UNGASS COUNTRY PROGRESS REPORT

LATVIA

Reporting period: January 2006 – December 2007

Submission date: *February 7, 2008*

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I. Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral Treatment
BBS	Bio-Behavioural Survey
CRIS	Country Response Information System
CSW	Commercial Sex Workers
EC	European Commission
ENCAP	EC project No.2005305 "Expanding network for Coordinated and Comprehensive Actions on HIV/AIDS Prevention Among IDUs and Bridging Population"
EU	European Union
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug User
LIC	Latvian Infectology Centre
LTC	Low Threshold Centres for Affected Population Groups
M&E	Monitoring and Evaluation
MDR-TB	Multi drug resistance tuberculosis
MoCFA	Ministry of Children and Family Affairs
MoES	Ministry of Education and Science
MoF	Ministry of Finances
MoH	Ministry of Health

MoI	Ministry of Interior
MoJ	Ministry of Justice
MoW	Ministry of Welfare
MSM	Men who have Sex with Men
NCC	National Coordination Committee for HIV and STI Prevention
NGO	Nongovernmental Organization
OST	Opioid Substitution Treatment
PHA	Public Health Agency
PLWHA	People Living with HIV/AIDS
PWHA	People Living with HIV/AIDS
RDS	Respondent Driven Sampling
SATLD	State Agency of Tuberculosis and Lung Disease
UK	United Kingdom
UNGASS	United Nations General Assembly Special Session
VCT	Voluntary Counselling and Testing

II. Status at glance

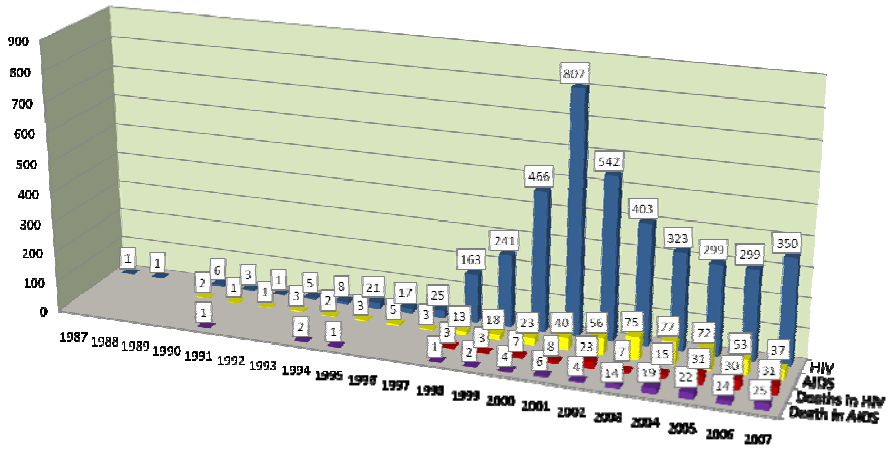
The National Coordination Committee (NCC) for HIV and STI prevention assumes responsibilities for coordinating national response to HIV/AIDS epidemic and for the national level Country Progress Reporting to the UNAIDS. The national level core indicators have been selected (Table 1).

NCC overseen and facilitated involvement of stakeholders in the Report debriefing data collection and preparation process, and endorses the final Country Progress Report prior to submission to UNAIDS.

State Agency "The Public Health Agency" under the Ministry of Health (MoH) conducted data and information collection, calculation for the national level indicators, and drafted narrative part of the Report. Stakeholders from relevant ministries (MoH, MoES, MoJ, MoF), NGOs and PLWHA were involved in the preparation process of the Report.

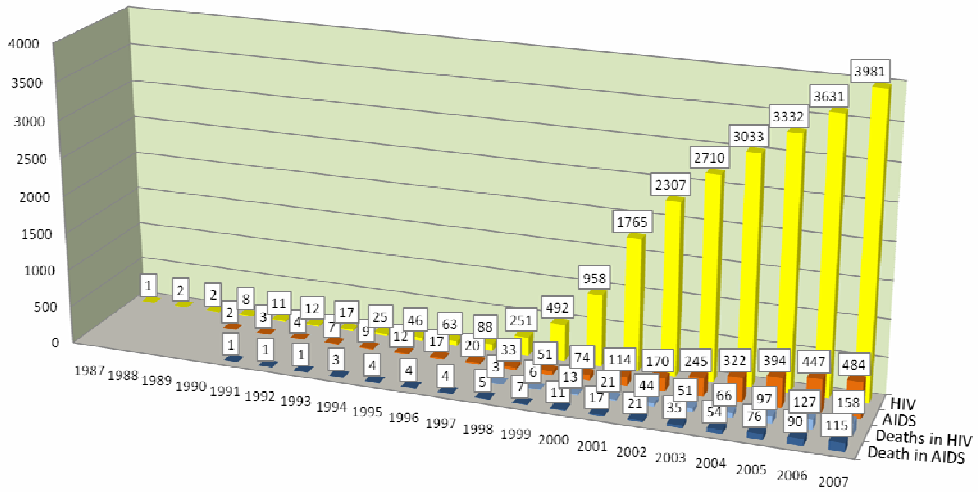
The spread of HIV/AIDS has become a long-term problem in Latvia. This problem implies serious consequences, i.e. possess threat to public health, social welfare and national economy. Latvia belongs to the EU countries with the highest HIV infection rates. The number of new HIV cases registered annually, while remains stable during last years, further increases the size (8-9% annually) of affected population (Figures 1, 2).

Figure 1: HIV/AIDS Cases by Year of Diagnosis (December 31, 2007)



Source: Public Health Agency[1]

Figure 2: Cumulative Number of HIV/AIDS Cases (December 31, 2007)



Source: Public Health Agency[2]

So far Latvia has a significant concentrated HIV epidemic particularly among IDUs, which also affecting other highly vulnerable and bridging population groups (IDUs, MSM, CSW and prisoners). Therefore, the epidemiological situation calls for continuous attention on the part of the government and society at whole.

Up until 2007, Latvia's response against HIV/AIDS was guided by the National AIDS Program (Program 2003-2007), which expires last year. Therefore, the drafting of the new National AIDS Program (Program 2008-2012) for the next planning period (2008-2012) and UNGASS (2008) reporting processes coincided and supplemented each other. Currently Latvia is in the process of approving a revised Program (2008-2012).

[1] www.sva.gov.lv
[2] www.sva.gov.lv

Table 1: UNGASS indicator data

No.	UNGASS indicators	2005	2007
National Commitment and Action			
1.	Domestic and international AIDS spending by categories and financing source	Reported	Reported
2.	National Composite Policy Index (Areas covered: gender, workplace programmes, stigma and discrimination, prevention, care and support, human rights, civil society involvement, and monitoring and evaluation)	Reported	Reported
National programme indicators			
3.	Percentage of donated blood units screened for HIV in a quality – assured manner	Not reported N/A*	Reported
4.	Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	Not reported N/A	Not reported N/A
5.	Percentage of HIV – positive pregnant women who received antiretroviral drugs to reduce the risk of mother – to – child transmission	Not reported N/A	Reported
6.	Percentage estimated HIV – positive incident TB cases that received treatment for TB and HIV	Not 2005 UNGASS indicator	Reported 2005 data
7.	Percentage of women and men aged 15 – 49 who received an HIV test in the last 12 months and who know their results	Not 2005 UNGASS indicator	Not reported N/A
8.	Percentage of most – at – risk populations - IDUs who received an HIV test in the last 12 months and who know their results	Not reported N/A	Reported
9.	Percentage of most – at – risk population – IDUs reached with HIV prevention programmes	Reported	Reported
10.	Percentage of orphaned and vulnerable children aged 0 – 17 whose households received free basic external support in caring for the child	Not reported N/R**	Not reported N/R
11.	Percentage of schools that provided life skills – based HIV education within the last academic year	Not reported N/R	Not reported N/R
Knowledge and behaviour indicators			
12.	Current school attendance among orphans and non – orphans aged 10 - 14	Not reported	Not reported

		N/R	N/R
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	Reported	Reported
14.	Percentage of most – at – risk populations - IDUs who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconception about HIV transmission	Reported	Reported
15.	Percentage of young women and men aged 15 – 24 who have had sexual intercourse before the age of 15	Not reported N/A	Reported
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 reported N/A	Not reported N/A
17.	Percentage of women and men aged 15 – 49 who have had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse	Not reported N/A	Not reported N/A
18.	Percentage of female and male sex workers reporting the use of a condom with their most recent client	Reported	Not reported N/A
19.	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Not reported N/A	Not reported N/A
20.	Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	Reported	Reported
21.	Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	Reported	Reported
Impact indicators			
22.	Percentage of young women and men aged 15 – 24 who are HIV – infected	Not reported N/A	Not reported N/A
23.	Percentage of most – at – risk – IDUs populations who are HIV – infected	Reported	Reported
24.	Percentage of adults and children with HIV still alive and known to be on treatment 12 months after initiation of antiretroviral therapy	Not reported N/A	Not reported N/A

* N/A – an absence of appropriate data

** N/R – was not considered relevant the epidemic in Latvia

III. Overview of the AIDS epidemic

Current epidemiological situation

Latvia so far belongs to the countries in EU where HIV infection rates are high. With 129.6 cases per million populations in 2005 -2006, Latvia has double the EU average rate but remains below Estonia, Portugal, UK and Luxemburg. The major HIV increase in Latvia was seen during 2001. Since the numbers declined and stabilized during 2005 - 2007 (Table 2).

Table 2: HIV and AIDS statistics 2003-2007

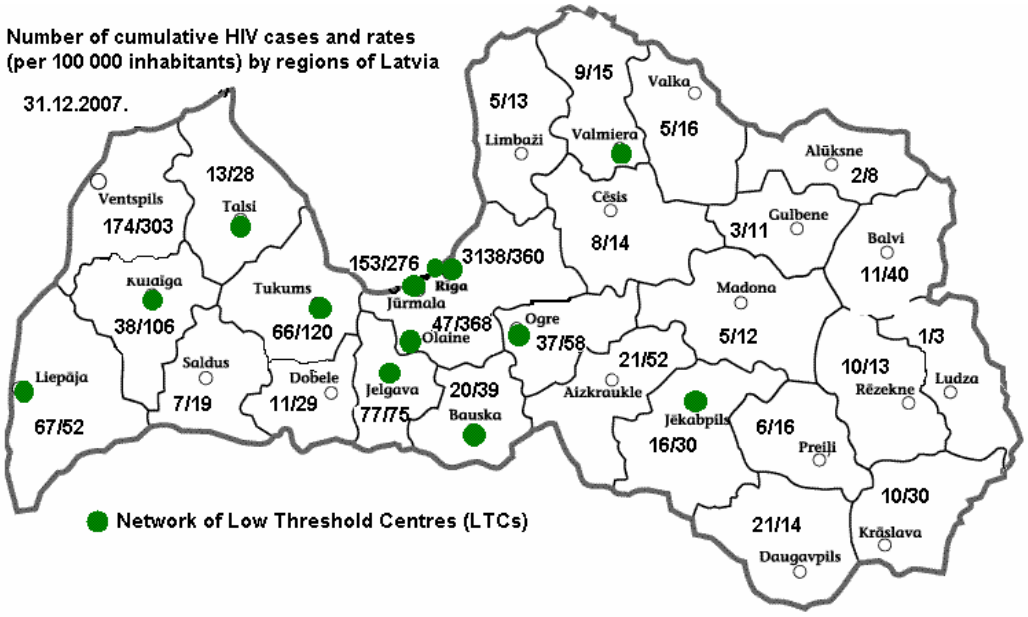
Indicator	**2003**	**2004**	**2005**	**2006**	**2007**
Number of new HIV cases per 100.000 population	17.4	14.0	13.0	13.1	15.3
Absolute number of HIV cases	403	323	299	299	350
New AIDS cases per 100.000 population	3.2	3.3	3.1	2.3	1.6
Absolute number of AIDS cases	75	77	72	53	37
AIDS related deaths per 100.000 population	0.6	0.8	1.0	0.6	1.1
Absolute number of AIDS related deaths	14	19	22	14	25

Source: Public Health Agency[3]

Regions of Latvia are differently affected by the infection. Riga shows the highest HIV prevalence figures (360 cases per 100.000 residents) along with Ventspils (303 cases per 100.000 residents), while Ludza, Aluksne and Madona regions have the lowest figures (Figure 3). Therefore, geographical focus of anti epidemic measures is essential to target resources in the geographical areas that are most at risk for epidemic spread.

[3] www.sva.gov.lv

Figure 3: HIV and AIDS by geographical location (as of December 31, 2007)



Source: Public Health Agency[4]

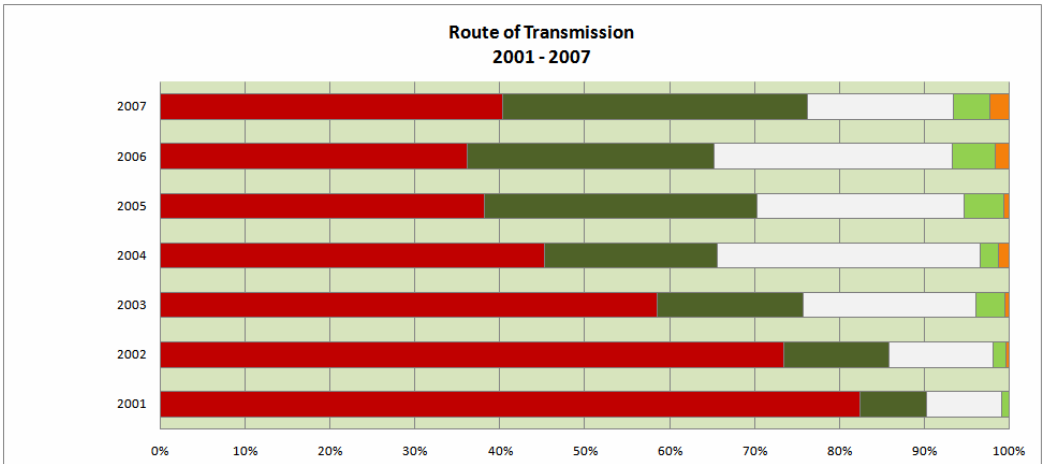
Routes of HIV transmission and affected population groups

The majority of HIV infected people are male IDUs who were infected through sharing of needles and syringes. IDUs clearly dominate in the current Latvia's epidemic and account for 63.2% of all registered cases, heterosexual transmission – 17.0%, homosexual transmission – 4.2%, and mother-to-child transmission – 0.6%.

Since 2001 the number of newly diagnosed HIV cases among IDUs and the proportion of IDUs among new cases have decreased gradually (Figure 4). In 2001 there were 665 cases registered as a result of IDU (82%), in 2003 – 236 cases (59%), in 2005 – 114 cases (38%), but in 2007 - 141 cases (40%).

[4] www.sva.gov.lv

Figure 4: HIV cases by route of transmission and year.



	2001	2002	2003	2004	2005	2006	2007
IDU	665	398	236	146	114	108	141
Heterosexual	63	67	69	66	96	87	126
Unidentified	72	67	82	100	73	84	60
Homosexual	7	8	14	7	14	15	15
Vertical transmission		2	2	4	2	5	8

Source: Public Health Agency[5]

While in Latvia transmission through intravenous drug use is the prevailing route for HIV spread, it has been declining, and heterosexual transmission increasing gradually. However, the epidemiological data presented in Figure 4 reflects only general trends and requires future analysis, before conclusions are drown. Therefore, in-depth studies such as Integrated Bio-Behavioural Survey (BBS) among risk groups are necessary. These studies help to understand the infection spread among groups-at-risk as well as link the infection rates with behavioural factors. This information is important to plan and undertake issue focused interventions among groups-at-risk.

Another contributor to new HIV cases is prison system[6]. In 2006 prisoners contributed 16% of all new cases, which used to be 30-33% during 2000-2003 respectively. Decline in the share of new HIV cases found in penitentiary system can be attributed to declining number of individuals tested by the prisons. If in 2000 the prison system tested 8.722 individuals, these numbers declined to 2,600 in 2006 (new entries per year approximately 3.000). Since 2000, due to lack of financial resources and outdated infrastructure the number of HIV tests has been reduced over the time. The incidence of HIV in prison is 10-fold higher than in the community. Therefore, the situation within penitentiary system remains challenging and still possesses risk for the HIV spread. Such risks are due to the fact that approximately 6.1 of prison population (December 31, 2006) is HIV positive. TB and especially Latvia's high

[5] www.sva.gov.lv

[6] Stöver H., Lehmann M., Olsena S., Upmace I., Skripste I., Trautmann F., Weilandt C. 2007. Capacity building for institutions involved in surveillance and prevention of communicable diseases in Latvia's penitentiary system. Twinning Light Project LV/2005/SO-01TL. www.sva.gov.lv

MDR-TB rates are serious threat to the Latvian prisons and to the society at large. Together with a comparable high HIV rate among prisoners, increasing HIV and MDR-TB co-infections can be noticed.

Growth in homosexual transmission observed on Figure 4, also calls for attention. While yet absolute numbers of HIV cases among MSM are low, as a share of new HIV cases it is growing, and since 2000 increased from around 1% to above 5% in 2006. In Western European countries homosexual transmission is the predominant mode for HIV spread, therefore Latvia needs to pay timely attention to this group. However, most behavioural issues related to MSMs, the size and geographic distribution isn't known.

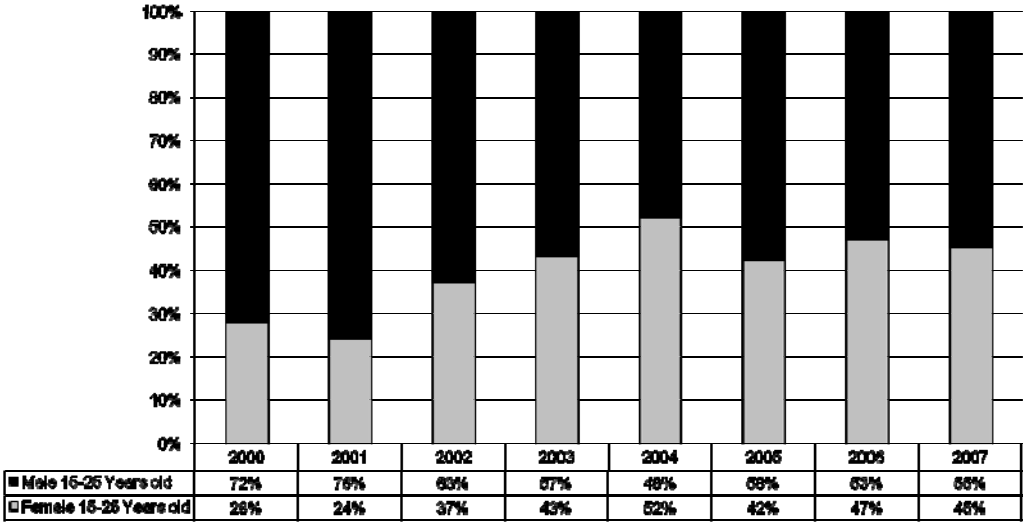
On average around four cases of vertical HIV transmission is reported in Latvia every year, which amounts to 20 cases per 100.000 newborns. In addition, annually ~30 HIV positive pregnant women are detected. As of December 31, 2007 there were 25 HIV infected children born to HIV infected mother in Latvia. Out of all HIV cases, among pregnant women 49.3% are reported due to sexual transmission and in 25.9%, the women have a history of drug injecting[7]. HIV cases among pregnant women in Latvia are mostly found among mothers that avoided adequate prenatal care as well. This may suggests that pregnant IDUs are not adequately reached by HIV testing during pre-natal care services in Latvia.

HIV infection by age and gender

At the outset of HIV epidemic during 2000-2001, males were more affected. However, over the course of recent years, infection is probably moving into female population and in 2006 females contributed 45% of cases found among people 15-25 years, while in 2000 this group only accounted for 28% of HIV positive cases (Figure 5); similar trend is seen among people older than 25 years (Figure 6). One explanation to the observed changes could be declining number of HIV cases detected in prisons and lower tests performed among LTC clients, which historically contributed HIV positive cases among males. However, further research is important to understand epidemic transition from males into females and to better plan response measures.

[7] Public Health Agency

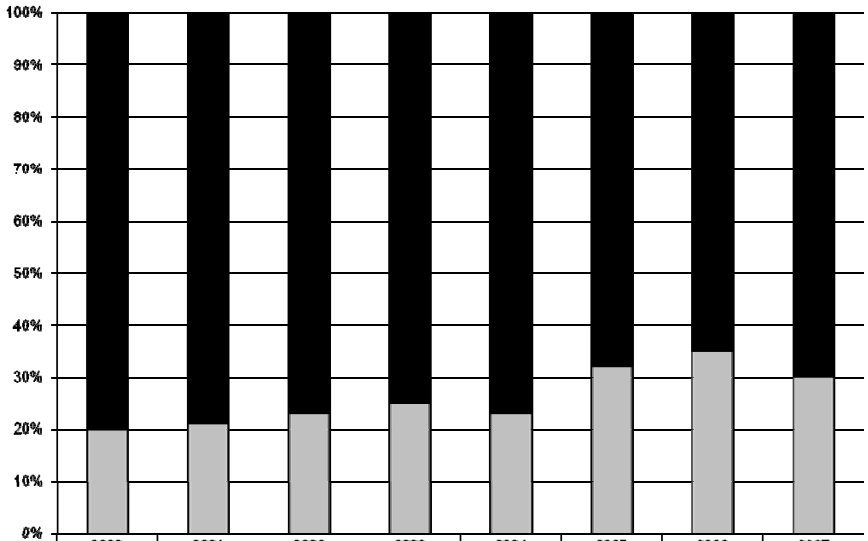
Figure5: Share of HIV infection among 15-25 years old by gender



	2000	2001	2002	2003	2004	2005	2006	2007
Male 15-25 Years old	72%	76%	63%	57%	48%	58%	53%	55%
Female 15-25 Years old	28%	24%	37%	43%	52%	42%	47%	45%

Source: Public Health Agency

Figure 6: Share of HIV infection among persons older than 25 year by gender



	2000	2001	2002	2003	2004	2005	2006	2007
Male older than 25 Years	80%	79%	77%	75%	77%	68%	65%	70%
Female older than 25 Years	20%	21%	23%	25%	23%	32%	35%	30%

Source: Public Health Agency

As HIV infection progressed in Latvia, older people became more affected and their share slowly increased. In 2001 up to 58% of new cases were detected among younger age group (15-24 year old), while in 2006 only 27% of new cases came from this group and the rest was detected among older ones (> 25 years). However, these changes could also be result of changes in annual testing volume among different risk groups.

In the given epidemiological context, the following primary and secondary target groups have been identified and the interventions necessary for preventing further spread of HIV within and beyond these groups have informed the national program:

Primary target groups include:

1. Intravenous drug users
2. Prisoners
3. Commercial sex workers
4. Men who have sex with men

Secondary target group is comprised of:

- Pregnant women without adequate antenatal care and with unknown HIV status and those that are HIV positive, to minimize possible vertical transmission;
- Schoolchildren that may engage in risk-behaviour and
- Individuals that face professional risk (health care personnel, social workers, prison and police staff).

HIV prevalence in the country

Latvia conducted Bio-Behavioural Surveys (BBS) in 1999 among MSM – visitors of gay clubs in two cities (Riga and Liepaja) and revealed HIV prevalence at 13.9%, but in 2001 and 2002 among street and bar prostitutes in Riga, and found HIV prevalence at 7.7% and 16% accordingly[8].

Since 2001 regular prevalence surveys took place among IDUs – clients of LTCs in Riga and Riga region (Table 3). However, the quality of survey could be questioned as the rates of HIV prevalence detected in 2005 was comparable to rates routinely detected (VCT) among clients of LTCs, which points to the issue that probably only LTC clients were enrolled in the study (2005), because Respondent Driven Sampling methodology was not used.

[8] The Latvian National Report on Monitoring the Follow-up to the Declaration of Commitment on HIV/AIDS, 2005.

Therefore, LTCs are considered as settings for provision of services based on multi-pronged approach with aim to reach sufficient availability and community penetration for IDUs and bridging population with VCT, with harm reduction interventions and information. LTCs are considered as focal points for continuous BBS as well.

Table 3: HIV prevalence among IDUs – clients of LTCs in capital city area by year

	2001	**2002**	**2003**	**2005**	**2007**
Routine VCT	185/ 1068 (17.3%)	122/ 832 (13.5%)	68/ 447 (15.2%)	11/ 261 (4.2%)	8/ 245 (3.3%)
Biological survey	36/ 261 (13.7%)	52/ 250 (21%)	45/ 205 (22%)	52/ 200 (26%)	94/ 417 (22.5%)

Source: Public Health Agency

It is evident that HIV prevalence estimated from routine VCT are decreasing since 2001 and this coincide with decline of newly diagnosed HIV cases by case reporting.

The prevalence rates estimated from BBS has increased and since 2002 remained relatively high and stable, notwithstanding, that newly diagnosed and reported HIV cases related to IDUs have substantially (by 64.6%) declined. Therefore the relatively high and stable HIV prevalence rates together with high (>90%) "HIV test seeking" behaviour among IDUs could present an evidence that concentrated epidemic has reached the "saturation phase", and prevalence rates could decrease in following years.

In 2007 within EC project Nr.2005305 "Expanding network for Coordinated and Comprehensive Actions on HIV/AIDS Prevention Among IDUs and Bridging Population" (ENCAP) the research "Study on the prevalence of HIV and other infections, and risk behaviour among IDUs in Latvia, Lithuania and Estonia" have been conducted by unified, validated methodology among IDUs. The aim of the study was to evaluate the prevalence of HIV, hepatitis B (HBV) and C (HCV), syphilis and related risk behaviour. Serological markers for HIV, HBV, HCV and syphilis infections have been detected in biological samples (venous blood specimens). Results of the survey are reflected in Table 4.

Table 4: Serosurvey results for IDUs: prevalence of HBV, HCV, HIV and syphilis infections markers

Sites	Sample size	Infection markers prevalence				
		HBsAg	**Anti-HBc**	**Anti-HCB**	**HIV**	**Syphilis**
Riga 1 APC	175	4 (2.3%)	97 (55.4%)	127 (72.5%)	38 (21.7%)	8 (4.6%)
Riga II D+L	242	8 (3.3%)	120 (49.5%)	174 (72%)	55 (22.7%)	10 (4.1%)
Kuldiga	18	0	10 (55.5%)	13 (72.2%)	4 (22.2%)	0
Jelgava	36	1 (2.7%)	14 (38.8%)	15 (41.6%)	0	0
Jekabpils	17	0	6 (35.2%)	7 (41.1%)	0	0
Liepaja	29	4 (13.7%)	19 (65.5%)	19 (65.5%)	0	0
Olaine	56	7 (12.5%)	21 (37.5%)	48 (85.7%)	8 (14.2%)	0
Total						
Riga	417	12 (2.8%)	217 (52%)	301 (72.1%)	93 (22.3%)	18 (4.3%)
Regions	156	12 (7.6%)	70 (44.8%)	102 (65.3%)	12 (7.6%)	0

Source: Public health Agency

Prevalence of HBV, HCV and syphilis infections markers among IDUs indicates risk of further HIV spread among IDUs and their sexual partners.

IV. National response to the AIDS epidemic

During the period January 2006 – December 2007 Latvia implemented intervention according Program (2003-2007) in areas:

1. Monitoring HIV/AIDS epidemic;
2. Prevention with an emphasis on reaching IDUs population;
3. Health care of PLWHA, including free provision of ARV;
4. Training of HIV/AIDS professionals;
5. Research.

The Program (2003-2007) expires last year. Therefore, it was essential to identify national policy priorities for the next planning period (2008-2012) that will help implement activities aimed at containing HIV epidemic. The Program (2008-2012) has to address issues not resolved during the previous years, as well as those identified in EU policy documents and reports produced by international projects and independent experts. In addition, the Program (2008-2012) has to focus on integrated issues related to both HIV and TB infections.

Five strategic objectives were identified to reach the goal of the Program (2008-2012):

1. Reduce new HIV cases among groups-at-risk (IDU, MSM, CSW and Prisoners) through targeted HIV prevention activities and through promoting changes in HIV risk related behaviour;
2. Implement wider prevention activities among general population with emphasis on youth;
3. Improve quality of life of PLWHA through provision of health and social care as well as avoiding stigma and discrimination;
4. Generate and use evidence for response planning and implementation management; develop the agreed country-level Monitoring and Evaluation Plan;
5. Strengthen national coordination capacity to respond to HIV and AIDS.

Currently Latvia is in the process of approving a revised Program (2008-2012).

Measures to reorganize MoH structures have been taken to avoid duplications and ensure more effective coordination and planning of prevention measures, to facilitate cooperation between national and municipal institutions. Public institutions “AIDS

Prevention Centre" and "Health Promotion State Agency" has been integrated into the State Agency "Public Health Agency" (PHA)[9].

PHA following its reorganization[10] is responsible for methodological leadership on HIV prevention issues and for reporting on HIV epidemic and response as well.

Two large scale nationally representative surveys have been conducted during 2007 and served as data sources for the core national-level indicators[11]:

1. Integrate Bio-Behavioural Survey (BBS) "Study of the prevalence of HIV and other infections and risk behaviour among injecting drug users in Latvia, Lithuania and Estonia". Survey has been done within EC project No.2005305 ENCAP; Work package 5 "Research"[12].

The study (October – December, 2007) was a cross-sectional survey of active IDUs (those who have injected over the preceding two months) from non-treatment settings (LTC services). Participants for the study have been recruited by RDS methodology. Behavioural survey has been conducted by trained interweavers. The structured questionnaire used in survey is based on WHO, Drug injecting study phase II survey version. Surveys final report will be published in June, 2008, accordingly the timetable of the ENCAP project.

2. Survey within ESPAD "European School Survey Project on Alcohol and Other Drugs"[13].

Survey has been conducted (April - May, 2007) among students from general comprehensive schools and vocational education institutions, based on national representative sample. Structured self-completed questionnaire adjusted by questions about HIV/AIDS (according UNGASS, 2008 indicator requirements[14]) has been used.

[9] Regulations No.17 of CoM, 10.01.2007, "On reorganization of AIDS Prevention Centre"
[10] Regulations No.433 of CoM, 26.06.2007, "Regulations of the State Agency "Public Health Agency";
[11] Guidelines on Construction of Core Indicators, 2008, UNAIDS
[12] www.aidsnetwork.eu
[13] www.espad.org
[14] Guidelines on Construction of Core Indicators, 2008, UNAIDS

Country level core indicator values

Table 5: National Programme indicators

Indicator	Values	
	2005	**2007**
Percentage of donated blood units screened for HIV in a quality – assured manner (indicator 3)	N/A	100%
Percentage of HIV – pregnant women who received antiretroviral drugs to reduce the risk of mother – to – child transmission (indicator 5)	N/A	97,4%
Percentage estimated HIV – positive incident TB cases that received treatment for TB and HIV (indicator 6)	57,4%	N/A*
Percentage of most –at – risk (IDUs) population who received an HIV test in the last 12 months and know their results (indicator 8)	N/A	61,3%
Percentage of most – at – risk (IDUs) population reached with HIV prevention programmes (indicator 9)	14,6%	46,8%**

*****Data for denominator from http://www.who.int/tb/country/en is available only for 2005.

**Data is not comparable because of different denominators: in 2007: number of respondents of survey; in 2005: total number of clients of LTCs.

Therefore results indicate:

1. "HIV test seeking" behaviour and VCT provision among IDUs population and access to VCT services (LTCs) is rather high (indicator 8);

2. Coverage of IDUs by HIV prevention programs needs to be expanded.

Knowledge and Behaviour indicators for young women and men aged 15 - 24

Indicator 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 misconception about HIV transmission

Table 6: Correct answers to question: Can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission?

Disaggregated	Indicator value	
	2005	**2007**
Males	45,5%	49,2%
Females	45,0%	51,0%
15 - 19	-	53,2%
20 - 24	-	18,8%
All 15 - 24	90,5%	50,1%

Table 7: Correct answers to question: can using condoms reduce the risk of HIV transmission?

Disaggregated	Indicator value	
	2005	**2007**
Males	45,4%	53,9%
Females	44,5%	51,9%
15 - 19	-	56,0%
20 - 24	-	20,5%
All 15 - 24	89,9%	52,8%

Table 8: Correct answers to question: can a healthy – looking person have HIV?

Disaggregated	Indicator value	
	2005	**2007**
Males	40,5%	47,0%
Females	41,4%	49,7%
15 - 19	-	51,4%
20 - 24	-	18,4%
All 15 - 24	81,9%	48,4%

Table 9: Correct answers to question: can person get HIV from mosquito bites?

Disaggregated	Indicator value	
	2005	**2007**
Males	23,1%	12,9%
Females	21,8%	15,6%
15 - 19	-	15,5%
20 - 24	-	3,4%
All 15 - 24	45,0%	14,4%

Table 10: Correct answers to question: can a person get HIV by sharing a meal with someone who is infected?

Disaggregated	Indicator value	
	2005	**2007**
Males	29,6%	21,3%
Females	33,3%	29,7%
15 - 19	-	27,2%
20 - 24	-	10,6%
All 15 - 24	63,0%	25,7%

Table 11: Correct answers to all five questions

Disaggregated	Indicator value	
	2005	**2007**
Males	15,6%	2,6%
Females	14,5%	3,0%
15 - 19	-	3,0%
20 - 24	-	0,7%
All 15 - 24	30,1%	2,8%

Table 12: Summary

	2005	2007	Changes
Can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission?	90,6%	50,1%	-44,7%
Can using condoms reduce the risk of HIV transmission?	90%	52,8%	-41,3%
Can a healthy – looking person have HIV?	81,9%	48,4%	-40,9%
Can person get HIV from mosquito bites?	45,1%	14,4%	-68%
Can a person get HIV by sharing a meal with someone who is infected?	63%	25,7%	-59%
Percentage of young women and men aged 15 – 24 who gave the correct answers to all five questions	30,1%	2,8%	-90,7%

Therefore, the knowledge about HIV transmission and how HIV sexual transmission can be avoided dramatically decreased in period between two surveys. One reason might be difference in surveys methodology: in 2005 randomly selected body (2452 young women and men aged 15-24) were used while in 2007 the main group was school students aged 13-18, among them small age group 20-24 (124 students of vocational schools) with very low scores are not representative.

Results indicate the urgent need to scale-up information and education activities on HIV and sexual-reproductive health among schoolchildren with emphasis to vocational schools (health education is not issue of curricula).

Indicator 15:

Percentage of young women and men aged 15 – 24 who have had sexual intercourse before the age of 15

Table 13: Percentage of young women and men aged 15 – 24 who have had sexual intercourse before the age of 15

Disaggregated	2007
Male	16,2%
Female	8,8%
15 - 19	13,0%
20 - 24	6,2%
All 15 - 24	12,3%

Knowledge and Behaviour indicators for IDUs

Indicator 14:

Percentage of most – at – risk (IDUs) population who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconception about HIV transmission

Table 14: Correct answers to question: can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission?

Disaggregated values	**Indicator value**	
	2005*	**2007**
Males	-	83,5%
Females	-	88,1%
<25	-	82,8%
+25	-	85,6%
All	91,2%	84,8%

*incomplete opportunity accordingly age groups

Table 15: Correct answers to question: can using condoms reduce the risk of HIV transmission?

Disaggregated values	**Indicator value**	
	2005*	**2007**
Males	-	67,0%
Females	-	72,2%
<25	-	65,7%
+25	-	69,6%
All	94,8%	68,4%

*incomplete opportunity accordingly age groups

Table 16: Correct answers to question: Can a healthy – looking person have HIV?

Disaggregated values	Indicator value	
	2005*	**2007**
Males	-	91,0%
Females	-	89,4%
<25	-	89,9%
+25	-	90,8%
All	88,6%	90,6%

*incomplete opportunity accordingly age groups

Table 17: Correct answers to question: can person get HIV from mosquito bites?

Disaggregated values	Indicator value	
	2005*	**2007**
Males	-	91,8%
Females	-	90,7%
<25	-	89,3%
+25	-	92,4%
All	58%	91,5%

*incomplete opportunity accordingly age groups

Table 18: Correct answers to question: can a person get HIV by sharing a meal with someone who is infected?

Disaggregated values	Indicator value	
	2005*	**2007**
Males	-	94,0%
Females	-	95,4%
<25	-	93,5%
+25	-	94,8%
All	73,1%	94,4%

*incomplete opportunity accordingly age groups

Table 19: Correct answers to all five questions

Disaggregated values	**Indicator value**	
	2005*	**2007**
Males	-	43,8%
Females	-	49,7%
<25	-	38,5%
+25	-	48,4%
All injecting Drug Users	50,94%	45,4%

*incomplete opportunity accordingly age groups

Table 20: Summary

	2005	**2007**	**Changes**
Can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission?	91,2%	84,8%	-7%
Can using condoms reduce the risk of HIV transmission?	94,8%	68,4%	-27,9%
Can a healthy – looking person have HIV?	88,6%	90,6%	+2,2%
Can person get HIV from mosquito bites?	58%	91,5%	+57,7%
Can a person get HIV by sharing a meal with someone who is infected?	73,1%	94,4%	+29,1%
Percentage of most – at – risk (IDUs) population respondents who gave the correct answers to all five questions	50,94%	45,4%	-10,9%

Indicator 20:

Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse

Table 21: Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse

Disaggregated	Indicator value	
	2005	**2007**
Males	57,1%	40,0%
Females	23,5%	33,9%
<25	35,3%	41,6%
+25	45,3%	36,9%
All	80,6%	38,3%

Indicator 21:

Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected

Table 22: Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected

Disaggregated values	Indicator value	
	2005 (data about last month)	**2007(data about last time)**
Males	20,1%	87,4%
Females	10%	95,5%
<25	15,1%	94,5%
+25	15,1%	87,5%
All injecting Drug Users	30,2%	89,6%

Therefore use of sterile injecting equipment among IDUs increased evidently, while knowledge how to avoid sexual transmission of HIV and use of condoms decreased. Consequently, condom distribution among LTC clients, safer sex promotion and sexual education activities should be scaled-up.

Impact indicators

Indicator 23:

Percentage of most – at – risk (IDUs) populations who are HIV – infected

Table 23: Percentage of most – at – risk (IDUs) populations who are HIV – infected

Disaggregated	**2007**
Male	21,1%
Female	26,1%
<25	14,5%
+25	26,2%
All	22,5%

V. Best practices

One of the most notable achievement of the national HIV/AIDS response in Latvia is the introduction of harm reduction programs for IDUs. In the middle of nineties, as a result of massive inflow of heroin, HIV epidemiological situation in Latvia radically changed - HIV infection started to spread among IDUs. In 1997 to prevent the epidemic AIDS Prevention Centre (since 2007 – unit of the PHA) developed and set up the first pilot Needle Exchange Program (NEP) in the Capital city Riga. This pilot project was aimed to establish first contacts with the hidden IDUs population, to inform IDUs about HIV prevention measures, to change syringes and needles and give out condoms and disinfectants to interrupt chains of new infections at their very start.

In the next stage of the Program (1999) in three cities (Riga, Jurmala, Olaine) street outreach activities were introduced and were based on practical knowledge of previous drug users (ex-users) who were employed as street workers. The street work proved to be particularly efficient and the capacity of the program increased manifold.

Since 1998 the injecting drug use is a major driving force for concentrated HIV epidemic in those localities of Latvia where no HIV prevention programs have been introduced due to the lack of human and financial capacities and other obstacles. At the same time it has to be noted that overall capacity of Riga program was too low – coverage of IDUs involved was insufficient to prevent spread of HIV. The implementation of the Project "Development of the Network of Outreach/Counselling Centres for IDUs in Latvia" (Task Force, Ministry of Health, AIDS Prevention centre, UNDP, 2002-2004) bridged this gap. The Low Threshold centres (LTCs) for IDUs have been established in 10 selected municipalities more affected by drug use and HIV infection.

This Project serves as a best practice example of the new model where state and municipal institutions cooperate to respond timely and to ensure sustainability of harm reduction activities without the external financing from the projects. State undertook management and supervision of HIV prevention programs' network, ensuring training for LTCs staff and provides materials (needles, syringes, disinfectants, condoms, rapid HIV tests, handbook for staff and informative materials). Municipalities in their turn provided LTCs' staff and pay for the premises. A local Network of LTCs working in the field of HIV prevention among IDUs was established. All LTCs provide diversified low-threshold services aimed to meet different needs of their target audience: needle exchange, outreach, VCT, disinfectants, condoms, group and individual risk reduction information and counselling, psychological support. Therefore, LTCs have been able to become a valuable addition to the existing municipal social services.

Previous experience to implement and manage HIV prevention programs for IDUs on the country level (12 LTCs at the end of 2007; Figure 3) allowed to extend project activities to the neighbouring countries (Lithuania, Estonia, Finland and Bulgaria) forming a comprehensive and expanding transnational network. On July 1st, 2006, a

new Project ,,Expanding Network for Coordinated and Comprehensive Actions on HIV/AIDS Prevention among IDUs and Bridging Population (ENCAP)"[15] was started in 5 countries and included 9 institutions. Project leader is the PHA (Latvia). The Project is financed from the EC Public Health Program and will last till July 2009.

The Project aims to prevent transmission of HIV and other infections (hepatitis B, C, STIs and tuberculosis) among IDUs and bridging population and to develop and strengthen the specially targeted networking for HIV/AIDS prevention in the project area. International coordination system (Steering Committee, Project coordination group and Transnational network) have been established and ensure three level networking among LTCs staff, municipal coordinators, state and national level institution representatives. During the Project coordination network meetings, experience exchange visits, trainings (seminars, workshops) all stakeholders involved have possibility to exchange the best practices, to learn and raise their capacities. Implementations of project activities are joint and solemn responsibility of all project partners and are divided accordingly. ENCAP project partners lead certain work packages according to their professional strength and experience. For example, Lithuania (AIDS Centre) leads public relation work package, Estonia (National Health Development Institute) leads research activities, and Finland (National Public Health Institute) provides training. Latvia's (PHA) responsibility is to ensure the network cooperation, to coordinate project implementation, to disseminate results on national and international levels, to promote common surveillance indicators and common, unified LTSs standards.

During the planning and implementation stages of this project a few innovative approaches have been used. In line with the World Health Organization (WHO) guidelines project follows up the tuberculosis prevalence trends among IDUs and the research covers also bridging population (IDUs sexual partners).

Therefore, the ENCAP project will have long term impact on transnational networking and partnership in the area of HIV prevention among most – at – risk population groups.

VI. Major challenges and remedial actions

The key challenges that the national HIV/AIDS response has faced and that are hindering Latvia's ability to reach the UNAIDS Declaration goals do not changed remarkably since 2005 and include the following:

- Limited, inadequate funding available for the implementation of the Program (2003-2007);

- Limited involvement of NGOs and PLWHA, particularly in service provision for key vulnerable populations (IDUs, MSM, CSW, prisoners);

[15] www.aidsnetwork.eu

- Limited coverage and the need to expand ARV treatment and low-threshold services for PLWHA and key vulnerable populations.

- Weakness of the monitoring and evaluation of the national HIV/AIDS response.

So far neither a financial plan integral to the Program (2003-2007), nor a stand-alone national HIV/AIDS account has been established. Most (85%) of the HIV/AIDS funding from state's budget is allocated to the MoH, so it looks like a health plan, and not a multisectoral plan. The services financed and sustained by the state's health budget include ARV and hospital treatment for PLWHA, HIV tests for laboratories within surveillance network and some specific prevention activities. Furthermore, there is an obvious disproportion among the budget funds used for treatment and those used for prevention.

The budget to support prevention programs did not allocated to municipalities, suggesting a highly centralized response to the epidemic, whereas most countries have recognized the importance of a decentralized approach.

The civil society and NGOs participation in the national HIV/AIDS response is limited in particular in areas of the low-threshold service provision to vulnerable population groups (IDUs, MSM, CSW, prisoners) mainly due to lack of resources. NGOs are funded mainly on a project basis with funding mainly from international donors. Latvia's accession to the European Union has restricted the availability of international funding for NGOs in the area of HIV/AIDS prevention.

According to the international experience groups-at-risk are best reached by NGOs, therefore effective engagement of NGO-sector is important. However, past and current funding for non-governmental sector is minimal, which doesn't allow NGOs to expand the coverage and offer services on a sustainable basis. NGOs need to be financially supported from state and local budget. Thus, finding the ways to finance and involve civil society in the national AIDS response becomes important under the Program (2008-2012).

Although the implementation of the Program (2003-2007) requires the involvement of other national stakeholders, e.g. MoES, MoD, MoJ (the Prison Administration) the direct budget allocations were not foreseen for these stakeholders. As a result HIV prevention activities in prisons are fragmentary, but harm reduction activities (needle exchange, substitution therapy) are not available at all.[16] Funding of heath care services in the prison system is very low an infrastructure outdated. Shortage of resources and staff limits prison health care system capacity to provide adequate level of testing, treatment and care to detainees, and as a result testing of prisoners declined and number of HIV cases detected in prisons decreased.

[16] Stöver H., Lehmann M., Olsena S., Upmace I., Skripste I., Trautmann F., Weilandt C. 2007. Capacity building for institutions involved in surveillance and prevention of communicable diseases in Latvia's penitentiary system. Twinning Light Project LV/2005/SO-01TL. www.sva.gov.lv

Latvia faces the need to increase (link) prison funding and treatment/ care provision within the penitentiary system to the public health care system in order to ensure health care services in prisons equal to services provided in society. The global experience shows that prisoners as well as other groups at risk are best served when outside agencies (governmental and NGOs) are involved in delivering HIV prevention and curative services. Therefore state's agencies (PHA, LIC, SATLD, RCPAD), that receive funding from budget have to deliver HIV/AIDS, TB, hepatitis, STI testing, prevention services and care in prisons. Such integration by involvement of respective agencies and NGOs should be aimed at developing and delivering confidential, competent and coordinated prevention, treatment and support to those in the places of detention. In order to control the spread of infectious diseases within the prison system it is essential to increase the knowledge, competencies and skills of the prison staff and prisoners through providing trainings, increase number of prisoners being tested (and therefore timely treated) for various diseases. Timely detection of HIV and TB cases or any co-infection will help initiate treatment as well as potentially will contribute to less risky behaviour among prisoners. Initiating harm reduction and Opioid Substitution Treatment (OST) in prison system and involving sizable number of IDUs is also essential. Political leadership and legislative and policy reforms will be the essential first step for such services to emerge in the prisons of Latvia.

Effective prevention of HIV spread among IDUs mainly is performed by harm reduction programs (provision of substitution or replacement treatment, needle exchange). Two opioid substitution programs are operating in Latvia (Riga): Methadeone program (since 1996) and Buphrenorphine program (since 2003); total 684 individuals have been served (2000-2006), currently 70 IDUs in Methadone program, and 120 IDUs in Buprenorphine program. Therefore, scaling-up OST and development of evidence-based harm reduction and drug treatment program for amphetamine injectors should be prioritized under the Program (2008-2012).

Scaling-up substitution treatment to levels that influence the "twin epidemics" of drug injecting and HIV will require broadening the network of service providers including regions. The effects of treatment should be evaluated through involvement of civil society (e.g. university research groups) to improve the quality of studies and offer sound evidence for policy development. The RCPAD should pay a key role and should become a national centre of expertise.

Programs for IDUs need to address co-infection with hepatitis B and C and clinical management of drug dependence, including Buprenorphine and Methadone management in ART context (WHO can provide technical advice). Currently only three patients of the Riga Methadone program are on ART. Methadone's role in increasing compliance with ART and preventing resistance is practically under-developed. Thus, current practice is not able to provide proper ARV treatment and care to the majority of those (IDUs) most in need.

Latvia has introduced treatment with ARV for PWHA, and as of December 31, 2007 total 381 patients were on treatment out of 2675 HIV/AIDS patients. ARV treatment has been established but now country faces the need for expanding the provision of ARV to all in need. Therefore, Latvia needs to develop multiple entry points to ARV

treatment by expanding low-threshold services and build-up counselling and support capacity of these services.

The rates of co-infection with hepatitis B and C are high and therefore treatments are required. However, cost sharing (i.e. patients are required to cover 25% of the cost of treatment, which amounts to ~400€) becomes significant financial access barrier for patients. In order to increase number of treated patients with co-infection (mainly hepatitis C) it is essential to revise policies and reduce the rate of cost sharing and/ or negotiated the lower price for drugs.

A key strategic priority that needs more emphasis is developing a mutual TB/HIV control strategy between the national HIV and TB programs. This is important, taking into account Latvia's rapidly increasing rates of TB/HIV co-infection, and very high recorded rates of MDR-TB. Cooperation between institutions working on HIV and TB surveillance should be strengthened through developing integrated HIV and TB surveillance, prevention and treatment guidelines.

The provision of care and psychosocial support to PLWHA is insufficient in comparison to the availability of ARV treatment. Greater emphasis should be placed on providing psychosocial support for PLWHA through the network of LTCs. Support to NGOs involved in providing such services should be increased.

As the number of PLWHA increases the need for palliative care for AIDS patients is growing. Therefore, national guidelines for such care will be developed and approved by the government.

Today Latvia fails in delivering adequate home-based care services for PLWHA. Therefore, under the Program (2008-2012) the concept for home-based care will be developed and used as the basis to establish, finance and deliver such kind of service to the people in need.

Latvia has to reach MSM and CSW population so far missed by targeted prevention measures. While prevention of HIV spread among these groups is important, very little is known about behaviour and size of these groups.

Routine HIV reporting system in Latvia does not capture well HIV cases among individuals involved in prostitution (male and female) and/ or using services of prostitutes. Neither allows monitoring the infection rates among those who are the sexual partners of IDUs. So there is a need to implement BBS among CSW and MSM in order to identify HIV prevalence and behaviour patterns among these groups-at-risk and for better planning of targeted preventive interventions. Therefore, under the new Program (2008-2012) it is planned to implement BBS among MSM (2008 and 2010), CSW (2009-2011) and IDUs (2009-2011), as well as population size estimates.

Over the last years the numbers and population of "unknown route of transmission" for newly diagnosed HIV cases increased and reached 28% in 2006 and are still high (17%) in 2007, that distorting epidemiological data and trends. The main reason for this increase might be attributed to shortcomings in pre- and post-test counselling, and failure of HIV test providers to assess and document individual risk factors. Thus, improving quality of VCT is important. Program will address these weaknesses, VCT

services will be expanded and the quality improved through developing and approving new VCT guidelines; introducing these guidelines in the postgraduate training curricula and training sufficient number of health care workers; assuring supply of the HIV surveillance laboratories network with adequate quantities of HIV test-kits. Improved quality and availability of VCT will increase number of people that received information about HIV/AIDS and were tested as well.

Activities aimed at preventing vertical transmission of HIV will be implemented during next 5-years that will assure adequate supply of HIV express tests to maternity wards and provision of preventive therapy against HIV vertical transmission (mother-to-child) in accordance with guidelines for HIV infection treatment. In order to avert vertical transmission primary HIV prevention along with prevention of unwanted pregnancy among HIV infected women will be carried out. Young women most at risk, those injecting drugs, involved in sex work or sexual partners of IDUs will be targeted.

VII. Support from the country's development partners

HIV epidemic does not concern only in Latvia but to the whole European Union. During the Council Meeting of the EU ministers of employment, social policy, consumer affairs and health, the decision was made to develop uniform policy and action to fight HIV/AIDS in EU and neighbouring countries[17].

Latvia is needed strengthened support within the framework of concerted EC level actions on HIV/AIDS in following action areas:

- Expanding and capacity building of integrated low-threshold service networks for specific vulnerable groups (IDUs, prisoners, MSM, CSW);
- Finding out adequate way of funding and involving civil society organizations in the national AIDS response;
- Expanding the provision of ARV to all in need and negotiating affordable lower prices of ARV with pharmaceutical companies.

Participation in EC funded projects will be assured (EC international cooperation project ENCAP 2005302, 2006-2009)[18].

Furthermore Latvia's expertise in the field of work with IDUs, including establishment and running of municipal LTCs can be shared with the developing countries in European region.

[17] Fight against HIV/AIDS in the EU and neighboring countries Draft Council Conclusion, Brussels, May 16, 2007

[18] Communication from the Commission to the Council and the European Parliament on combating HIV/AIDS within the European Union and neighbouring countries, 2006-2009, Brussels, December 15, 2005, COM (2005) 654

VIII. Monitoring and evaluation environment

The overall coordination of the national AIDS response is carried out by the Coordination Commission of Limiting Spread of STI and HIV Infection established under MoH, which includes members from other line ministries (MoCFA, MoI, MoD, MoES, MoJ and MoW) and from NGOs. The decisions of the Coordination Commission are informed by programmatic and epidemiological information collected by PHA.

MoH is responsible to monitor and evaluate outcomes of the national AIDS response and submit annual (and evaluation) reports to the Cabinet of Ministers.

Latvia is yet missing one agreed country-level Monitoring and Evaluation (M&E) System, which has to be developed to satisfy completely “Three Ones” principle. The M&E plan was not included in the Program (2003-2007). Indicators used in the Program (2003-2007) are process, performance and coverage indicators. There are no defined indicators for measuring the impact (prevalence) and outcome (behaviour) of both particular parts (activity areas, service areas) of the Program (2003-2007), and the Program (2003-2007) as a whole. Therefore, under the new Program (2008-2012) this M&E framework will be developed and used to monitor overall implementation of Program (2008-2012) and evaluate its impact. As a result, the set of indicators proposed in this document will be expanded, and become a part of the agreed country-level M&E System. The information generated by this system will be used when mid-term and final evaluation of the Program (2008-2012) will take place during 2009 and 2012 respectively to identify weaknesses and success of implementation, and if necessary, adjustments will be made during mid-term of.

PHA will be responsible entity to collect data and information in accordance with the M&E plan for Program (2008-2012) will compile proposed indicators and prepare reports for national and international consumption.

Consequently, national coordination and multisectoral response will be strengthened through moving away from information sharing to using M&E framework, monitoring the progress of implementation, uncovering the implementation weaknesses, taking decisions on corrective/ improvement measures.

Annexes

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

Annex 2: National Composite Policy Index