COUNTRY PROGRESS REPORT

LATVIA

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Treatment
ECDC	European Centre for Disease Prevention and Control
EU	European Union
HIV	Human Immunodeficiency Virus
ICL	State Agency Infectology Centre of Latvia
IDU	Injecting Drug User
MoH	Ministry of Health
MSM	Men who have sex with men
NCC	National Coordination Committee for HIV, TB and STI prevention
NCPI	National Commitments and Policy Instrument
NGO	Nongovernmental Organization
PLWHA	People Living with HIV/AIDS
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

I Status at a glance

Inclusiveness of the Stakeholders in the Report Writing Process

Latvia has an established and comprehensive healthcare system, which is overseen by the Ministry of Health (MoH). Healthcare in Latvia is largely publically financed and HIV surveillance and treatment are provided centrally by the Infectology Centre of Latvia (ICL) which is a focal contact point for epidemiological surveillance and laboratory diagnostic capacity for HIV.

The report has been prepared by the HIV/AIDS Surveillance and Prevention Unit, representatives of Infectious Diseases Surveillance and Immunization Unit, Epidemiological Safety and Public Health Department of ICL and the reporting process has been coordinated by the Epidemiological Safety Unit of the Ministry of Health.

The major partners gave their contribution to this report through providing the all needed information trough consultations and phone interviews.

Partners:

- Governmental institutions
  - Clinic of Tuberculosis and Lung Diseases
  - HIV/AIDS Outpatient Department
- NGOs
  - Support centre for those affected by HIV/AIDS "DIA+LOGS"
  - Association „HIV.LV"
  - Support Group for People Living with HIV/AIDS „AGIHAS"
  - Latvia's association for family planning and sexual health „Papardes zieds"
  - „Baltic HIV Association"
  - Association of LGBT and their friends "Mozaika"
- WHO Country Office in Latvia

Status of the Epidemic

The first HIV case was reported in 1987 in Latvia. By the end of 2011, there had been 5187 diagnoses of HIV infection and 1052 diagnoses of AIDS reported in

Latvia in total. In 2010-2011, HIV infection was reported in 50 of 119 municipalities and regional cities (42%).

In 2010-2011 almost half (48%) of new HIV cases occurred trough heterosexual route of transmission, but 31% of new HIV cases occurred trough injecting drug use. In relatively high proportion (14%) of cases transmission mode remained unknown.

The policy and programmatic response

The national HIV/AIDS prevention policy in Latvia has been developing and implementing in the mainstream of health policy development by the leadership of MoH since 1993, and is based on the national Public Health Strategy and national programmes to limit spread of HIV/AIDS in Latvia. First national program has been implemented in 1999; however current interventions in Latvia are implemented according to the new Program for Limiting the Spread of HIV for 2009-2013 (hereafter – the Programme), which has been developed, agreed and formally adopted by Government in May, 2009. This new program addresses issues not resolved during the previous years, as well as those issues identified in EU policy documents and reports produced by international projects and independent experts.

The National HIV, Tuberculosis and STIs Prevention Coordination Committee (NCC) continued its duties assuming responsibilities of advisory body for government for the implementation and coordination of the national response to the HIV/AIDS epidemic in the reporting period.

Indicator table

Indicator	**Results 2011**
Target 1. **Reduce sexual transmission of HIV by 50 per cent by 2015** ***General population***	
1.1. Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	32%
1.2. Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	5,2%

1.3. Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	18,3%
1.4. Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse	Not reported
1.5. Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	Not reported
1.6. Percentage of young people aged 15-24 who are living with HIV	Not reported
Target 1. *Sex workers*	
1.7. Percentage of sex workers reached with HIV prevention programmes	48,7%
1.8. Percentage of sex workers reporting the use of a condom with their most recent client	85,5%
1.9. Percentage of sex workers who have received an HIV test in the past12 months and know their results	49,6%
1.10. Percentage of sex workers who are living with HIV	22,2%
Target 1. *Men who have sex with men*	
1.11. Percentage of men who have sex with men reached with HIV prevention programmes	43,4% (2010 results)
1.12. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	39,8% (2010 results)
1.13. Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	25,7% (2010 results)
1.14. Percentage of men who have sex with men who are living with HIV	7,8% (2010 results)
Target 2. Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015	
2.1. Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	19 syringes per person
2.2. Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	55,6% (2010 results)
2.3. Percentage of people who inject drugs who reported using	Not reported

sterile injecting equipment the last time they injected	
2.4. Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	Not reported
2.5. Percentage of people who inject drugs who are living with HIV	11,2%
Target 3. Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS related maternal deaths	
3.1. Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	83%
3.2. Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	100%
3.3. Mother-to-child transmission of HIV (modelled)	Not reported
Target 4. Have 15 million people living with HIV on antiretroviral treatment by 2015	
4.1. Percentage of eligible adults and children currently receiving antiretroviral therapy	Reported
4.2. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	42%
Target 5. Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015	
5.1. Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	53%
Target 6. Reach a significant level of annual global expenditure (US$22-24 billion) in low- and middle-income countries	
6.1. Domestic and international AIDS spending by categories and financing sources	Public Subtotal – LVL 2 976 669 International Subtotal – LVL 91525 Private Subtotal – LVL 4271 (2010 data)
Target 7. Critical Enablers and Synergies with Development Sectors	
7.1. National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society	Reported

involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)	
7.2. Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	Not reported

II Overview of the AIDS epidemic

The first HIV case in Latvia was reported in 1987. During 1987-2011 (December 31, 2011) 5187 cases of HIV infection and 1052 cases of AIDS were registered. During 2010-2011, 573 cases of HIV infection and 223 cases of AIDS infection were registered.

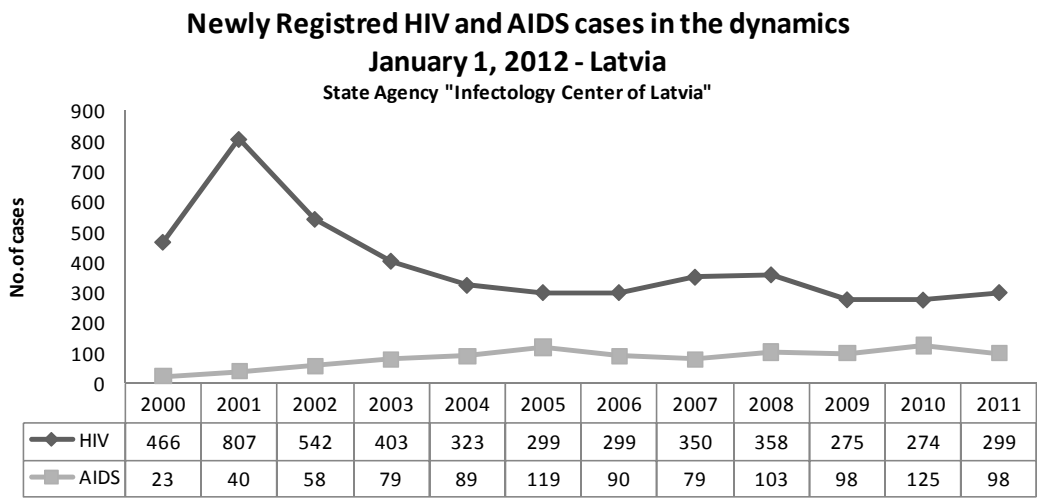
Until 1997, new HIV cases were registered rarely, but, starting in 1998, the registered number of cases increased gradually. Most cases (807 newly registered HIV cases) were registered in 2001 and then until 2006 there was a decrease in the number of new cases, but in 2008 and 2009 - a slight increase. In 2010 and 2011 were not significant changes in the number of newly registered HIV cases, only a small increase were reported in 2011 (2010 – 274, 2011 – 299).

The first two AIDS cases were registered in 1990. Rapid increase of new AIDS cases observed from 1998 (13 newly registered AIDS cases) until 2005 (119 newly registered AIDS cases). Over the next few years the number of cases was various but the highest point reached in 2010, when there were 125 newly registered AIDS cases (Figure 1).

There is possibility that the number of new AIDS cases is increasing due to the fact that the disease for persons, which have been infected with HIV 10 years ago, when incidence of HIV was very high, has now transferred to AIDS. The reason for the increase of AIDS cases might be insufficient funding for the timely initiation of treatment – WHO recommends that treatment should be started at 350 and less CD4 cells, but treatment is started, when number of CD4 cells is 200, in Latvia.

The total number of people who died with the diagnosis of AIDS in the period 1987-2011 was 399 (2010 – 43, 2011 – 26), but with the diagnosis of HIV – 434 (2010 – 56, 2011 – 69).

Figure 1



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
HIV	466	807	542	403	323	299	299	350	358	275	274	299
AIDS	23	40	58	79	89	119	90	79	103	98	125	98

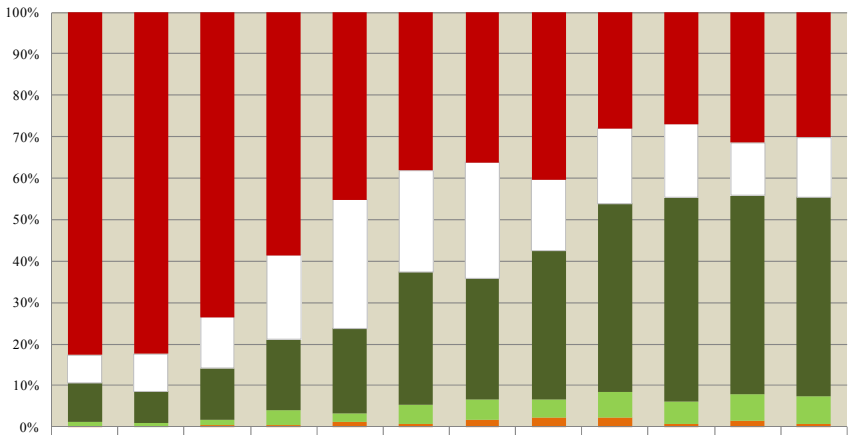
Data source: ICL[1]

From 1987 to 1993, infection occurred only through sexual transmission (heterosexual, homosexual transmission). In 1995 the first case, when HIV infection has been associated with injecting drug use, was registered, and from 1998 to 2007 this was the most common mode of HIV transmission. The first HIV vertical transmission (mother-to child) case was registered in 1999. Since 2001 the percentage of sexual contact transmission of HIV (especially heterosexual) increased, but HIV infection through drug injection decreased respectively.

In 2010 and 2011 the most common HIV transmission ways were heterosexual transmission (2010 – 131 (47,8%), 2011 – 144 (48,1%) cases) and injecting drug use (2010 – 86 (31,4%), 2011 – 90 (30,1%) cases). (Figure 2)

[1] http://www.lic.gov.lv/index.php?p=7793&pp=10879&lang=258

Figure 2



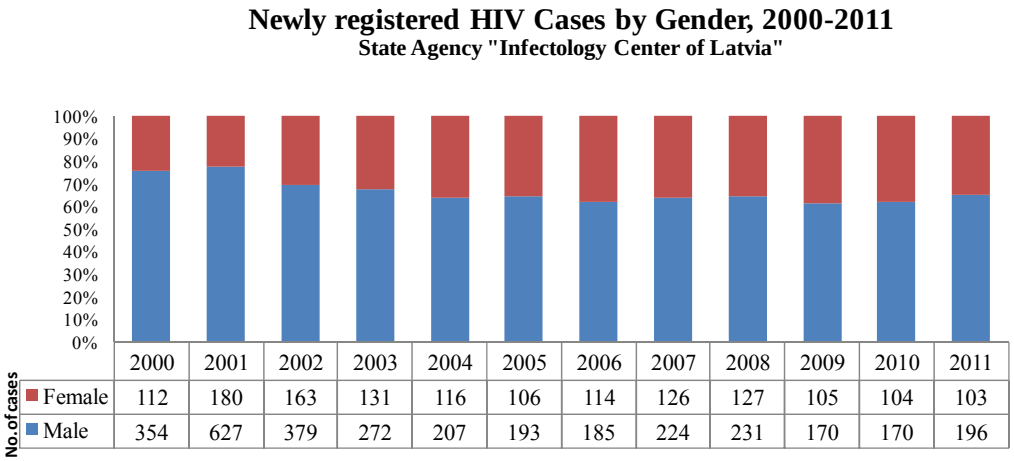
No.of cases	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Injecting drug use	385	665	398	236	146	114	108	141	100	74	86	90
Unknown way of infection	31	72	67	82	100	73	84	60	65	49	35	43
Heterosexual	44	63	67	69	66	96	87	126	163	135	131	144
Homosexual	5	7	8	14	7	14	15	15	22	15	18	20
Mother-to child	1		2	2	4	2	5	8	8	2	4	2

Data source: ICL

HIV cases were registered only among males from 1987 to 1993. In Latvia HIV-infected female was first registered in 1994. Although males are infected with HIV more often than females, since 1994 there has been a gradual percentage increase in HIV-infected females. (2010 - 38% of HIV-infected were females, 2011 – 34% were females). (Figure 3)

Most of HIV cases were registered in the 20-24 years age group (December 31, 2011 males-836 (16% of all 5187 cases), females-475 (9%)). The lowest number of cases were registered in the 10-14 years age group (December 31, 2011 males-12 (0,2%), females-1 (0,02%)).

Figure 3

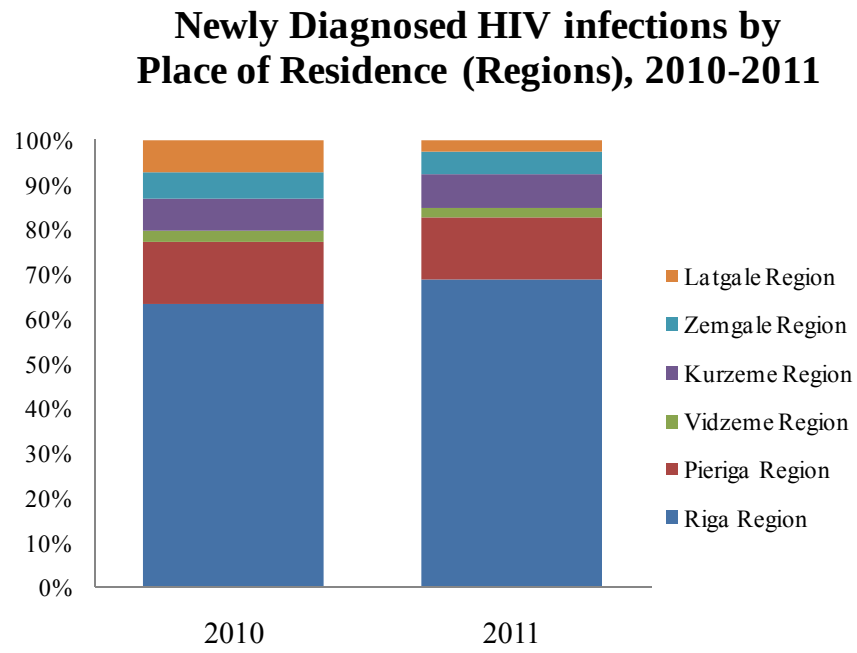


Data source: ICL

There are six statistical regions in Latvia (Zemgale, Kurzeme, Vidzeme, Latgale, Pieriga regions and the capital Riga). In 2010 63% of newly diagnosed HIV infections were registered in Riga region (174 cases) and the least – 3% of newly diagnosed HIV infections - in Vidzeme region (7 cases). (Figure 4)

A similar trend of HIV prevalence was observed in 2011 - 69% of newly diagnosed HIV infections was in Riga (207 cases) and the least – 2% of newly diagnosed HIV infections - in Vidzeme region (5 cases). (Figure 4)

Figure 4



Data source: ICL

III National response to the AIDS epidemic

Programme for Limiting the Spread of HIV for 2009–2013

The national HIV/AIDS policy is based on the national Public Health Strategy and the Programme represents a routine stage in the policy of reducing HIV prevalence. In line with the EU position, advice given by international organizations, recommendations developed in the framework of transnational projects and with the assistance of independent experts, this programme targets issues related to harm reduction measures and continued pharmacotherapy for injecting drug users, prevention and diagnostics of HIV infection and related diseases, especially in prison settings, improved health care services and evidence-based planning. Unlike the previous programme, this programme integrates issues related to HIV and TB co-infection.

The Programme has the following objectives:

- Reduce new HIV cases in total and among main risk groups (IDUs, prisoners, sex workers) through targeted HIV prevention activities and through promoting changes in HIV related risk behavior;
- Implement wider prevention strategies among general population;
- Improve quality of life of PLWHA through provision of health and social care as well as avoiding stigma and discrimination;
- Generate and use evidence for response planning and implementation management;
- Strengthen national coordination capacity to respond to HIV and AIDS.

National HIV, Tuberculosis and STIs Prevention Coordination Committee

Under the auspices of the MoH acts a NCC - a governmental advisory committee for the implementation and coordination of the national response to HIV/AIDS. This commission meets quarterly and is led by the MoH. Membership includes governmental institutions (MoH, Ministry of Justice, Ministry of Defence, Ministry of Education and Science), NGOs and WHO Country Office in Latvia. In

recent years NCC membership has been afforced by representatives from more NGOs and representatives from private sector).[2]

HIV case management

Currently ICL is responsible for HIV case management and provides:

- Diagnosis, laboratory and clinical monitoring of patients;
- HIV/AIDS treatment and care, including anti-retroviral treatment (ART);
- Provides ART in prisons;
- ART for prevention of mother-to-child transmission of HIV;
- Post-exposure prophylaxis;
- Laboratory confirmation of HIV infection for the network of 24 laboratories performing screening on HIV;
- Management of HIV co-infection;
- HIV/AIDS hotline;
- Training of medical professionals.

Analyzing NCPI data since 2005, we can see that there are no significant changes in rate of strategy planning efforts in HIV programmes, political support, prevention, treatments, care and support of monitoring and evaluation – respondents from governmental institutions have rated these issues in NCPI about 7 or 8 points of 10 since 2005.

There has been significant increase in rate of enforcement of existing laws and regulations in relation to human rights protection and HIV by representatives from NGOs - 4 points of 10 in 2005 to 7 points of 10 in 2011.

Overall, in question related to prevention where respondents had to evaluate to what extent has HIV prevention been implemented, government officials trend to evaluate it better than representatives from NGOs, but in comparison with NCPI data from 2009, in 2011 representatives from NGOs evaluated HIV prevention components slightly better. Fact that government officials tend to evaluate prevention of HIV better than representatives of NGOs is confirmed in rate of efforts in the

[2] Ministry of Health 18.06.2008 order No. 105 "On Establishing Commission for Coordinating the Limiting of the Spread of HIV Infection, Tuberculosis and Sexually Transmitted Infections" (amendments 03.08.2010, order No.153);

implementation of HIV prevention programmes – government officials have rated it with 7 points of 10, but representatives from NGOs – 4 points of 10 (and this low rate is stable since 2005).

Similar situation is about evaluation of HIV treatment, care and support programmes – government officials rate it with 8 points of 10, but representatives from NGOs – with 5 points of 10 (7 points in 2005 and 2007, 6 points in 2009).

Some important changes in national response to the AIDS epidemic in Latvia have been made during the period January 2010 – December 2011. By the end of 2009, methadone therapy was available only in 2 cities in Latvia – in Riga and Jelgava, but trough support of UNODC, by the end of 2011 therapy is available already in 10 cities in Latvia. Some improvements have been made in availability of ART - since January 2010, all antiretroviral medicines have been included on the reimbursable list and qualify for 100% reimbursement. Moreover, decentralization of treatment has occurred. Since January 2010, people on ART can now get treatment from local infectious diseases specialists in 7 cities of Latvia and it is possible to get ART from any pharmacy with a contract with the National Health Service. However, PLWHIV concerns over confidentiality and fact, that maybe they are not informed of this possibility, have meant that very few people on ART have taken up this offer. Still, guidelines allowing ART for asymptomatic people with CD4 count <200 are outdated and may limit access to ART.

Health promotion work is undertaken by the network of 18 LTCs which offer information and advice, free condom distribution, confidential HIV rapid counseling and testing and needle exchange. In 2010, the LTCs performed 1421 HIV rapid test (reactivity - 5,8 %) distributed over 310000 syringes and over 57000 condoms. In 2011, the LTCs performed 1261 HIV rapid test (reactivity - 6,7%), distributed barely 340000 syringes and barely 87000 condoms. The network of LTCs is coordinated by the Infectology Centre of Latvia and is financed and organized by local municipalities or NGOs.

Two large scale nationally representative surveys have been conducted during the reporting period and served as data sources for the core national-level indicators:

- HIV/AIDS and STIs Bio-Behavioral Surveillance Survey (BBSS) among Sex Workers

Cross-sectional research, sample size – 117 female sex workers.

The EU-funded project (Public Health programme) BORDERNETwork, co-funded by the German Ministry of Health and coordinated by SPI Forschung gGmbH, Berlin.

In Latvia the project was managed by Latvia's Association for Family Planning and Sexual Health "Papardes zieds" **.**

- EMIS - The European MSM Internet survey[3]

Cross-sectional research, sample size – 708.

A joint project of academic, governmental, non-governmental, and social online media partners from 35 European countries (EU and neighboring countries) to inform European prevention planning for a group highly affected by infections with HIV and other sexually transmitted infections (STIs): gay, bisexual, and other men who have sex with men (MSM), funded by Executive Agency for Health and Consumers, EU Health Programme 2008-2013

In Latvia the project was managed by Infectology Center of Latvia in collaboration with NGO "Mozaika"

[3] http://www.emis-project.eu/publications

Target 1.

Reduce sexual transmission of HIV by 50 per cent by 2015

General population

Table 1 Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

	All n=1052	Males all ages n=521	Males 15-19 n=262	Males 20-24 n=259	Females all ages n=531	Females 15-19 n=261	Females 20-24 n=270
Percentage of respondents who gave correct answers to all 5 questions	32,0	29,4	26,0	32,8	34,7	32,6	36,7
Percentage of respondents who gave a correct answer to question 1 "Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?"	87,0	84,5	82,4	86,5	89,5	87,4	91,5
Percentage of respondents who gave a correct answer to question 2 "Can a person reduce the risk of getting HIV by using a condom every time they have sex?"	86,6	87,1	84,7	89,6	86,1	82,8	89,3
Percentage of respondents who gave a correct answer to question 3 "Can a healthy-looking person have HIV" ?	79,4	75,4	71,0	79,9	83,2	78,9	87,4
Percentage of respondents who gave a correct answer to question 4 "Can a person get HIV from mosquito bites ?"	48,7	47,8	45,0	50,6	49,5	51,0	48,1
Percentage of respondents who gave a correct answer to question 5 "Can a person get HIV from sharing food with someone who is infected ?"	60,3	57,0	55,7	58,3	63,5	61,3	65,6

Only 32% of young women and men aged 15-24 gave correct answers to all 5 questions. Overall young men gave more incorrect answers than women, so it can be concluded that there is need for educational programmes addressed to this population.

Table 2 Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15

	All n=1052	Males all ages n=521	Males 15-19 n=262	Males 20-24 n=259	Females all ages n=531	Females 15-19 n=261	Females 20-24 n=270
Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	5,2	6,5	6,1	6,9	4,0	6,1	1,9

Table 3 Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months

	All n=2617	Males all ages n=1304	Females all ages n=1313
Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	18,3	23,1	13,6

Males more than females reported that they have had sexual intercourse with more than one partner in the past 12 months.

Sex workers

Table 4

	All Sex Workers (females) (n=117)	<25 (n=20)	25+ (n=97)
Percentage of sex workers reached with HIV prevention programmes	48,7	50,0	48,5
Percentage of female and male sex workers reporting the use of a condom with their most recent client	85,5	80,0	86,6

Percentage of sex workers who received an HIV test in the last 12 months and who know their results	49,6	60,0	47,4
Percentage of sex workers who are living with HIV	22,2	15,0	23,7

Table 5 Percentage of sex workers who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

	All n=116
Percentage of respondents who gave correct answers to all 5 questions	58,1
Percentage of respondents who gave a correct answer to question 1 "Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?"	86,2
Percentage of respondents who gave a correct answer to question 2 "Can a person reduce the risk of getting HIV by using a condom every time they have sex?"	93,9
Percentage of respondents who gave a correct answer to question 3 "Can a healthy-looking person have HIV" ?	94,0
Percentage of respondents who gave a correct answer to question 4 "Can a person get HIV from mosquito bites ?"	69,8
Percentage of respondents who gave a correct answer to question 5 "Can a person get HIV from sharing food with someone who is infected ?"	91,4

Data source: HIV/AIDS and STIs Bio-Behavioral Surveillance Survey (BBSS) among Sex Workers

Men who have sex with men

Table 6

	All MSM	<25	25+
Percentage of men who have sex with men reached with HIV prevention programmes	43,4 (n=705)	38,6 (n=184)	45,1 (n=521)
Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	39,8 (n=487)	40,2 (n=122)	39,7 (n=365)
Percentage of men who have sex with men who received an HIV test in the last 12 months and who know their results	25,7 (n=674)	23,9 (n=180)	26,3 (n=494)
Percentage of men who have sex with men who test positive for HIV	7,8 (n=347)	3,1 (n=65)	8,9 (n=282)

Table 7 Percentage of men who have sex with men who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission - percentage of MSM who gave correct answers to all 5 questions

Disaggregated values	Indicator value	
	2008	2010
All	48,4 (n=250)	34,2 (n=705)
<25	42,3 (n=104)	25,5 (n=184)
>25	52,7 (n=146)	37,2 (n=521)

Note: these data are not comparable, because 2010 data are from The European MSM Internet Survey where respondents answered if they agree or disagree with following statements:

- You cannot be confident about whether someone has HIV or not from their appearance,
- Effective treatment of HIV infection reduces the risk of HIV being transmitted,
- HIV cannot be passed during kissing, including deep kissing, because saliva does not transmit HIV,
- You can pick up HIV through your penis while being "active" in unprotected anal or vaginal sex with an infected partner, even if you don't ejaculate,
- You can pick up HIV through your rectum while being "passive" in unprotected anal sex with an infected partner

Target 2. Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015

Table 8 Percentage of people who inject drugs who are living with HIV

Percentage of people who inject drugs who are living with HIV	2007	2011
	22,6 (n=407)	11,2

Note: this data are not comparable, because in 2007, data measurement toll was survey of IDUs in Riga, but information about HIV prevalence among IDUs in 2011 is from LTCs network routine data from all Latvia.

Target 3. Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS related maternal deaths

Table 9 Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission

Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	2006	2007	2008	2009	2011
	97,4% (n=38)	97,4% (n=38)	43,9% (n=82)	98,3 (n=57)	83% (n=58)

Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission is unstable; however since year 2008 relatively high proportion of HIV-positive pregnant women haven't receive this treatment so there is need for some improvements.

Target 4. Have 15 million people living with HIV on antiretroviral treatment by 2015

Table 10 Number of adults and children with advanced HIV infection who are currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) at the end of the reporting period (no information about number of people diagnosed with HIV infection who are eligible for ART)

	All	Males	Females	<15	15+	MSM	IDUs	Prisoners
2008	334	240	94	23	311			
2009	439	-	-	26	413			
2011	560	382	178	25	535	59	248	40

Number of adults and children who are currently receiving ART had increased by 68% in comparison with 2008. Still, guidelines allowing ART for asymptomatic people with CD4 count <200 are outdated and a serious barrier to access to ART.

Target 5. Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015

Table 11 Estimated HIV-positive incident TB cases that received treatment for both TB and HIV

	All Cases	Males	Females	<15	15+
2005	57,4% (n=47)				
2009	13,1% (n=61)	16,2% (n=37)	8,3% (n=24)		13,1% (n=61)
2011	53% (n=89)				

IV Best practices

In December, 2011, "Guidelines for Municipalities in Health Promotion" which includes issues related to prevention of HIV/AIDS have been developed.

These guidelines include a set of recommendations on HIV prevention activities, for example:

- to support non-governmental youth organizations and promote peer education activities on HIV / AIDS;
- to organize health related education for parents to-be, where prevention of mother-to child transmission of HIV and promotion of early entry into prenatal care shall be included;
- to organize health days in schools, including activities on risks related with various objects found in public places such as used syringes, condoms;
- to use capacity and resources of LTCs in selective prevention providing counseling for pregnant IDUs;
- to involve local pharmacies in prevention of HIV/AIDS by organization of syringe and needle assembling;
- to distribute information (on NGOs that provides support to PLWHA, LTCs and locations of methadone treatment points) in hospitals, social services, night shelters etc.

Guidelines for Municipalities in Health Promotion also include recommendation on activities that should be held on World AIDS Day, suggesting, that following activities could be organized:

- concerts, exhibitions;
- awareness-raising activities involving doctors, representatives of NGOs;
- activities in schools, for example, an essay or a drawing competitions;
- distribution of information about HIV testing options, etc.

V Major challenges and remedial actions

The principal problems targeted by the Programme are:

1 Inadequate planning of prevention and control measures outside Riga, especially in the areas with the highest HIV infection risk;
2 HIV transmission among injecting drug users and availability of harm reduction measures;
3 Risk of HIV infection and related diseases in prisons;
4 Availability of health care services to HIV positive persons and AIDS patients;
5 Inadequate planning and administration of evidence-based prevention measures against HIV infection.

Reported progress in implementing the national HIV Programme in Latvia[4]

The role of civil society in the national response to HIV is reported to have been increased. A memorandum of cooperation has been agreed between the Cabinet of Ministers and NGOs. There is an inter-disciplinary and intersectoral Commission (NCC) responsible for coordinating activities related to HIV, TB and sexually-transmitted infections. NCC includes representatives from NGOs and private companies. Topics deliberated by NCC have included the implementation of the national HIV programme; the implementation of the UNODC HIV project; ARV prices and distribution; health care of PLHIV, including in prisons; linkages between HIV infection and TB; and the role of general practitioners in the health care of the HIV-infected person. A critical report (International Treatment Preparedness Coalition, 2010) produced by NGOs entitled 'Missing the Target' was also discussed by NCC.

There has been substantial reform of institutions within the MoH. A number of agencies were closed including the Public Health Agency. New agencies were formed, including the Health Payment Centre and the Centre of Health Economics (Since 2011 Health Payment Centre and the Centre of Health Economics are combined into one service, called - National Health Service). The Latvia Infectology Centre took on a number of activities previously carried out by the Public Health

[4] I.Šmate, G.Grīsle, 2011 On the Implementation of Programme for Limiting the Spread of Human Immunodeficiency Virus (HIV) for 2009 – 2013 in 2009 and 2010

Agency including monitoring and epidemiological surveillance of infectious diseases and methodological support to health care institutions and education providers related to infectious diseases. The State Agency of TB and Lung Diseases were also brought under the supervision of the Latvia Infectology Center.

There have also been a number of other reforms of how health care is organized and funded in Latvia. These included:

- Introduction of HIV laboratory testing methods to state-funded outpatient laboratory services
- Ensuring PLHIV were provided for patients groups eligible to receive home health care
- Including all antiretroviral medicines within the list of medicines that can be reimbursed by the Health Payments Centre
- Seeking to ensure better detection and treatment of HIV/TB co-infection

Following the assessment of the situation in the health care of prison inmates and considering the financial resources allocated for the functioning of places of imprisonment and the significant decrease of this funding, the scope of work of Latvian Prison Hospital was significantly reduced in 2009. Currently the Latvian Prison Hospital provides health care only to prison inmates with communicable or psycho-neurological diseases. Thus, in 2010, when the Latvian Prison Hospital operated on a restricted scale, there was no clarity about the volume of funding that in the future would be channeled for the health care of prison inmates and the development of public health care system.

Thus, the Ministry of Justice has started negotiations with the Moh on possible improvements in the health care of prison inmates.

Despite severe budget and staff cuts due to economic crisis, harm reduction education has been introduced in more than a half of Latvian prisons. The project[5] has developed a number of training modules and information materials, and nearly 4000 people have participated in various capacity building events.

[5] Regional project "HIV/AIDS prevention and care among injecting drug users and in prison settings in Estonia, Latvia and Lithuania" (Project duration 2006-2011)

NCC has identified problems[6] that need to be solved in the coming years, for example:

- insufficient motivation of the HIV infected children's parents to take their children regularly to doctor and regularly give antiretroviral drugs;
- insufficient motivation among the injecting drug users and regular medication use;
- insufficient cooperation between gynecologists and the state agency "Infectology Centre of Latvia" for ensuring vertical prophylaxis (gynecologists, detecting HIV infection, do not refer the patient timely to the state agency "Infectology Centre of Latvia") ;
- insufficient provision and exchange of information among health care staff (imprecise entries into the medical records on the treatment that an HIV positive pregnant woman has received, frequently these pregnant women belong to social risk groups and themselves do not know what kind of treatment they have received);
- general practitioners should be trained on prescribing antiretroviral drugs;
- in general the rate of performing HIV tests is low at HIV prevention centers (31%); likewise, the survey carried out in the framework of UNODC project identifies other shortcomings as well.

Recommendations from WHO Mid-Term Evaluation of the Latvian HIV Programme 2009-2013[7]:

1 There is need for further reform of health structures;

2 There is need for more participation of NGOs in the response to HIV including in prisons;

3 There is need to refocus the national response to HIV on injecting drug users;

4 This must include ensuring continuity of services in prisons;

[6] The Commission's action plans and minutes of the meetings are kept at the state agency "Infectology Centre of Latvia", which acts as the secretariat for the Commission;

[7] Ulrich Laukamm-Josten, Pierpaolo de Colombani, Kees de Joncheere, Roger Drew, Irina Eramova, Signe Rotberga, Heino Stöver and Anna Zakowicz. *Mid-term evaluation of the Latvian National HIV Programme: 2009-2013*. 2011.

5 There is need for a clearer policy on HIV testing and counselling;

6 National ART guidelines must be brought into line with the European norm;

7 There is need to finalize guidelines on TB preventive treatment for PLHIV;

8 The opportunity should be seized for a specialist in health financing to conduct a thorough review of the health budget to ensure that funds are being allocated to the most important priorities;

9 The MoH should pursue measures to further reduce the price of ARVs.

Recommendations from ECDC Country Mission Report „Country mission HIV, STI and hepatitis B and C Latvia, 26th-30th September 2011"[8]:

1 Treatment guidelines need to be expanded in line with European standards;

2 Support for Low Threshold Services for people who inject drugs should be continued and strengthened to avoid a serious resurgence of HIV infection in this group and high risk of further transmission to the general population through sexual contact.

[8] ECDC. *Country Mission Report.* Country mission HIV, STI and hepatitis B and C Latvia, 26th-30th September 2011. *Conclusions and recommendations, p. 21.*

VI Support from the country's development partners

During 2010-2011, input into regional response to HIV/AIDS and capacity building has been made mostly by UNODC, WHO etc. However, in 2011 funding from UNODC has stopped.

NGOs play a critical role in effective response to HIV. They allow for participation of people living with HIV and populations particularly affected by the epidemic, they provide accountability mechanisms for government, provide essential services, particularly those that governments find difficult to provide e.g. for IDUs and in prisons. But there are very few NGOs and their capacity is limited.

To ensure achievement of targets, Latvia requires partner assistance in following action areas:

- Financial support to develop the behavioral surveillance and to help the country to develop a second generation surveillance system.
- More participation of NGOs in the response to HIV including in prisons. The most important means of achieving this would be by providing reliable and sustainable funding.
- Extending partnership between governmental and non-governmental organizations.

VII Monitoring and evaluation environment

Monitoring and evaluation in Latvia includes a data collection strategy (epidemiological surveillance of HIV, behavioral surveys and routine programme implementation monitoring) and more than 50 indicators, but doesn't include a data analysis strategy, data dissemination and use strategy and guidelines on tools for data collection currently. The competent authority for the surveillance of the Programme outcomes and impact assessment is the MoH, but sectoral ministries, local governments and NGOs are involved in implementation of the Programme tasks, but the responsible entity to collect data and information in accordance with the Programme is the HIV/AIDS Surveillance and Prevention Department of ICL.

As an integral part of the collaborative agreement between the Government of the Republic of Latvia and the World Health Organization to support the scaling up the response to HIV in Latvia, external experts have done a mid-term evaluation of the Programme in 2011. According to the mid-term evaluation, there is need for improvement of this monitoring and evaluation system, because there are currently too many (50+) indicators, but some key indicators are missing. Some indicators are difficult to interpret, or they are unclear or ambiguous, so there is a pressing need to review and revise the indicators and targets being used to track the Programme. The limited focus on quality assurance in the delivery of a variety of services is of concern.

The capacity for monitoring, evaluation and quality assurance needs to be rapidly developed, because there is no national Monitoring and Evaluation Unit in Latvia. Relevant training and technical support is needed. NGOs have to significantly increase their capacity to monitor the implementation of services that they provide.

The results of the monitoring and evaluation of the HIV situation is used for programme improvement, for resource allocation and revising the national HIV response.