prevention; UNAIDS 2007

[14] see *Guidelines on construction of core indicators*, UNAIDS 2002 and UNAIDS 2005, respectively, for the key questions in previous NCPI questionnaires

2. Data gathering

Each section should be completed by (a) desk review and (b) interviewing key people most knowledgeable about that topic:

- *Strategic Plan and Political Support:* the Director or Deputy Director of the National AIDS Programme or National AIDS Council, the Heads of the AIDS Programme at provincial and at district levels and UNAIDS
- *Monitoring and Evaluation:* Officers of the National AIDS Committee or equivalent, Ministry of Health, HIV focal points of other ministries.
- *Human rights:* Ministry of Justice officials, human rights commissioners, and representatives of human rights and other relevant nongovernmental organizations and legal aid centres/institutions, persons living with HIV.
- *Civil society participation:* key representatives of major civil society organizations working in the area of HIV, persons living with HIV.
- *Prevention and Treatment, care and support:* Ministries and major implementing agencies/organizations in those areas, including nongovernmental organizations and persons living with HIV.

3. Data entry, analysis and interpretation

Once the NCPI is fully completed, the technical coordinators need to carefully review all responses to determine if additional consultations or review of more documents are needed. It is important to analyze the data for each of the NCPI sections and include a write-up in the Country Progress Report in terms of progress made in policy/strategy development and implementation of programmes to tackle the country's AIDS epidemic. Comments on the agreements/discrepancies between overlapping questions in Part A and Part B should also be included, as well as a trend analysis on the key NCPI data since 2003, where available. The NCPI findings need to be presented, discussed and agreed during the national UNGASS consultation workshop (see 4 below). It is strongly encouraged to enter the final agreed data in the Country Response Information System (CRIS). If this is not possible, an electronic version of the completed questionnaire should be submitted as an annex to the Country Progress Report.

4. Consultation workshop organized by the NAC (or equivalent)

It is strongly recommended that the NAC (or equivalent) organizes a one-day broad consultation forum to discuss and endorse the major findings of the UNGASS Country Progress Report, including the results from the NCPI. It is expected that civil society organizations, including faith-based organizations, people living with HIV, gender equality groups, women's rights groups, human rights/legal advocacy organizations, and other major nongovernmental organizations are invited to participate.

NCPI Respondents

[Indicate all respondents whose responses were compiled to fill out (parts of) the NCPI in the below table; add as many rows as needed]

NCPI – PART A [to be administered to government officials]

Organisation	Name/Position	Respondents to Part A [indicate which parts each respondent was queried on]				
		A.I	A.II	A.III	A.IV	A.V
KTL - HIV unit	M. Salminen, Head	☑	☑	☑	☑	☑
MoSAH	M. Saarinen, Dir.	☑	☑	☑	☑	☑
MoFA	H. Mikkola, Advisor	☑	☑	☐	☐	☐
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐

NCPI – PART B [to be administered to nongovernmental organizations, bilateral agencies, and UN organizations]

Organisation	Name/Position	Respondents to Part B [indicate which parts each respondent was queried on]			
		B.I	B.II	B.III	B.IV
NGO/CS HIV-network	B. Rantakari, Chair	☑	☑	☑	☑
Finnish AIDS Council	C. Björkenheim, Dir.	☑	☑	☑	☑
STAKES	M. Anttila, S. Specialist	☑	☑	☑	☑
		☐	☐	☐	☐
		☐	☐	☐	☐

Note: In the NCPI answers, N/A stands for "Not Applicable"

National Composite Policy Index questionnaire

Part A

[to be administered to government officials]

I. Strategic plan

1. Has the country developed a national multisectoral strategy/action framework to combat AIDS?

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

Yes ☑	Period covered: *[write in]* 2002-2006	Not Applicable (N/A)	No ☐

IF NO or N/A, briefly explain

***IF YES*, complete questions 1.1 through 1.10; otherwise, go to question 2.**

1.1 How long has the country had a multisectoral strategy/action framework?

Number of Years:

1.2 Which sectors are included in the multisectoral strategy/action framework with a specific HIV budget for their activities?

Sectors included	Strategy/Action framework		Earmarked budget	
Health	Yes ☑	No ☐	Yes ☐	No ☑
Education	Yes ☑	No ☐	Yes ☐	No ☑
Labour	Yes ☑	No ☐	Yes ☐	No ☑
Transportation	Yes ☐	No ☑	Yes ☐	No ☐
Military/Police	Yes ☑	No ☐	Yes ☐	No ☑
Women	Yes ☑	No ☐	Yes ☐	No ☑
Young people	Yes ☑	No ☐	Yes ☐	No ☑
Other*: *[write in]* Justice	Yes ☑	No ☐	Yes ☐	No ☑

* Any of the following: Agriculture, Finance, Human Resources, Justice, Minerals and Energy, Planning, Public Works, Tourism, Trade and Industry.

IF NO earmarked budget, how is the money allocated?

HIV/AIDS actions are integrated into the general budgets of all the sectors. For example, for the health and social welfare sector, both municipal, different district/regional level and national level funding budgeting guides activities.

Budgets are fixed through a combination of earmarking and discretionary use at all levels, but most funds are allocated using annual and long term planning and monitoring systems.

For example, the National Public Health Institute receives its funding through the govermental annual MoSAH sector budget, but has relatively large freedom of internal fund allocation for different public health purposes. Plans and budgets are set annually, and yearly objectives and targets are set through an annual plan set up with the MoSAH.

1.3 Does the multisectoral strategy/action framework address the following target populations, settings and cross-cutting issues?

Target populations	
a. Women and girls	a. Yes ☑ No ☐
b. Young women/young men	b. Yes ☑ No ☐
c. Specific vulnerable sub- populations[15]	c. Yes ☑ No ☐
d. Orphans and other vulnerable children	d. Yes ☑ No ☐
Settings	
e. Workplace	e. Yes ☑ No ☐
f. Schools	f. Yes ☑ No ☐
g. Prisons	g. Yes ☑ No ☐
Cross-cutting issues	
h. HIV, AIDS and poverty	h. Yes ☐ No ☑
i. Human rights protection	i. Yes ☑ No ☐
j. PLHIV involvement	j. Yes ☑ No ☐
k. Addressing stigma and discrimination	k. Yes ☑ No ☐
l. Gender empowerment and/or gender equality	l. Yes ☑ No ☐

1.4 Were target populations identified through a process of a needs assessment or needs analysis?

Yes ☑	No ☐

IF YES, when was this needs assessment /analysis conducted? Year: 2001, new assessment in progress

IF NO, how were target populations identified?

[15] Sub-populations that have been locally identified as being at higher risk of HIV transmission (injecting drug users, men having sex with men, sex workers and their clients, cross-border migrants, migrant workers, internally displaced people, refugees, prisoners, etc.).

1.5 What are the target populations in the country? *[write in]*

1.6 Does the multisectoral strategy/action framework include an operational plan?

Yes ☐	No ☑

1.7 Does the multisectoral strategy/action framework or operational plan include:

a.	Formal programme goals?	Yes ☑	No ☐
b.	Clear targets and/or milestones?	Yes ☐	No ☑
c.	Detailed budget of costs per programmatic area?	Yes ☐	No ☑
d.	Indications of funding sources?	Yes ☐	No ☑
e.	Monitoring and Evaluation framework?	Yes ☑	No ☐

1.8 Has the country ensured "full involvement and participation" of civil society[16] in the development of the multisectoral strategy/action framework?

Active involvement ☑	Moderate involvement ☐	No involvement ☐

IF active involvement, briefly explain how this was done:

Civil society/NGO actors were an active part of the MoSAH HIV expert group which acts as the NAC and drafted the previous HIV policy. In addition to taking part of the drafting process, the HIV policy document was sent out for review to various governmental and civil society/NGO actors before launching it in 2002.

A similar but even more involving process is currently in place to draft a new HIV strategy document.

IF NO or MODERATE involvement, briefly explain:

1.9 Has the multisectoral strategy/action framework been endorsed by most external Development Partners (bi-laterals; multi-laterals)?

NOT APPLICABLE. Finland is a Donor Country
MoFA development co-op strategy is endorsed

Yes ☑	No ☐

[16] Civil society includes among others: Networks of people living with HIV; women's organizations; young people's organizations; faith-based organizations; AIDS service organizations; Community-based organizations; organizations of key affected groups (including MSM, SW, IDU, migrants, refugees/displaced populations, prisoners); workers organizations, human rights organizations; etc. For the purpose of the NCPI, the private sector is considered separately.

1.10 Have external Development Partners (bi-laterals; multi-laterals) aligned and harmonized their HIV and AIDS programmes to the national multisectoral strategy/action framework?

Yes, all partners ☐	Yes, some partners ☐	No ☑

IF SOME or NO, briefly explain

NOT APPLICABLE, see previous point 1.9

2. Has the country integrated HIV and AIDS into its general development plans such as: a) National Development Plans, b) Common Country Assessments/ United Nations Development Assistance Framework, c) Poverty Reduction Strategy Papers, d) Sector Wide Approach?

Yes ☑ AS DONOR	No ☐	N/A ☐

2.1 ***IF YES***, in which development plans is policy support for HIV and AIDS integrated?

a) ☑ b) ☑ c) ☐ d) ☑ e) other ☐

2.2 ***IF YES***, which policy areas below are included in these development plans?

✓ Check for policy/strategy included

Policy Area	Development Plans				
	a)	b)	c)	d)	e)
HIV Prevention	☐	☑	☐	☑	☐
Treatment for opportunistic infections	☐	☐	☐	☐	☐
Antiretroviral therapy	☐	☑	☐	☑	☐
Care and support (including social security or other schemes)	☐	☑	☐	☐	☐
AIDS impact alleviation	☑	☑	☐	☑	☐
Reduction of **gender** inequalities as they relate to HIV prevention/treatment, care and/or support	☑	☑	☐	☑	☐
Reduction of **income** inequalities as they relate to HIV prevention/ treatment, care and /or support	☑	☑	☐	☑	☐
Reduction of stigma and discrimination	☑	☑	☐	☑	☐
Women's economic empowerment (e.g. access to credit, access to land, training)	☑	☑	☐	☑	☐
Other: *[write in]*	☐	☐	☐	☐	☐

3. Has the country evaluated the impact of HIV and AIDS on its socio-economic development for planning purposes?

Yes ☑	No ☐	N/A ☐

3.1 ***IF YES***, to what extent has it informed resource allocation decisions?

Low					High
0 ☐	1 ☐	2 ☐	3 ☐	4 ✓	5 ☐

4. Does the country have a strategy/action framework for addressing HIV and AIDS issues among its national uniformed services such as military, police, peacekeepers, prison staff, etc?

Yes ☑	No ☐

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

Behavioural change communication	Yes ☑	No ☑
Condom provision	Yes ☐	No ☑
HIV testing and counselling★	Yes ☑	No ☐
STI services	Yes ☑	No ☐
Treatment	Yes ☑	No ☐
Care and support	Yes ☑	No ☐
Others: *[write in]*	Yes ☐	No ☐

★***What is the approach taken to HIV testing and counselling?*** Is HIV testing voluntary or mandatory (e.g. at enrolment)? Briefly explain:

The functions in point 4.1 are performed as part of regular public- and workers health care, prison social- and health care.

HIV testing and counselling guidelines do not differ from the civil sector, and are also based on VCT. There is no mandatory testing in the military, police, peacekeepers or prison staff. There is an active policy of HIV risk communication and behavioural training for peacekeepers and HIV-testing promotion for returning staff.

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

Yes ☑	No ☐

5.1 Has the National Strategic Plan/operational plan and national AIDS budget been revised accordingly?

NOT APPLICABLE. Access is universal and budgeted through the regular social and health care budget

Yes ☐	No ☐

5.2 Have the estimates of the size of the main target population sub-groups been updated?

Yes ☑	No ☐

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

Estimates and projected needs ☐	Estimates only ☑	No ☐

5.4 Is HIV and AIDS programme coverage being monitored?

Yes ☑	No ☐

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

Yes ☑	No ☐

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

Yes ☑	No ☐

IF YES, which population sub-groups?

MSM - men having sex with men
IDU - Injecting drug users
Heterosexual
MTCT - mother to child transmission
Immigrants

(c) ***IF YES***, is coverage monitored by geographical area?

Yes ☑	No ☐

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

National, provincial and municipal. All monitoring activities are integrated into regular social- and health care monitoring schemes. National monitoring is less detailed than regional.

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

Each of these components exist as part of the public health care system, therefore no need for development only due to HIV/AIDS is necessary. Development is done through general development of the system

Yes ☐	No ☑

Overall, how would you rate *strategy planning efforts* in the HIV and AIDS programmes in 2007 and in 2005?											
2007	Poor										Good
	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ✓	9 ☐	10 ☐
2005	Poor										Good
	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ✓	9 ☐	10 ☐
Comments on progress made since 2005:											

II. Political support

Strong political support includes government and political leaders who speak out often about AIDS and regularly chair important meetings, allocation of national budgets to support the AIDS programmes and effective use of government and civil society organizations and processes to support effective AIDS programmes.

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

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

2. Does the country have an officially recognized national multisectoral AIDS management/coordination body? (National AIDS Council or equivalent)?

Yes ☑	No ☐

IF NO, briefly explain:

The Ministry of Social Affairs and Health (MoSAH) has set the HIV expert group which performs these functions.

2.1 ***IF YES***, when was it created? Year: 1989

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

[write in name and title/function]

Chair: Dr. Merja Saarinen, senior adviser, MoSAH
Vice-Chair: Dr. Mika Salminen, Head of HIV unit, National Public Health Institute - KTL

2.3 ***IF YES***, does it:

have terms of reference?	Yes ☑	No ☐
have active Government leadership and participation?	Yes ☑	No ☐
have a defined membership?	Yes ☑	No ☐
include civil society representatives?	Yes ☑	No ☐
IF YES, what percentage? *[write in]* 30 %		
include people living with HIV?	Yes ☑	No ☐
include the private sector?	Yes ☑	No ☐
have an action plan?	Yes ☐	No ☑
have a functional Secretariat?	Yes ☑	No ☐
meet at least quarterly?	Yes ☑	No ☐
review actions on policy decisions regularly?	Yes ☐	No ☑
actively promote policy decisions?	Yes ☑	No ☐
provide opportunity for civil society to influence decision-making?	Yes ☑	No ☐
strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	Yes ☐	No ☑

3. Does the country have a national AIDS body or other mechanism that promotes interaction between government, people living with HIV, civil society and the private sector for implementing HIV and AIDS strategies/ programmes?

Yes ☑	No ☐

3.1 ***IF YES***, does it include?

Terms of reference	Yes ☑	No ☐
Defined membership	Yes ☑	No ☐
Action plan	Yes ☑	No ☐
Functional Secretariat	Yes ☑	No ☐
Regular meetings	Yes ☑	No ☐
	Frequency of meetings:	

IF YES, What are the main achievements?

This entire function is integrated into the National Aids Council equaivalent, the MoSAH HIV expert group.

IF YES, What are the main challenges for the work of this body?

The body has no set powers or budget of its own, but can only make recommendations or work out guididance documents.

However, the body has substantial indirect power through its members and can (and has done so in the past) strongly influence both policy making and even budgetary measures through both governmental and civil society actors.

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

Percentage: NOT KNOWN

5. What kind of support does the NAC (or equivalent) provide to implementing partners of the national programme, particularly to civil society organizations?

Information on priority needs and services	Yes ☑	No ☐
Technical guidance/materials	Yes ☐	No ☑
Drugs/supplies procurement and distribution	Yes ☐	No ☑
Coordination with other implementing partners	Yes ☑	No ☐
Capacity-building	Yes ☐	No ☑
Other: *[write in]*		

6. Has the country reviewed national policies and legislation to determine which, if any, are inconsistent with the National AIDS Control policies?

Yes ☑	No ☐

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

Yes ☑	No ☐

6.2 ***IF YES***, which policies and legislation were amended and when?

Policy/Law: Needle exchange policy, Law on Infectious diseases	Year: 2004

Policy/Law:	Year:

[List as many as relevant]

Overall, how would you rate *strategy planning efforts* in the HIV and AIDS programmes in 2007 and in 2005?											
2007	Poor										Good
	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☑	9 ☐	10 ☐
2005	Poor										Good
	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☑	9 ☐	10 ☐
Comments on progress made since 2005:											

III. Prevention

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

Yes ☐	No ☑	N/A ☐

1.1 ***IF YES***, what key messages are explicitly promoted?

✓ Check for key message explicitly promoted

Be sexually abstinent	☐
Delay sexual debut	☐
Be faithful	☐
Reduce the number of sexual partners	☐
Use condoms consistently	☐
Engage in safe(r) sex	☐
Avoid commercial sex	☐
Abstain from injecting drugs	☐
Use clean needles and syringes	☐
Fight against violence against women	☐
Greater acceptance and involvement of people living with HIV	☐
Greater involvement of men in reproductive health programmes	☐
Other: *[write in]*	☐

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

Yes ☐	No ☑

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

Yes ☑	No ☐

2.1 Is HIV education part of the curriculum in

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

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

Yes ☑	No ☐

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

Yes ☐	No ☑

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

Yes ☑	No ☐

IF NO, briefly explain:

Included in HIV and STD strategies as well as Drug Policy Action programmes

3.1 ***IF YES***, which sub-populations and what elements of HIV prevention do the policy/strategy address?

✓ Check for policy/strategy included

	IDU	MSM	Sex workers	Clients of sex workers	Prison inmates	Other sub-populations* YOUTH
Targeted information on risk reduction and HIV education	☑	☑	☑	☐	☑	☑
Stigma & discrimination reduction	☐	☐	☑	☐	☐	☐
Condom promotion	☑	☑	☑	☐	☑	☑
HIV testing & counselling	☑	☑	☑	☐	☑	☑
Reproductive health, including STI prevention & treatment	☑	☑	☑	☐	☑	☑
Vulnerability reduction (e.g. income generation)	N/A	N/A	☑	N/A	N/A	☐
Drug substitution therapy	☑	N/A	N/A	N/A	N/A	☐
Needle & syringe exchange	☑	N/A	N/A	N/A	N/A	☐

Overall, how would you rate *policy efforts* in support of HIV prevention in 2007 and in 2005?

2007	Poor										Good
	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ✓	9 ☐	10 ☐
2005	Poor										Good
	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ✓	9 ☐	10 ☐

Comments on progress made since 2005:

4. Has the country identified the districts (or equivalent geographical/ decentralized level) in need of HIV prevention programmes?

Yes ☑	No ☐

IF NO, how are HIV prevention programmes being scaled-up?:

IF YES, to what extent have the following HIV prevention programmes been implemented in identified districts* in need?

✓ Check the relevant implementation level for each activity or indicate N/A if not applicable

HIV prevention programmes	The activity is available in		
	all districts* in need	*most* districts* in need	*some* districts* in need
Blood safety	☑	☐	☐
Universal precautions in health care settings	☑	☐	☐
Prevention of mother-to-child transmission of HIV	☑	☐	☐
IEC on risk reduction	☐	☐	☑
IEC on stigma and discrimination reduction	☐	☐	☑
Condom promotion	☐	☐	☑
HIV testing & counselling	☑	☐	☐
Harm reduction for injecting drug users	☐	☑	☐
Risk reduction for men who have sex with men	☐	☐	☑
Risk reduction for sex workers	☐	☐	☑
Programmes for other vulnerable sub-populations	☐	☐	☑
Reproductive health services including STI prevention & treatment	☑	☐	☐
School-based AIDS education for young people	☑	☐	☐
Programmes for out-of-school young people	☐	☐	☑
HIV prevention in the workplace	☐	☐	☑
Other *[write in]*	☐	☐	☐

* *Districts or equivalent geographical/de-centralized level in urban and rural areas*

Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2007 and in 2005?											
2007	Poor										Good
	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☑	8 ☐	9 ☐	10 ☐
2005	Poor										Good
	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☑	8 ☐	9 ☐	10 ☐
Comments on progress made since 2005:											

IV. Treatment, care and support

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

Yes ☑	No ☐

1.1 ***IF YES***, does it give sufficient attention to barriers for women, children and most-at-risk populations?

Yes ☑	No ☐

2. Has the country identified the districts (or equivalent geographical/ decentralized level) in need of HIV and AIDS treatment, care and support services?

Yes ☑	No ☐	N/A ☐

IF NO, how are HIV and AIDS treatment, care and support services being scaled-up?

IF YES, to what extent have the following HIV and AIDS treatment, care and support services been implemented in the identified districts* in need?

✓ Check the relevant implementation level for each activity or indicate N/A if not applicable

HIV treatment, care and support services	The service is available in		
	all districts* in need	*most* districts* in need	*some* districts* in need
Antiretroviral therapy	☑	☐	☐
Nutritional care	☑	☐	☐
Paediatric AIDS treatment	☑	☐	☐
Sexually transmitted infection management	☑	☐	☐
Psychosocial support for people living with HIV and their families	☐	☐	☑
Home-based care	☑	☐	☐
Palliative care and treatment of common HIV-related infections	☑	☐	☐
HIV testing and counselling for TB patients	☑	☐	☐
TB screening for HIV-infected people	☑	☐	☐
TB preventive therapy for HIV-infected people	☑	☐	☐
TB infection control in HIV treatment and care facilities	☑	☐	☐
Cotrimoxazole prophylaxis in HIV-infected people	☑	☐	☐
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	☑	☐	☐
HIV treatment services in the workplace or treatment referral systems through the workplace	☑	☐	☐
HIV care and support in the workplace (including alternative working arrangements)	☑	☐	☐
Other programmes: *[write in]*	☐	☐	☐

**Districts or equivalent de-centralized governmental level in urban and rural areas*

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

Yes ☐	No ☑

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

Yes ☑	No ☐

4.1 ***IF YES***, for which commodities?: *[write in]*

All above.

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

Yes ☐	No ☐	N/A ☑

5.1 ***IF YES***, is there an operational definition for OVC in the country?

Yes ☐	No ☐

5.2 ***IF YES***, does the country have a national action plan specifically for OVC?

Yes ☐	No ☐

5.3 ***IF YES***, does the country have an estimate of OVC being reached by existing interventions?

Yes ☐	No ☐

IF YES, what percentage of OVC is being reached? % *[write in]*

Overall, how would you rate the efforts to meet the needs of orphans and other vulnerable children?											
2007	Poor										Good
	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ✓
2005	Poor										Good
	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ✓
Comments on progress made since 2005:											

IV. Monitoring and evaluation

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

Yes ☑	Years covered: *[write in]*	In progress ☐	No ☐

1.1. ***IF YES***, was the M&E plan endorsed by key partners in M&E?

Yes ☐	No ☑

1.2. ***IF YES***, was the M&E plan developed in consultation with civil society, including people living with HIV?

Yes ☐	No ☑

1.3. ***IF YES***, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?

Yes, all partners ☐	Yes, most partners ☐	Yes, but only some partners ☑	No ☐

2. Does the Monitoring and Evaluation plan include?

a data collection and analysis strategy	Yes ☑	No ☐
behavioural surveillance	Yes ☑	No ☐
HIV surveillance	Yes ☑	No ☐
a well-defined standardized set of indicators	Yes ☑	No ☐
guidelines on tools for data collection	Yes ☐	No ☑
a strategy for assessing quality and accuracy of data	Yes ☐	No ☑
a data dissemination and use strategy	Yes ☐	No ☑

3. Is there a budget for the M&E plan?

Yes ☐	Years covered: *[write in]*	In progress ☐	No ☑

3.1 ***IF YES***, has funding been secured?

Yes ☑	No ☐

4. Is there a functional M&E Unit or Department?

Yes ☑	In progress ☐	No ☐

IF NO, what are the main obstacles to establishing a functional M&E Unit/Department?

4.1 ***IF YES***, is the M&E Unit/Department based

in the NAC (or equivalent)?	Yes ☐	No ☐
in the Ministry of Health?	Yes ☐	No ☐
elsewhere? *[write in]* Monitoring and evaluation is performed in a multi sectorial fashion, where each responsible authority performs M&E activities as part of their annual business cycle. In addition, there are National level M&E activities for HIV/AIDS within the MoSAH, the National Public Health Institute and STAKES		

4.2 ***IF YES***, how many and what type of permanent and temporary professional staff are working in the M&E Unit/Department?

Number of permanent staff:		
Position: *[write in]* Not possible to separately estimate	Full time / Part time? N/A	Since when?: N/A
Position: *[write in]*	Full time / Part time?	Since when?:
Position: *[write in]*	Full time / Part time?	Since when?:
Position: *[write in]*	Full time / Part time?	Since when?:

Etc.

Number of temporary staff:	

4.3 ***IF YES***, are there mechanisms in place to ensure that all major implementing partners submit their M&E data/reports to the M&E Unit/Department for review and consideration in the country's national reports?

Yes ☑	No ☐

IF YES, does this mechanism work? What are the major challenges?

The mechanisms works relatively well. The major challenge is to identify the correct actors within the different sectors. This significantly slows down data collection.

4.4 ***IF YES***, to what degree do UN, bi-laterals, and other institutions share their M&E results?

Low					High
0 ☐	1 ☐	2 ☐	3 ☐	4 ✓	5 ☐

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

No ☑	Yes, but meets irregularly ☐	Yes, meets regularly ☐

IF YES, Date last meeting: *[write in]*

5.1 Does it include representation from civil society, including people living with HIV?

Yes ☐	No ☐

IF YES, describe the role of civil society representatives and people living with HIV in the working group?

6. Does the M&E Unit/Department manage a central national database?

Yes ☐	No ☑	N/A ☐

6.1 ***IF YES***, what type is it? *[write in]*

6.2 ***IF YES***, does it include information about the content, target populations and geographical coverage of programmatic activities, as well as their implementing organizations?

Yes ☐	No ☐

6.3 Is there a functional* Health Information System?

National level	Yes ☑	No ☐
Sub-national level ***IF YES***, at what level(s)? *[write in]* Provincial and health district, municipal	Yes ☑	No ☐

*(*regularly reporting data from health facilities which are aggregated at district level and sent to national level; and data are analysed and used at different levels)*

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

Yes ☑	No ☐

7. To what extent is M&E data used in planning and implementation?

Low					High
0 ☐	1 ☐	2 ☐	3 ☐	4 ☑	5 ☐

What are examples of data use?

One of the main indicators used are outcome indicators, i. e. incidence and prevalence data on HIV-infection and AIDS. These are actively followed and analyzed for use in policy guidance.

As an example, when the incidence of HIV among IDU suddenly rose in 1998, a very strong effort for policy change was put in place, introducing strong prevention methods including injection equipment exchange and eventually leading to radical legislative change.

Another example comes from behavioural surveillance: when school surveys showed very variable access to comprehensive sexuality and reproductive health education during a 10-year period (due to a relaxing of educational guidelines), curricula standards were changed to ensure similar content and access in all schools.

What are the main challenges to data use?

Data is scattered into many databases

8. In the last year, was training in M&E conducted

At national level?	Yes ☐	No ☑
IF YES, Number of individuals trained: *[write in]*		
At sub-national level?	Yes ☐	No ☑
IF YES, Number of individuals trained: *[write in]*		
Including civil society?	Yes ☐	No ☑
IF YES, Number of individuals trained: *[write in]*		

Overall, how would you rate the *M&E efforts* of the AIDS programme in 2007 and in 2005?

2007	Poor											Good
	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☑	7 ☐	8 ☐	9 ☐	10 ☐	
2005	Poor											Good
	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☑	7 ☐	8 ☐	9 ☐	10 ☐	

Comments on progress made since 2005:

Part B

[to be administered to representatives from nongovernmental organizations, bilateral agencies, and UN organizations]

I. Human rights

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

Yes	No
☑	☐

1.1 ***IF YES***, specify: *[write in]* Finland has general non-discrimination provisions, however, there are no provisions specifically mentioning HIV

2. Does the country have non-discrimination laws or regulations which specify protections for vulnerable sub-populations?

Yes	No
☑	☐

2.1 ***IF YES***, for which sub-populations?

Women	Yes ☑	No ☐
Young people	Yes ☐	No ☐
IDU	Yes ☑	No ☐
MSM	Yes ☑	No ☐
Sex Workers	Yes ☐	No ☐
Prison inmates	Yes ☑	No ☐
Migrants/mobile populations	Yes ☑	No ☐
Other: *[write in]* Yes. Transsexuals. The laws protect against discrimination on the basis of gender, heatlh status, social and economic status, sexual orientation, ethnicity and any other comparable property (Non-discrimination Act - Yhdenvertaisuuslaki and Constitution, Basic Rights and Liberties, Act on Gender Confirmation of a Transsexual). However, while Basic Rights and Liberties in the Constitution define rather comprehensively the equality, the separate act, in turn, limits certain rights just to specific subgroups such as ethnic minorities excluding e.g. sexual minorities.		

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

Authorities such as Ombudsman, Ombudsman for Minorities and Ombudsman of Gender Equality ensure the implementation of laws. The Ombudsman of Gender Equality monitors the implementation of the equality between women and men and the Ombudsman of Minorities advances the status and legal protection of ethnic minorities and foreigners in Finland. The other vulnerable groups do not have an ombudsman for their cause. These authorities amy give recommendations and advice, which are not legally binding.

IF YES, Describe any systems of redress put in place to ensure the laws are having their desired effect:

No anwear

3. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for vulnerable sub-populations?

Yes	No
☑	☐

3.1 ***IF YES***, for which sub-populations?

Women	Yes ☐	No ☑
Young people	Yes ☐	No ☑
IDU	Yes ☐	No ☑
MSM	Yes ☐	No ☑
Sex Workers	Yes ☐	No ☑
Prison inmates	Yes ☐	No ☑
Migrants/mobile populations	Yes ☑	No ☐
Other: *[write in]*		

IF YES, briefly describe the content of these laws, regulations or policies and how they pose barriers:

Answer given by the MoSAH/KTL: Migrants have in certain situations limited access to treatment. Complete access to the public health care system without private insurance coverage is dependent on legal long term residence status or subject to bilateral and/or multilateral agreements between Finland and the migrants home country. However, emergency medical care is available for all, including illegal immigrants.

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

Yes ☑	No ☑

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

Yes ☑	No ☑

IF YES, briefly describe this mechanism

Point 4. Original answer by the the Civil Society/NGO sector: NO

Point 5. Original answer by the the Civil Society/NGO sector: NO
Cases are being recorded if made officially with an authority (report of an offence), however, unofficial e.g. NGO database of cases of criminalization does not exist.

Point 4. Additional comments by the MoSAH and KTL. Human rights are indeed NOT mentioned specifically in the MoSAH 2002-2006 HIV policy document. However, key objective 14. of the HIV-policy document states "Legislation will deb developed in response to the changing situation to ensure the RIGHTS and access to effective HIV prevention and treatment PLWHA." (free unofficial translation).

Human rights ARE explicitly mentioned In the 2004 MoFA international development assistance HIV/AIDS strategy. They are mentioned as a separate point of priority area 10. of the strategy.

Point 5. Additional comments by the MoSAH and KTL. Cases alleged discrimination can be addressed in several ways. In the case of alleged discrimination or misconduct within the health care system, a complaint can be issued with the regional (provincial) authorities and will be duly processed. A Patient Ombudsman is available at health care units throughout the country for assistance in filing such complaints. If misconduct or discrimination is found to have taken place, punitive measures are available. On a national level, complaints can be filed with the Ombudsman for Justice or can also in the case of the health care misconduct be dealt with by the National Authority for Medicolegal Affairs (Terveydenhuollon oikeusturvakeskus). Finally, cases of discrimination or misconduct can be filed and tried in civil courts. Proceedings are generally public, but can be decided by the court to be non-public. Charges have led to punishments. Each of these mechanisms have been used in the past and the outcomes and proceedings are filed within the official government or judicial systems.

6. Has the Government, through political and financial support, involved most-at-risk populations in governmental HIV-policy design and programme implementation?

Yes ☑	No ☐

IF YES, describe some examples

All following groups (independently or through interest groups) were represented in the process: PLWHAs, sex workers, women and migrants. In addition, the HIV expert team of the MoSAH includes representatives of civil society.

The challenge at the policy level is that the existent HIV-policy is only a proposal, the government has not ratified it. HIV strategy has not bee turned into a programme (action plan).

State funds projects implemented by NGOs, Finland's slot machine association funds the basic operating conditions of NGOs as well as provides project support

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

HIV prevention services	Yes ☑	No ☐
Anti-retroviral treatment	Yes ☑	No ☐
HIV-related care and support interventions	Yes ☑	No ☐

IF YES, given resource constraints, briefly describe what steps are in place to implement these policies:

Law of Public Health (Kansanterveyslaki § 13), Patients' Bill of Rights legislation (Laki potilaan oikeuksista ja asemasta) and Communicable Disease Act (Tartuntatautilaki)

8. Does the country have a policy to ensure equal access for women and men, to prevention, treatment, care and support? In particular, to ensure access for women outside the context of pregnancy and childbirth?

Yes ☑	No ☐

9. Does the country have a policy to ensure equal access for most-at-risk populations to prevention, treatment, care and support?

Yes ☑	No ☐

9.1 Are there differences in approaches for different most-at-risk populations?

Yes ☐	No ☑

IF YES, briefly explain the differences:

Act on Gender Equality (Tasa-arvolaki), Non-Discrimination Act (Yhdenvertaisuuslaki) ensure that all are treated equally, however, in practice the approaches vary depending on the special needs of each population.

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

Yes ☑	No ☑

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

Yes ☑	No ☐

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

Yes ☑	No ☑

IF YES, describe the effectiveness of this review committee

Point 10. Original answer by Civil society is NO.

11.Including the medical research. Finland has not run through any other kind of research

NGOs receive research requests for data gathering (statistics and PLWHAs for interviews etc.). NGOs decide independently whether they cooperate or provide information.

Point 10. Original answer by Civil society is NO.

Point 10.
Additional comments by MoSAH and KTL: there is no law explicitly forbidding testing of HIV, but general laws of patient rights and codes of conduct (including the Helsinki declaration on medical ethics) restrict all medical testing to tests that are aimed to BENEFIT the individual tested. This is also explicitly stated in the Law on Workers Health. In addition, all clinical microbiological tests are only allowed to be performed by licensed actors. These statutes therefore

point 11.1
Additional comments by MoSAH and KTL: the Law on Medical Research (Laki lääketieteellisestä tutkimuksesta) specifies that for all medical research involving human subjects, the protocols must be reviewed and approved by an ethical committee prior to implementation. Ethical committees always have layman members, however, there is not a provision for disease specific participation (such as by PLWHA).

12. Does the country have the following human rights monitoring and enforcement mechanisms?

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

Yes ☑	No ☐

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

Yes ☐	No ☑

– Performance indicators or benchmarks for

a) compliance with human rights standards in the context of HIV efforts

Yes ☐	No ☑

b) reduction of HIV-related stigma and discrimination

Yes ☐	No ☑

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

Answer given by the MoSAH and KTL: the Ombudsman of Justice can and has in the past given judgements in these issues.

13. Have members of the judiciary (including labour courts/ employment tribunals) been trained/sensitized to HIV and AIDS and human rights issues that may come up in the context of their work?

Yes ☐	No ☑

14. Are the following legal support services available in the country?

– Legal aid systems for HIV and AIDS casework

Yes ☑	No ☑

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

Pubic defenders office (yleinen oikeusasiatoimisto) provides services for people with scarce funds

Yes ☑	No ☐

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

Yes ☑	No ☑

15. Are there programmes designed to change societal attitudes of stigmatization associated with HIV and AIDS to understanding and acceptance?

Yes ☑	No ☐

IF YES, what types of programmes?

Media	Yes ☑	No ☐
School education	Yes ☑	No ☐
Personalities regularly speaking out	Yes ☑	No ☐

Other: *[write in]*

In practice, just NGOs have such programmes.

Comment by MoSAH and KTL. NGOs are largely supported by governmental grants

Overall, how would you rate the *policies, laws and regulations* in place to promote and protect human rights in relation to HIV and AIDS in 2007 and in 2005?

2007	Poor											Good
	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ✓	9 ☐	10 ☐	
2005	Poor											Good
	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ✓	9 ☐	10 ☐	

Comments on progress made since 2005:

On the policy level there have not been changes. The amount of laws and regulations prohibiting the discrimination is vast but not specific, e. g. PLWHAs are not specifically mentioned.

Overall, how would you rate the *effort to enforce* the existing policies, laws and regulations in 2007 and in 2005?

2007	Poor											Good
	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐	
2005	Poor											Good
	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐	

Comments on progress made since 2005:

The efforts have been few. As said above government has not ratified the HIV-strategy nor is there a HIV programme to be implemented.

Comment by the MoSAH and KTL: It is correct that there is no specific programme. The HIV policy is an expert guidance document which should help in establishing good practices and guide efforts in all relevant sectors. For enforcement there are mechanisms in place, such as the various Ombudsmen and the general judiciary system. In addition, there is the National Authority for Medicolegal Affairs which has jurisdiction in the area.

II. Civil society[17] participation

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

Low					High
0	1	2	3 ✓	4	5

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

Low					High
0	1	2	3 ✓	4	5

3. To what extent are the services provided by civil society in areas of HIV prevention, treatment, care and support included

   a. in both the National Strategic plans and national reports?

Low					High
0	1	2	3	4 ✓	5

   b. in the national budget?

Low					High
0 ✓	1	2	3	4	5

4. Has the country included civil society in a National Review of the National Strategic Plan?

Yes ☑	No ☐

IF YES, when was the Review conducted? Year: *[write in]* This process is ongoing (2007)

5. To what extent is the civil society sector representation in HIV-related efforts inclusive of its diversity?

Low					High
0	1	2	3	4	5 ✓

List the types of organizations representing civil society in HIV and AIDS efforts:

Networks of people living with HIV
Women's organizations
Faith-based organizations
AIDS service organizations
Organizations of vulnerable subpopulations (including MSM, SW, IDU, migrants, refugees/displaced populations, prisoners)
Human rights organizations

[17] Civil society includes among others: Networks of people living with HIV; women's organizations; young people's organizations; faith-based organizations; AIDS service organizations; Community-based organizations; organizations of vulnerable sub-populations (including MSM, SW, IDU, migrants, refugees/displaced populations, prisoners); workers organizations, human rights organizations; etc. For the purpose of the NCPI, the private sector is considered separately.

6. To what extent is civil society able to access

a. adequate financial support to implement its HIV activities?

Low					High
0 ☐	1 ☐	2 ☐	3 ☐	4 ☑	5 ☐

b. adequate technical support to implement its HIV activities?

Low					High
0 ☑	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

Overall, how would you rate the efforts to increase *civil society participation* in 2007 and in 2005?											
2007	Poor										Good
	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☑	9 ☐	10 ☐
2005	Poor										Good
	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☑	7 ☐	8 ☐	9 ☐	10 ☐
Comments on progress made since 2005:											

III. Prevention

1. Has the country identified the districts (or equivalent geographical/ decentralized level) in need of HIV prevention programmes?

Yes ☑	No ☐

IF NO, how are HIV prevention programmes being scaled-up?:

Original answer by Civil society/NGO:
For IDU but only on NGO level. However, in the urban setting districts change rapidly and launched information is already outdated.

Comment by MoSAH and KTL:
HIV Prevention programmes are available and have a wide geographic coverage for most areas.

IF YES, to what extent have the following HIV prevention programmes been implemented in identified districts in need?

✓ Check the relevant implementation level for each activity or indicate N/A if not applicable

HIV prevention programmes	The service is available in		
	all districts* in need	*most* districts* in need	*some* districts* in need
Blood safety	☑	☐	☐
Universal precautions in health care settings	☑	☐	☐
Prevention of mother-to-child transmission of HIV	☑	☐	☐
IEC on risk reduction	☐	☐	☑
IEC on stigma and discrimination reduction	☐	☐	☑
Condom promotion	☐	☐	☑
HIV testing & counselling	☑	☐	☐
Harm reduction for injecting drug users	☐	☑	☐
Risk reduction for men who have sex with men	☐	☐	☑
Risk reduction for sex workers	☐	☐	☑
Programmes for other most-at-risk populations	☐	☐	☑
Reproductive health services including STI prevention & treatment	☑	☐	☐
School-based AIDS education for young people	☑	☐	☐
Programmes for out-of-school young people	☐	☐	☑
HIV prevention in the workplace	☐	☐	☑
Other programmes: *[write in]* The answers to this table were given by the MoSAH and KTL	☐	☐	☐

**Districts or equivalent geographical/de-centralized levels in urban and rural areas*

Overall, how would you rate the efforts in the *implementation* of HIV prevention programmes in 2007 and in 2005?											
2007	Poor										Good
	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ✓	8 ☐	9 ☐	10 ☐
2005	Poor										Good
	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ✓	8 ☐	9 ☐	10 ☐
Comments on progress made since 2005:											

IV. Treatment, care and support

1. Has the country identified the districts (or equivalent geographical/ decentralized level) in need of HIV and AIDS treatment, care and support services?

Yes ☐	No ☑

IF NO, how are HIV and AIDS treatment, care and support services being scaled-up?:

Comment by MoSAH and KTL: Access to treatment, care and support is based on the public social welfare/support and health care system and available throughout the country.

IF YES, to what extent have the following HIV and AIDS treatment, care and support services been implemented in the identified districts★ in need?

✓ Check the relevant implementation level for each activity or indicate N/A if not applicable

HIV and AIDS treatment, care and support services	The service is available in		
	all districts* in need	*most* districts* in need	*some* districts* in need
Antiretroviral therapy	☑	☐	☐
Nutritional care	☑	☐	☐
Paediatric AIDS treatment	☑	☐	☐
Sexually transmitted infection management	☑	☐	☐
Psychosocial support for people living with HIV and their families	☑	☐	☐
Home-based care	☑	☐	☐
Palliative care and treatment of common HIV-related infections	☑	☐	☐
HIV testing and counselling for TB patients	☑	☐	☐
TB screening for HIV-infected people	☑	☐	☐
TB preventive therapy for HIV-infected people	☑	☐	☐
TB infection control in HIV treatment and care facilities	☑	☐	☐
Cotrimoxazole prophylaxis in HIV-infected people	☑	☐	☐

★*Districts or equivalent geographical de-centralized governmental levels in urban and rural areas*

HIV and AIDS treatment, care and support services	The service is available in		
	all districts* in need	*most* districts* in need	*some* districts* in need
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	☑	☐	☐
HIV treatment services in the workplace or treatment referral systems through the workplace	☑	☐	☐
HIV care and support in the workplace (including alternative working arrangements)	☐	☐	☑
Other programmes: *[write in]* The answers to this table were given by the MoSAH and KTL	☐	☐	☐

**Districts or equivalent geographical de-centralized governmental levels in urban and rural areas*

Overall, how would you rate the efforts in the *implementation* of HIV treatment, care and support programmes in 2007 and in 2005?

2007 Poor Good

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☑ 9 ☑ 10 ☐

2005 Poor Good

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☑ 8 ☐ 9 ☑ 10 ☐

Comments on progress made since 2005:

The answers above are divided as follows:

Treatment: 2005: 9, 2007: 9
Care and support: 2005: 8, 2007: 7

Treatment has always been good. Care and support has weakened as there are more PLWHAs and the amount of nursing staff has not increased.

2. What percentage of the following HIV programmes or services is estimated to be provided by civil society?

Prevention for youth	☐ <25%	☑ 25-50%	☐ 50-75%	☐ >75%
Prevention for vulnerable sub-populations				
- IDU	☐ <25%	☐ 25-50%	☐ 50-75%	☑ >75%
- MSM	☐ <25%	☐ 25-50%	☐ 50-75%	☑ >75%
- Sex workers	☐ <25%	☐ 25-50%	☐ 50-75%	☑ >75%
Counselling and Testing	☐ <25%	☐ 25-50%	☐ 50-75%	☐ >75%
Clinical services (OI/ART)*	☑ <25%	☐ 25-50%	☐ 50-75%	☐ >75%
Home-based care	☑ <25%	☐ 25-50%	☐ 50-75%	☐ >75%
Programmes for OVC**	☑ <25%	☐ 25-50%	☐ 50-75%	☐ >75%

**OI Opportunistic infections;*

***OVC Orphans and other vulnerable children*

3. Does the country have a policy or strategy to address the additional HIV- and AIDS-related needs of orphans and other vulnerable children (OVC)?

Yes ☐	No ☐	N/A ☑

5.1 ***IF YES***, is there an operational definition for OVC in the country?

Yes ☐	No ☐

5.2 ***IF YES***, does the country have a national action plan specifically for OVC?

Yes ☐	No ☐

5.3 ***IF YES***, does the country have an estimate of OVC being reached by existing interventions?

Yes ☐	No ☐

IF YES, what percentage of OVC is being reached? % *[write in]*

General Assembly

Distr.: General
2 August 2001

Twenty-sixth special session
Agenda item 8

Resolution adopted by the General Assembly

[*without reference to a Main Committee (A/S-26/L.2)*]

S-26/2. Declaration of Commitment on HIV/AIDS

The General Assembly

Adopts the Declaration of Commitment on the human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) annexed to the present resolution.

8th plenary meeting
27 June 2001

Annex

Declaration of Commitment on HIV/AIDS

"Global Crisis – Global Action"

1. We, heads of State and Government and representatives of States and Governments, assembled at the United Nations, from 25 to 27 June 2001, for the twenty-sixth special session of the General Assembly, convened in accordance with resolution 55/13 of 3 November 2000, as a matter of urgency, to review and address the problem of HIV/AIDS in all its aspects, as well as to secure a global commitment to enhancing coordination and intensification of national, regional and international efforts to combat it in a comprehensive manner;

2. Deeply concerned that the global HIV/AIDS epidemic, through its devastating scale and impact, constitutes a global emergency and one of the most formidable challenges to human life and dignity, as well as to the effective enjoyment of human rights, which undermines social and economic development throughout the world and affects all levels of society – national, community, family and individual;

3. Noting with profound concern that by the end of 2000, 36.1 million people worldwide were living with HIV/AIDS, 90 per cent in developing countries and 75 per cent in sub-Saharan Africa;

4. Noting with grave concern that all people, rich and poor, without distinction as to age, gender or race, are affected by the HIV/AIDS epidemic, further noting that

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people in developing countries are the most affected and that women, young adults and children, in particular girls, are the most vulnerable;

5. Concerned also that the continuing spread of HIV/AIDS will constitute a serious obstacle to the realization of the global development goals we adopted at the Millennium Summit of the United Nations;

6. Recalling and reaffirming our previous commitments on HIV/AIDS made through:

- The United Nations Millennium Declaration, of 8 September 2000;[1]
- The political declaration and further actions and initiatives to implement the commitments made at the World Summit for Social Development, of 1 July 2000;[2]
- The political declaration[3] and further action and initiatives to implement the Beijing Declaration and Platform for Action,[4] of 10 June 2000;
- Key actions for the further implementation of the Programme of Action of the International Conference on Population and Development, of 2 July 1999;[5]
- The regional call for action to fight HIV/AIDS in Asia and the Pacific, of 25 April 2001;
- The Abuja Declaration and Framework for Action for the fight against HIV/AIDS, tuberculosis and other related infectious diseases in Africa, of 27 April 2001;
- The Declaration of the Tenth Ibero-American Summit of heads of State, of 18 November 2000;
- The Pan-Caribbean Partnership against HIV/AIDS, of 14 February 2001;
- The European Union Programme for Action: Accelerated action on HIV/AIDS, malaria and tuberculosis in the context of poverty reduction, of 14 May 2001;
- The Baltic Sea Declaration on HIV/AIDS Prevention, of 4 May 2000;
- The Central Asian Declaration on HIV/AIDS, of 18 May 2001;

7. Convinced of the need to have an urgent, coordinated and sustained response to the HIV/AIDS epidemic, which will build on the experience and lessons learned over the past 20 years;

8. Noting with grave concern that Africa, in particular sub-Saharan Africa, is currently the worst-affected region, where HIV/AIDS is considered a state of emergency which threatens development, social cohesion, political stability, food security and life expectancy and imposes a devastating economic burden, and that the dramatic situation on the continent needs urgent and exceptional national, regional and international action;

9. Welcoming the commitments of African heads of State or Government at the Abuja special summit in April 2001, particularly their pledge to set a target of

[1] See resolution 55/2.
[2] Resolution S-24/2, annex, sects. I and III.
[3] Resolution S-23/2, annex.
[4] Resolution S-23/3, annex.
[5] Resolution S-21/2, annex.

allocating at least 15 per cent of their annual national budgets for the improvement of the health sector to help to address the HIV/AIDS epidemic; and recognizing that action to reach this target, by those countries whose resources are limited, will need to be complemented by increased international assistance;

10. Recognizing also that other regions are seriously affected and confront similar threats, particularly the Caribbean region, with the second-highest rate of HIV infection after sub-Saharan Africa, the Asia-Pacific region where 7.5 million people are already living with HIV/AIDS, the Latin American region with 1.5 million people living with HIV/AIDS and the Central and Eastern European region with very rapidly rising infection rates, and that the potential exists for a rapid escalation of the epidemic and its impact throughout the world if no specific measures are taken;

11. Recognizing that poverty, underdevelopment and illiteracy are among the principal contributing factors to the spread of HIV/AIDS, and noting with grave concern that HIV/AIDS is compounding poverty and is now reversing or impeding development in many countries and should therefore be addressed in an integrated manner;

12. Noting that armed conflicts and natural disasters also exacerbate the spread of the epidemic;

13. Noting further that stigma, silence, discrimination and denial, as well as a lack of confidentiality, undermine prevention, care and treatment efforts and increase the impact of the epidemic on individuals, families, communities and nations and must also be addressed;

14. Stressing that gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS;

15. Recognizing that access to medication in the context of pandemics such as HIV/AIDS is one of the fundamental elements to achieve progressively the full realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health;

16. Recognizing that the full realization of human rights and fundamental freedoms for all is an essential element in a global response to the HIV/AIDS pandemic, including in the areas of prevention, care, support and treatment, and that it reduces vulnerability to HIV/AIDS and prevents stigma and related discrimination against people living with or at risk of HIV/AIDS;

17. Acknowledging that prevention of HIV infection must be the mainstay of the national, regional and international response to the epidemic, and that prevention, care, support and treatment for those infected and affected by HIV/AIDS are mutually reinforcing elements of an effective response and must be integrated in a comprehensive approach to combat the epidemic;

18. Recognizing the need to achieve the prevention goals set out in the present Declaration in order to stop the spread of the epidemic, and acknowledging that all countries must continue to emphasize widespread and effective prevention, including awareness-raising campaigns through education, nutrition, information and health-care services;

19. Recognizing that care, support and treatment can contribute to effective prevention through an increased acceptance of voluntary and confidential counselling and testing, and by keeping people living with HIV/AIDS and vulnerable groups in close contact with health-care systems and facilitating their access to information, counselling and preventive supplies;

20. Emphasizing the important role of cultural, family, ethical and religious factors in the prevention of the epidemic and in treatment, care and support, taking into account the particularities of each country as well as the importance of respecting all human rights and fundamental freedoms;

21. Noting with concern that some negative economic, social, cultural, political, financial and legal factors are hampering awareness, education, prevention, care, treatment and support efforts;

22. Noting the importance of establishing and strengthening human resources and national health and social infrastructures as imperatives for the effective delivery of prevention, treatment, care and support services;

23. Recognizing that effective prevention, care and treatment strategies will require behavioural changes and increased availability of and non-discriminatory access to, inter alia, vaccines, condoms, microbicides, lubricants, sterile injecting equipment, drugs, including anti-retroviral therapy, diagnostics and related technologies, as well as increased research and development;

24. Recognizing also that the cost, availability and affordability of drugs and related technology are significant factors to be reviewed and addressed in all aspects and that there is a need to reduce the cost of these drugs and technologies in close collaboration with the private sector and pharmaceutical companies;

25. Acknowledging that the lack of affordable pharmaceuticals and of feasible supply structures and health systems continues to hinder an effective response to HIV/AIDS in many countries, especially for the poorest people, and recalling efforts to make drugs available at low prices for those in need;

26. Welcoming the efforts of countries to promote innovation and the development of domestic industries consistent with international law in order to increase access to medicines to protect the health of their populations, and noting that the impact of international trade agreements on access to or local manufacturing of essential drugs and on the development of new drugs needs to be evaluated further;

27. Welcoming the progress made in some countries to contain the epidemic, particularly through: strong political commitment and leadership at the highest levels, including community leadership; effective use of available resources and traditional medicines; successful prevention, care, support and treatment strategies; education and information initiatives; working in partnership with communities, civil society, people living with HIV/AIDS and vulnerable groups; and the active promotion and protection of human rights; and recognizing the importance of sharing and building on our collective and diverse experiences, through regional and international cooperation including North-South, South-South and triangular cooperation;

28. Acknowledging that resources devoted to combating the epidemic both at the national and international levels are not commensurate with the magnitude of the problem;

29. Recognizing the fundamental importance of strengthening national, regional and subregional capacities to address and effectively combat HIV/AIDS and that this will require increased and sustained human, financial and technical resources through strengthened national action and cooperation and increased regional, subregional and international cooperation;

30. Recognizing that external debt and debt-servicing problems have substantially constrained the capacity of many developing countries, as well as countries with economies in transition, to finance the fight against HIV/AIDS;

31. Affirming the key role played by the family in prevention, care, support and treatment of persons affected and infected by HIV/AIDS, bearing in mind that in different cultural, social and political systems various forms of the family exist;

32. Affirming that beyond the key role played by communities, strong partnerships among Governments, the United Nations system, intergovernmental organizations, people living with HIV/AIDS and vulnerable groups, medical, scientific and educational institutions, non-governmental organizations, the business sector including generic and research-based pharmaceutical companies, trade unions, the media, parliamentarians, foundations, community organizations, faith-based organizations and traditional leaders are important;

33. Acknowledging the particular role and significant contribution of people living with HIV/AIDS, young people and civil society actors in addressing the problem of HIV/AIDS in all its aspects, and recognizing that their full involvement and participation in the design, planning, implementation and evaluation of programmes is crucial to the development of effective responses to the HIV/AIDS epidemic;

34. Further acknowledging the efforts of international humanitarian organizations combating the epidemic, including the volunteers of the International Federation of Red Cross and Red Crescent Societies in the most affected areas all over the world;

35. Commending the leadership role on HIV/AIDS policy and coordination in the United Nations system of the Programme Coordinating Board of the Joint United Nations Programme on HIV/AIDS (UNAIDS); and noting its endorsement in December 2000 of the Global Strategy Framework on HIV/AIDS, which could assist, as appropriate, Member States and relevant civil society actors in the development of HIV/AIDS strategies, taking into account the particular context of the epidemic in different parts of the world;

36. Solemnly declare our commitment to address the HIV/AIDS crisis by taking action as follows, taking into account the diverse situations and circumstances in different regions and countries throughout the world;

Leadership

Strong leadership at all levels of society is essential for an effective response to the epidemic

Leadership by Governments in combating HIV/AIDS is essential and their efforts should be complemented by the full and active participation of civil society, the business community and the private sector

Leadership involves personal commitment and concrete actions

At the national level

37. By 2003, ensure the development and implementation of multisectoral national strategies and financing plans for combating HIV/AIDS that address the epidemic in forthright terms; confront stigma, silence and denial; address gender and age-based dimensions of the epidemic; eliminate discrimination and marginalization; involve partnerships with civil society and the business sector and the full participation of people living with HIV/AIDS, those in vulnerable groups and people mostly at risk, particularly women and young people; are resourced to the extent possible from national budgets without excluding other sources, inter alia, international cooperation; fully promote and protect all human rights and fundamental freedoms, including the right to the highest attainable standard of physical and mental health; integrate a gender perspective; address risk, vulnerability, prevention, care, treatment and support and reduction of the impact of the epidemic; and strengthen health, education and legal system capacity;

38. By 2003, integrate HIV/AIDS prevention, care, treatment and support and impact-mitigation priorities into the mainstream of development planning, including in poverty eradication strategies, national budget allocations and sectoral development plans;

At the regional and subregional level

39. Urge and support regional organizations and partners to be actively involved in addressing the crisis; intensify regional, subregional and interregional cooperation and coordination; and develop regional strategies and responses in support of expanded country-level efforts;

40. Support all regional and subregional initiatives on HIV/AIDS including: the International Partnership against AIDS in Africa (IPAA) and the ECA-African Development Forum African Consensus and Plan of Action: Leadership to overcome HIV/AIDS; the Abuja Declaration and Framework for Action for the fight against HIV/AIDS, tuberculosis and other related infectious diseases in Africa; the CARICOM Pan-Caribbean Partnership against HIV/AIDS; the ESCAP regional call for action to fight HIV/AIDS in Asia and the Pacific; the Baltic Sea Initiative and Action Plan; the Horizontal Technical Cooperation Group on HIV/AIDS in Latin America and the Caribbean; and the European Union Programme for Action: Accelerated action on HIV/AIDS, malaria and tuberculosis in the context of poverty reduction;

41. Encourage the development of regional approaches and plans to address HIV/AIDS;

42. Encourage and support local and national organizations to expand and strengthen regional partnerships, coalitions and networks;

43. Encourage the United Nations Economic and Social Council to request the regional commissions, within their respective mandates and resources, to support national efforts in their respective regions in combating HIV/AIDS;

At the global level

44. Support greater action and coordination by all relevant organizations of the United Nations system, including their full participation in the development and

implementation of a regularly updated United Nations strategic plan for HIV/AIDS, guided by the principles contained in the present Declaration;

45. Support greater cooperation between relevant organizations of the United Nations system and international organizations combating HIV/AIDS;

46. Foster stronger collaboration and the development of innovative partnerships between the public and private sectors, and by 2003 establish and strengthen mechanisms that involve the private sector and civil society partners and people living with HIV/AIDS and vulnerable groups in the fight against HIV/AIDS;

Prevention

Prevention must be the mainstay of our response

47. By 2003, establish time-bound national targets to achieve the internationally agreed global prevention goal to reduce by 2005 HIV prevalence among young men and women aged 15 to 24 in the most affected countries by 25 per cent and by 25 per cent globally by 2010, and intensify efforts to achieve these targets as well as to challenge gender stereotypes and attitudes, and gender inequalities in relation to HIV/AIDS, encouraging the active involvement of men and boys;

48. By 2003, establish national prevention targets, recognizing and addressing factors leading to the spread of the epidemic and increasing people's vulnerability, to reduce HIV incidence for those identifiable groups, within particular local contexts, which currently have high or increasing rates of HIV infection, or which available public health information indicates are at the highest risk of new infection;

49. By 2005, strengthen the response to HIV/AIDS in the world of work by establishing and implementing prevention and care programmes in public, private and informal work sectors, and take measures to provide a supportive workplace environment for people living with HIV/AIDS;

50. By 2005, develop and begin to implement national, regional and international strategies that facilitate access to HIV/AIDS prevention programmes for migrants and mobile workers, including the provision of information on health and social services;

51. By 2003, implement universal precautions in health-care settings to prevent transmission of HIV infection;

52. By 2005, ensure: that a wide range of prevention programmes which take account of local circumstances, ethics and cultural values, is available in all countries, particularly the most affected countries, including information, education and communication, in languages most understood by communities and respectful of cultures, aimed at reducing risk-taking behaviour and encouraging responsible sexual behaviour, including abstinence and fidelity; expanded access to essential commodities, including male and female condoms and sterile injecting equipment; harm-reduction efforts related to drug use; expanded access to voluntary and confidential counselling and testing; safe blood supplies; and early and effective treatment of sexually transmittable infections;

53. By 2005, ensure that at least 90 per cent, and by 2010 at least 95 per cent of young men and women aged 15 to 24 have access to the information, education, including peer education and youth-specific HIV education, and services necessary

to develop the life skills required to reduce their vulnerability to HIV infection, in full partnership with young persons, parents, families, educators and health-care providers;

54. By 2005, reduce the proportion of infants infected with HIV by 20 per cent, and by 50 per cent by 2010, by ensuring that 80 per cent of pregnant women accessing antenatal care have information, counselling and other HIV-prevention services available to them, increasing the availability of and providing access for HIV-infected women and babies to effective treatment to reduce mother-to-child transmission of HIV, as well as through effective interventions for HIV-infected women, including voluntary and confidential counselling and testing, access to treatment, especially anti-retroviral therapy and, where appropriate, breast-milk substitutes and the provision of a continuum of care;

Care, support and treatment

Care, support and treatment are fundamental elements of an effective response

55. By 2003, ensure that national strategies, supported by regional and international strategies, are developed in close collaboration with the international community, including Governments and relevant intergovernmental organizations, as well as with civil society and the business sector, to strengthen health-care systems and address factors affecting the provision of HIV-related drugs, including anti-retroviral drugs, inter alia, affordability and pricing, including differential pricing, and technical and health-care system capacity. Also, in an urgent manner make every effort to provide progressively and in a sustainable manner, the highest attainable standard of treatment for HIV/AIDS, including the prevention and treatment of opportunistic infections, and effective use of quality-controlled anti-retroviral therapy in a careful and monitored manner to improve adherence and effectiveness and reduce the risk of developing resistance; and to cooperate constructively in strengthening pharmaceutical policies and practices, including those applicable to generic drugs and intellectual property regimes, in order further to promote innovation and the development of domestic industries consistent with international law;

56. By 2005, develop and make significant progress in implementing comprehensive care strategies to: strengthen family and community-based care, including that provided by the informal sector, and health-care systems to provide and monitor treatment to people living with HIV/AIDS, including infected children, and to support individuals, households, families and communities affected by HIV/AIDS; and improve the capacity and working conditions of health-care personnel, and the effectiveness of supply systems, financing plans and referral mechanisms required to provide access to affordable medicines, including anti-retroviral drugs, diagnostics and related technologies, as well as quality medical, palliative and psychosocial care;

57. By 2003, ensure that national strategies are developed in order to provide psychosocial care for individuals, families and communities affected by HIV/AIDS;

HIV/AIDS and human rights

Realization of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS

Respect for the rights of people living with HIV/AIDS drives an effective response

58. By 2003, enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups, in particular to ensure their access to, inter alia, education, inheritance, employment, health care, social and health services, prevention, support and treatment, information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat stigma and social exclusion connected with the epidemic;

59. By 2005, bearing in mind the context and character of the epidemic and that, globally, women and girls are disproportionately affected by HIV/AIDS, develop and accelerate the implementation of national strategies that promote the advancement of women and women's full enjoyment of all human rights; promote shared responsibility of men and women to ensure safe sex; and empower women to have control over and decide freely and responsibly on matters related to their sexuality to increase their ability to protect themselves from HIV infection;

60. By 2005, implement measures to increase capacities of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and health services, including for sexual and reproductive health, and through prevention education that promotes gender equality within a culturally and gender-sensitive framework;

61. By 2005, ensure development and accelerated implementation of national strategies for women's empowerment, the promotion and protection of women's full enjoyment of all human rights and reduction of their vulnerability to HIV/AIDS through the elimination of all forms of discrimination, as well as all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls;

Reducing vulnerability

The vulnerable must be given priority in the response

Empowering women is essential for reducing vulnerability

62. By 2003, in order to complement prevention programmes that address activities which place individuals at risk of HIV infection, such as risky and unsafe sexual behaviour and injecting drug use, have in place in all countries strategies, policies and programmes that identify and begin to address those factors that make individuals particularly vulnerable to HIV infection, including underdevelopment, economic insecurity, poverty, lack of empowerment of women, lack of education, social exclusion, illiteracy, discrimination, lack of information and/or commodities for self-protection, and all types of sexual exploitation of women, girls and boys, including for commercial reasons. Such strategies, policies and programmes should

address the gender dimension of the epidemic, specify the action that will be taken to address vulnerability and set targets for achievement;

63. By 2003, develop and/or strengthen strategies, policies and programmes which recognize the importance of the family in reducing vulnerability, inter alia, in educating and guiding children and take account of cultural, religious and ethical factors, to reduce the vulnerability of children and young people by ensuring access of both girls and boys to primary and secondary education, including HIV/AIDS in curricula for adolescents; ensuring safe and secure environments, especially for young girls; expanding good-quality, youth-friendly information and sexual health education and counselling services; strengthening reproductive and sexual health programmes; and involving families and young people in planning, implementing and evaluating HIV/AIDS prevention and care programmes, to the extent possible;

64. By 2003, develop and/or strengthen national strategies, policies and programmes, supported by regional and international initiatives, as appropriate, through a participatory approach, to promote and protect the health of those identifiable groups which currently have high or increasing rates of HIV infection or which public health information indicates are at greatest risk of and most vulnerable to new infection as indicated by such factors as the local history of the epidemic, poverty, sexual practices, drug-using behaviour, livelihood, institutional location, disrupted social structures and population movements, forced or otherwise;

Children orphaned and made vulnerable by HIV/AIDS

Children orphaned and affected by HIV/AIDS need special assistance

65. By 2003, develop and by 2005 implement national policies and strategies to build and strengthen governmental, family and community capacities to provide a supportive environment for orphans and girls and boys infected and affected by HIV/AIDS, including by providing appropriate counselling and psychosocial support, ensuring their enrolment in school and access to shelter, good nutrition and health and social services on an equal basis with other children; and protect orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance;

66. Ensure non-discrimination and full and equal enjoyment of all human rights through the promotion of an active and visible policy of de-stigmatization of children orphaned and made vulnerable by HIV/AIDS;

67. Urge the international community, particularly donor countries, civil society, as well as the private sector, to complement effectively national programmes to support programmes for children orphaned or made vulnerable by HIV/AIDS in affected regions and in countries at high risk and to direct special assistance to sub-Saharan Africa;

Alleviating social and economic impact

To address HIV/AIDS is to invest in sustainable development

68. By 2003, evaluate the economic and social impact of the HIV/AIDS epidemic and develop multisectoral strategies to address the impact at the individual, family, community and national levels; develop and accelerate the implementation of national poverty eradication strategies to address the impact of HIV/AIDS on household income, livelihoods and access to basic social services, with special focus on individuals, families and communities severely affected by the epidemic; review the social and economic impact of HIV/AIDS at all levels of society, especially on women and the elderly, particularly in their role as caregivers, and in families affected by HIV/AIDS, and address their special needs; and adjust and adapt economic and social development policies, including social protection policies, to address the impact of HIV/AIDS on economic growth, provision of essential economic services, labour productivity, government revenues, and deficit-creating pressures on public resources;

69. By 2003, develop a national legal and policy framework that protects in the workplace the rights and dignity of persons living with and affected by HIV/AIDS and those at the greatest risk of HIV/AIDS, in consultation with representatives of employers and workers, taking account of established international guidelines on HIV/AIDS in the workplace;

Research and development

With no cure for HIV/AIDS yet found, further research and development is crucial

70. Increase investment in and accelerate research on the development of HIV vaccines, while building national research capacity, especially in developing countries, and especially for viral strains prevalent in highly affected regions; in addition, support and encourage increased national and international investment in HIV/AIDS-related research and development, including biomedical, operations, social, cultural and behavioural research and in traditional medicine to improve prevention and therapeutic approaches; accelerate access to prevention, care and treatment and care technologies for HIV/AIDS (and its associated opportunistic infections and malignancies and sexually transmitted diseases), including female-controlled methods and microbicides, and in particular, appropriate, safe and affordable HIV vaccines and their delivery, and to diagnostics, tests and methods to prevent mother-to-child transmission; improve our understanding of factors which influence the epidemic and actions which address it, inter alia, through increased funding and public/private partnerships; and create a conducive environment for research and ensure that it is based on the highest ethical standards;

71. Support and encourage the development of national and international research infrastructures, laboratory capacity, improved surveillance systems, data collection, processing and dissemination, and the training of basic and clinical researchers, social scientists, health-care providers and technicians, with a focus on the countries most affected by HIV/AIDS, particularly developing countries and those countries experiencing or at risk of a rapid expansion of the epidemic;

72. Develop and evaluate suitable approaches for monitoring treatment efficacy, toxicity, side effects, drug interactions and drug resistance, and develop

methodologies to monitor the impact of treatment on HIV transmission and risk behaviours;

73. Strengthen international and regional cooperation, in particular North-South, South-South and triangular cooperation, related to the transfer of relevant technologies suitable to the environment in the prevention and care of HIV/AIDS, the exchange of experiences and best practices, researchers and research findings and strengthen the role of UNAIDS in this process. In this context, encourage ownership of the end results of these cooperative research findings and technologies by all parties to the research, reflecting their relevant contribution and dependent upon their providing legal protection to such findings; and affirm that all such research should be free from bias;

74. By 2003, ensure that all research protocols for the investigation of HIV-related treatment, including anti-retroviral therapies and vaccines, based on international guidelines and best practices, are evaluated by independent committees of ethics, in which persons living with HIV/AIDS and caregivers for anti-retroviral therapy participate;

HIV/AIDS in conflict and disaster-affected regions

Conflicts and disasters contribute to the spread of HIV/AIDS

75. By 2003, develop and begin to implement national strategies that incorporate HIV/AIDS awareness, prevention, care and treatment elements into programmes or actions that respond to emergency situations, recognizing that populations destabilized by armed conflict, humanitarian emergencies and natural disasters, including refugees, internally displaced persons, and in particular women and children, are at increased risk of exposure to HIV infection; and, where appropriate, factor HIV/AIDS components into international assistance programmes;

76. Call on all United Nations agencies, regional and international organizations, as well as non-governmental organizations involved with the provision and delivery of international assistance to countries and regions affected by conflicts, humanitarian crises or natural disasters, to incorporate as a matter of urgency HIV/AIDS prevention, care and awareness elements into their plans and programmes and provide HIV/AIDS awareness and training to their personnel;

77. By 2003, have in place national strategies to address the spread of HIV among national uniformed services, where this is required, including armed forces and civil defence forces, and consider ways of using personnel from these services who are educated and trained in HIV/AIDS awareness and prevention to assist with HIV/ AIDS awareness and prevention activities, including participation in emergency, humanitarian, disaster relief and rehabilitation assistance;

78. By 2003, ensure the inclusion of HIV/AIDS awareness and training, including a gender component, into guidelines designed for use by defence personnel and other personnel involved in international peacekeeping operations, while also continuing with ongoing education and prevention efforts, including pre-deployment orientation, for these personnel;

Resources

The HIV/AIDS challenge cannot be met without new, additional and sustained resources

79. Ensure that the resources provided for the global response to address HIV/AIDS are substantial, sustained and geared towards achieving results;

80. By 2005, through a series of incremental steps, reach an overall target of annual expenditure on the epidemic of between 7 and 10 billion United States dollars in low and middle-income countries and those countries experiencing or at risk of experiencing rapid expansion for prevention, care, treatment, support and mitigation of the impact of HIV/AIDS, and take measures to ensure that the resources needed are made available, particularly from donor countries and also from national budgets, bearing in mind that resources of the most affected countries are seriously limited;

81. Call on the international community, where possible, to provide assistance for HIV/AIDS prevention, care and treatment in developing countries on a grant basis;

82. Increase and prioritize national budgetary allocations for HIV/AIDS programmes as required, and ensure that adequate allocations are made by all ministries and other relevant stakeholders;

83. Urge the developed countries that have not done so to strive to meet the targets of 0.7 per cent of their gross national product for overall official development assistance and the targets of earmarking 0.15 per cent to 0.20 per cent of gross national product as official development assistance for least developed countries as agreed, as soon as possible, taking into account the urgency and gravity of the HIV/AIDS epidemic;

84. Urge the international community to complement and supplement efforts of developing countries that commit increased national funds to fight the HIV/AIDS epidemic through increased international development assistance, particularly those countries most affected by HIV/AIDS, particularly in Africa, especially in sub-Saharan Africa, the Caribbean, countries at high risk of expansion of the HIV/AIDS epidemic and other affected regions whose resources to deal with the epidemic are seriously limited;

85. Integrate HIV/AIDS actions in development assistance programmes and poverty eradication strategies as appropriate, and encourage the most effective and transparent use of all resources allocated;

86. Call on the international community, and invite civil society and the private sector to take appropriate measures to help to alleviate the social and economic impact of HIV/AIDS in the most affected developing countries;

87. Without further delay, implement the enhanced Heavily Indebted Poor Country (HIPC) Initiative and agree to cancel all bilateral official debts of HIPC countries as soon as possible, especially those most affected by HIV/AIDS, in return for demonstrable commitments by them to poverty eradication, and urge the use of debt service savings to finance poverty eradication programmes, particularly for prevention, treatment, care and support for HIV/AIDS and other infections;

88. Call for speedy and concerted action to address effectively the debt problems of least developed countries, low-income developing countries, and middle-income

developing countries, particularly those affected by HIV/AIDS, in a comprehensive, equitable, development-oriented and durable way through various national and international measures designed to make their debt sustainable in the long term and thereby to improve their capacity to deal with the HIV/AIDS epidemic, including, as appropriate, existing orderly mechanisms for debt reduction, such as debt swaps for projects aimed at the prevention, care and treatment of HIV/AIDS;

89. Encourage increased investment in HIV/AIDS-related research nationally, regionally and internationally, in particular for the development of sustainable and affordable prevention technologies, such as vaccines and microbicides, and encourage the proactive preparation of financial and logistic plans to facilitate rapid access to vaccines when they become available;

90. Support the establishment, on an urgent basis, of a global HIV/AIDS and health fund to finance an urgent and expanded response to the epidemic based on an integrated approach to prevention, care, support and treatment and to assist Governments, inter alia, in their efforts to combat HIV/AIDS with due priority to the most affected countries, notably in sub-Saharan Africa and the Caribbean and to those countries at high risk, and mobilize contributions to the fund from public and private sources with a special appeal to donor countries, foundations, the business community, including pharmaceutical companies, the private sector, philanthropists and wealthy individuals;

91. By 2002, launch a worldwide fund-raising campaign aimed at the general public as well as the private sector, conducted by UNAIDS with the support and collaboration of interested partners at all levels, to contribute to the global HIV/AIDS and health fund;

92. Direct increased funding to national, regional and subregional commissions and organizations to enable them to assist Governments at the national, regional and subregional level in their efforts to respond to the crisis;

93. Provide the UNAIDS co-sponsoring agencies and the UNAIDS secretariat with the resources needed to work with countries in support of the goals of the present Declaration;

Follow-up

Maintaining the momentum and monitoring progress are essential

At the national level

94. Conduct national periodic reviews with the participation of civil society, particularly people living with HIV/AIDS, vulnerable groups and caregivers, of progress achieved in realizing these commitments, identify problems and obstacles to achieving progress, and ensure wide dissemination of the results of these reviews;

95. Develop appropriate monitoring and evaluation mechanisms to assist with follow-up in measuring and assessing progress, and develop appropriate monitoring and evaluation instruments, with adequate epidemiological data;

96. By 2003, establish or strengthen effective monitoring systems, where appropriate, for the promotion and protection of human rights of people living with HIV/AIDS;

At the regional level

97. Include HIV/AIDS and related public health concerns, as appropriate, on the agenda of regional meetings at the ministerial and head of State and Government level;

98. Support data collection and processing to facilitate periodic reviews by regional commissions and/or regional organizations of progress in implementing regional strategies and addressing regional priorities, and ensure wide dissemination of the results of these reviews;

99. Encourage the exchange between countries of information and experiences in implementing the measures and commitments contained in the present Declaration, and in particular facilitate intensified South-South and triangular cooperation;

At the global level

100. Devote sufficient time and at least one full day of the annual session of the General Assembly to review and debate a report of the Secretary-General on progress achieved in realizing the commitments set out in the present Declaration, with a view to identifying problems and constraints and making recommendations on action needed to make further progress;

101. Ensure that HIV/AIDS issues are included on the agenda of all appropriate United Nations conferences and meetings;

102. Support initiatives to convene conferences, seminars, workshops, training programmes and courses to follow up issues raised in the present Declaration, and in this regard encourage participation in and wide dissemination of the outcomes of the forthcoming Dakar Conference on access to care for HIV infection; the Sixth International Congress on AIDS in Asia and the Pacific; the Twelfth International Conference on AIDS and Sexually Transmitted Infections in Africa; the Fourteenth International Conference on AIDS, Barcelona, Spain; the Tenth International Conference on People Living with HIV/AIDS, Port-of-Spain; the Second Forum and Third Conference of the Horizontal Technical Cooperation Group on HIV/AIDS and Sexually Transmitted Infections in Latin America and the Caribbean, Havana; the Fifth International Conference on Home and Community Care for Persons Living with HIV/AIDS, Chiang Mai, Thailand;

103. Explore, with a view to improving equity in access to essential drugs, the feasibility of developing and implementing, in collaboration with non-governmental organizations and other concerned partners, systems for the voluntary monitoring and reporting of global drug prices;

We recognize and express our appreciation to those who have led the effort to raise awareness of the HIV/AIDS epidemic and to deal with its complex challenges;

We look forward to strong leadership by Governments and concerted efforts with the full and active participation of the United Nations, the entire multilateral system, civil society, the business community and private sector;

And finally, we call on all countries to take the necessary steps to implement the present Declaration, in strengthened partnership and cooperation with other multilateral and bilateral partners and with civil society.

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