UNGASS COUNTRY PROGRESS REPORT LATVIA

Reporting period: January 2008 – December 2009

Submission date: March 31, 2010

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I. ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Treatment
BBS	Bio-Behavioural Survey
CoM	Cabinet of Ministers
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" (2006 – 2009)
EU	European Union
GP	General Practitioner
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human Immunodeficiency Virus
ICL	Infectology Centre of Latvia
IDUs	Injecting Drug Users
LTC	Low Threshold Centres for Affected Population Groups
M&E	Monitoring and Evaluation
MDR-TB	Multidrug-resistant tuberculosis
MoD	Ministry of Defence
MoES	Ministry of Education and Science
MoF	Ministry of Finances
MoH	Ministry of Health
MoIA	Ministry of Internal Affairs
MoJ	Ministry of Justice
MoW	Ministry of Welfare

MSM	Men who have Sex with Men
NCC	National Coordination Committee for HIV, TB and STI prevention
NGO	Nongovernmental Organization
OST	Opioid Substitution Treatment
PLWHA	People Living with HIV/AIDS
Program (2009 – 2013)	The Program for limiting spread of HIV/AIDS in Latvia for period 2009 - 2013
RCPDA	Riga Centre of Psychiatry and Addiction Disorders
RDS	Respondent Driven Sampling
Report	Country Progress Report 2008 - 2009
TB	Tuberculosis
TLDSA	Tuberculosis and Lung Diseases State Agency
UK	United Kingdom
UNGASS	United Nations General Assembly Special Session
VCT	Voluntary Counselling and Testing

II. STATUS AT GLANCE

Latvia's HIV epidemic is spreading largely through injecting drug use so far. Some sexual spread is occurring between IDUs and their sex partners, and also affecting other highly vulnerable and bridging population groups (prisoners, MSM, CSW).

There is no evidence of a generalized sexual epidemic nor is it likely that such an epidemic will occur. Providing effective prevention, care and treatment services, focused on IDUs and their sex partners will be a central issue to control the spread of HIV/AIDS in Latvia.

During 2008-2009, the new Program for limiting spread of HIV/AIDS in Latvia for period 2009-2013 was developed and adopted with a government order No.437, June 30, 2009.

The National Coordination Committee for HIV, TB and STI prevention (NCC) under MoH assumes responsibilities of advisory body for government for the implementation and coordination of the national response to HIV/AIDS epidemic.

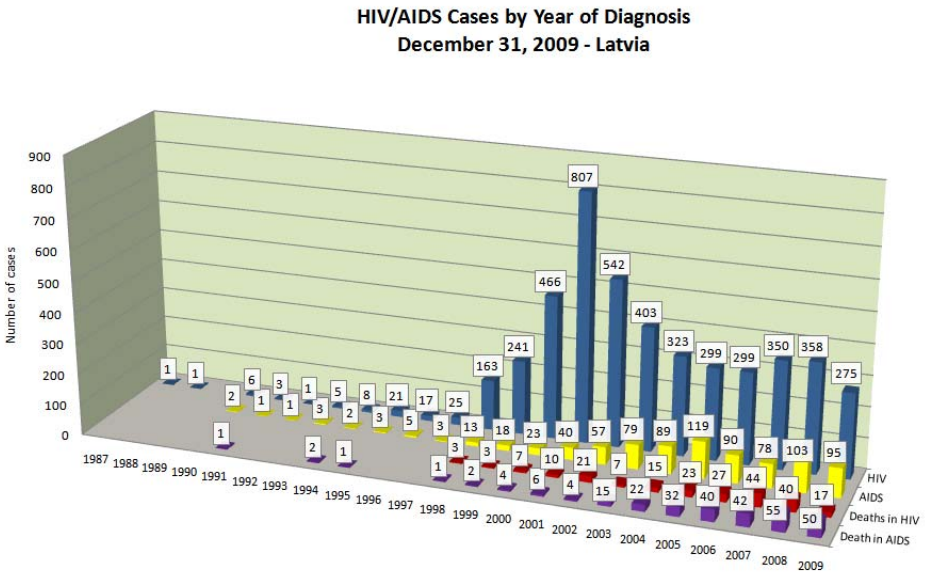
NCC overseen and facilitated the preparatory process, data collection, involvement of stakeholders, and endorses the final Country Progress Report prior to submission to UNAIDS. The set of the national level core indicators have been selected (Table 1).

The AIDS and STI Prevention Centre within the State Agency "The Public Health Agency" under the MoH, and after reorganization (from September 2009) the AIDS Program Department of the Infectology Centre of Latvia (ICL) 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, MoW, MoD), NGOs and PLWHA were involved in the preparation process of the report.

HIV and AIDS rates in Latvia are among the highest in the EU (ECDC, WHO, 2009); HIV infection rate in Latvia in 2008 was nearly three times higher as that in the EU: 157.6 per million population as compared to 60.6 per million in the EU. At the end of 2009 cumulative 4614 HIV cases (4339 as of December 31, 2008) had been registered in the country, of these 824 (729 as of December 31, 2008) were AIDS cases.

The most recent data (2009) shows the lowest number (275) of new HIV registered cases per year since 2001. (Figure 1)

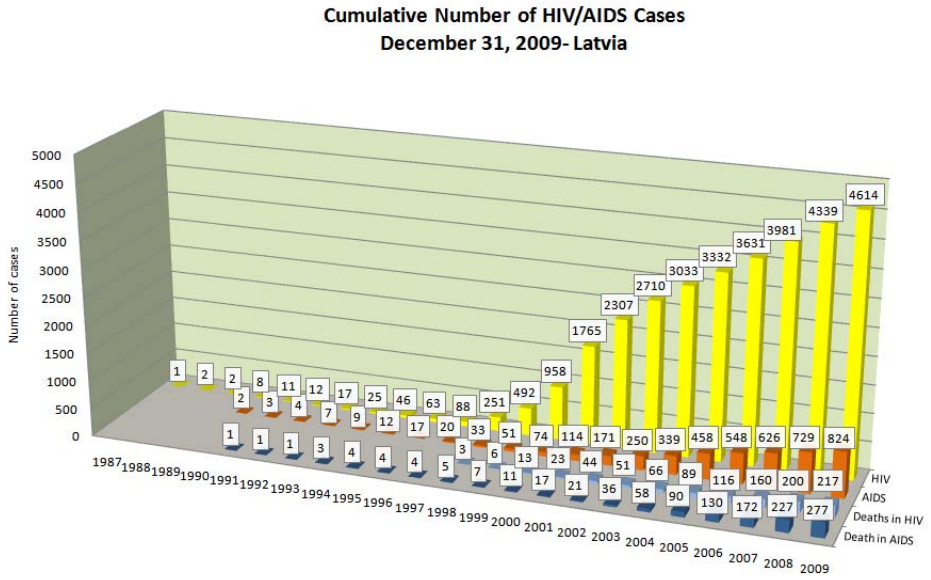
Figure 1. HIV/AIDS Cases by Year of Diagnosis (December 31, 2009)



Source: ICL

The number of new HIV cases registered annually, while declines or remains stable during the last years, further increases the size (8-9% annually) of affected population. (Figure 2)

Figure 2. Cumulative Number of HIV/AIDS Cases (December 31, 2009)



Source: ICL

Table 1: The National level core indicators

No.	UNGASS indicators	2007	2009
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	Reported	Reported

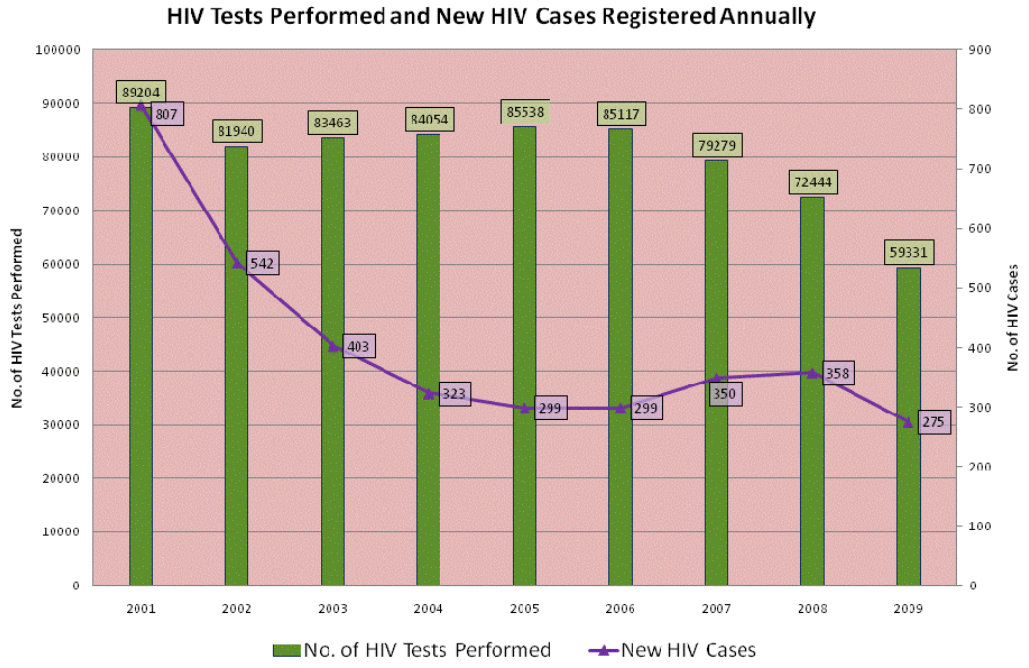
4.	Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	Not reported N/A	Not reported N/A
5.	Percentage of HIV – positive pregnant women who received antiretroviral drugs to reduce the risk of mother – to – child transmission	Not reported N/A	Reported
6.	Percentage estimated HIV – positive incident TB cases that received treatment for TB and HIV	Reported 2005 data	Reported
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 reported N/A	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	Reported	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 N/R	Not reported 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	Not reported N/A
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	Reported	Not reported N/A
16.	Percentage of women and men aged 15 – 49 who have had sexual intercourse with more than one partner in the last 12	Not reported	Not reported

	months	N/A	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	Not reported N/A	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	Reported
20.	Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	Reported	Not reported N/A
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 known to be on treatment 12 months after initiation of antiretroviral therapy	Not reported N/A	Not reported N/A
25.	Percentage of infants born to HIV-infected mothers who are infected	Not reported N/A	Not reported N/A

III. OVERVIEW OF THE HIV/AIDS EPIDEMIC

The monitoring of HIV/AIDS in Latvia is the responsibility of the ICL under the MoH. The key surveillance instrument for monitoring of the HIV epidemic in Latvia is HIV case reporting that is completely adapted to meet all requirements of ECDC and WHO/Euro surveillance program. The number of HIV tests performed annually for diagnostic purposes is 80,000 tests on average (approximately 300 per 10^4 population) (Figure 3)

Figure 3. HIV tests performed and new HIV cases registered annually



Source: ICL

VCT is now widely available at a range of health facilities. It is mandatory for health staff to offer HIV test to all TB patients, pregnant women, persons from high risk groups (IDUs, CSW), STI patients, and prisoners at entry to prison system. Consequently HIV case reporting provides useful information to monitor the major trends of HIV epidemic in Latvia over time.

Current status. From January 1, 1987 to December 31, 2009 a cumulative total of 4614 (204 per 100.000 population) HIV infections were registered in Latvia (population 2.3 million[1]), of these 824 have developed AIDS and 494 have died. However, the actual number of HIV-infected people may be higher than this. For

[1] http://www.csb.lv/csp/content/?cat=2269

example, international agencies estimated that there were 10.000 people living with HIV in Latvia at the end of 2007 according to UNAIDS[2].

Latvia so far belongs to the countries in EU where HIV infection rates are high. With 157.6 cases per million populations in 2008, Latvia has doubled the EU average rate but remains below Estonia. The major HIV increase in Latvia was observed during 2001. Since the numbers declined and stabilized during 2005-2009. (Table 2)

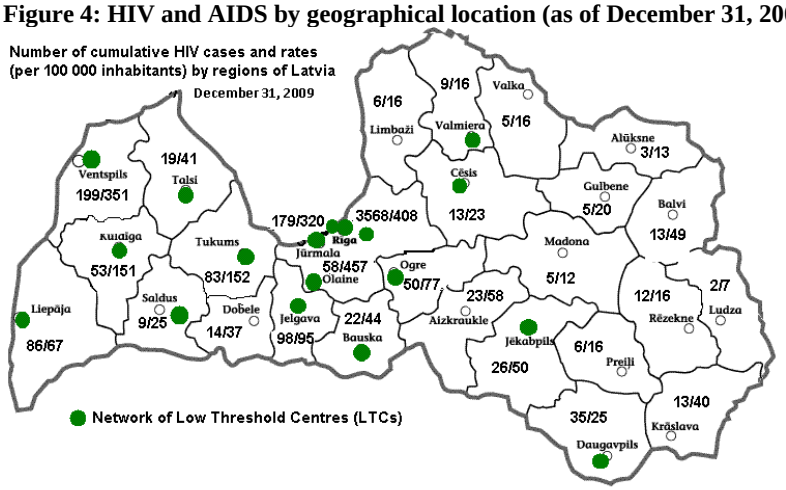
Table 2: HIV/AIDS statistics 2005-2009

Indicator	2005	2006	2007	2008	2009
Number of new HIV cases per 100.000 population	13.0	13.1	15.4	15,8	12,2
Absolute number of HIV cases	299	299	350	358	275
New AIDS cases per 100.000 population	5.2	3.9	3.4	4.5	4.2
Absolute number of AIDS cases	119	90	78	103	95
AIDS related deaths per 100.000 population	1.4	1.7	1.8	2.4	2.2
Absolute number of AIDS related deaths	32	40	42	55	50

Source: ICL

HIV infections are distributed unevenly through the regions of Latvia. Riga, the capital and the largest city in Latvia, and its surroundings (873.447 inhabitants at the beginning of 2009[3]) appeared to be a central scene of HIV spread and drug use. Riga and the region show the highest HIV prevalence figures (408 cases per 100.000 residents), while Ludza, Aluksne and Madona regions have the lowest figures (Figure 4).

Figure 4: HIV and AIDS by geographical location (as of December 31, 2009)



[2] 2008 Report on the Global AIDS Epidemic, UNAIDS/WHO, July 2008
[3] http://www.csb.gov.lv/

Source: ICL

HIV prevalence rates. HIV prevalence surveys took place since 2001 among IDUs in capital city Riga, using LTCs services for recruiting respondents. So, mainly LTCs clients were enrolled in the status samples. Respondent driven sampling (RDS) methodology was introduced in 2007. Results of biological survey and routine VCT are presented in Table 3.

Table 3. HIV prevalence among IDUs

Year	2001	2002	2003	2005	2008
Routine VCT through LTCs	100/ 521 (19.2%)	106/ 802 (13.3%)	68/ 518 (13.2%)	68/ 669 (10.2%)	67/ 712 (9.5%)
Biological survey	36/ 261 (13.7%)	52/ 250 (21%)	45/ 205 (22%)	52/ 200 (26%)	92/ 407 (22.6%)

Source: ICL

It is evident that HIV prevalence estimated from routine VCT are decreasing since 2001 and this coincidence with decline of newly diagnosed HIV cases by case reporting. (Figure 3)

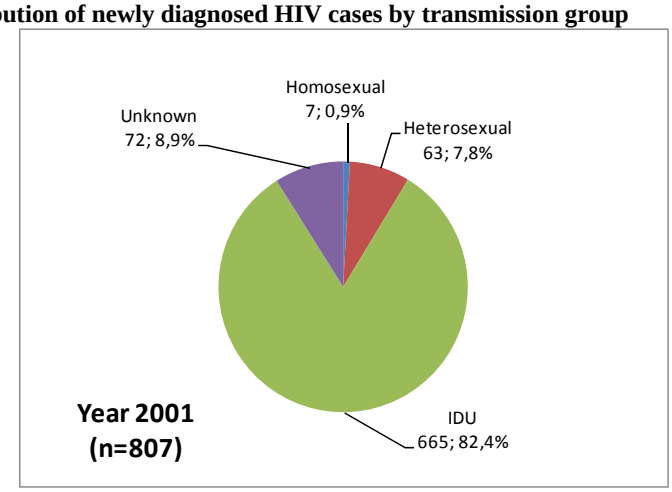
The prevalence rates estimated from special biological survey has increased and remained high and relatively stable, notwithstanding, that newly diagnosed and reported HIV cases related to IDUs have substantially declined since 2002.

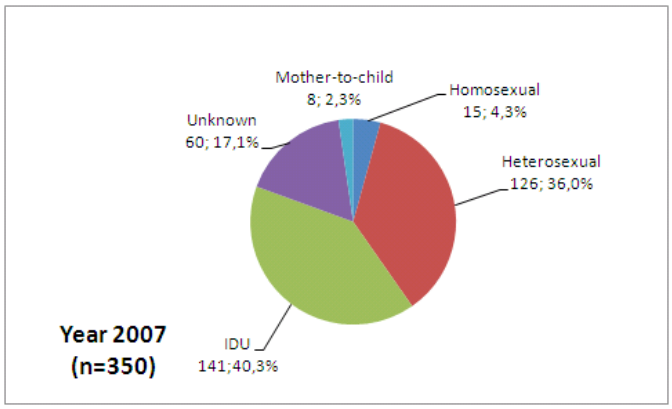
Relatively stable HIV prevalence rates since 2002 among IDUs could present evidence that concentrated epidemic has reached its “saturation phase” and prevalence rates could decrease in following years.

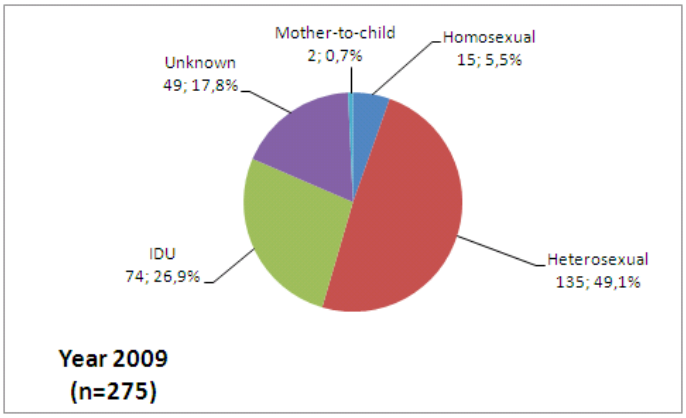
Routes of HIV transmission and affected population groups. The majority of PLWHA is male IDUs who were infected through sharing of needles and syringes. IDUs clearly dominate in the current Latvia’s epidemic and account for 58.3% of all registered cases, heterosexual transmission – 21.1%, homosexual transmission 4.4 %, mother-to-child transmission – 0.8%, and unidentified transmission 15.5%.

Since 2001 the number of newly diagnosed HIV cases among IDUs and the proportion of IDUs among new cases have decreased gradually. In 2001 there were 665 cases registered as a result of IDU (82%), in 2005 – 114 cases (38%), in 2007 – 141 cases (40%), and in 2009 - 74 cases (27%). (Figure 5)

Figure 5: Distribution of newly diagnosed HIV cases by transmission group

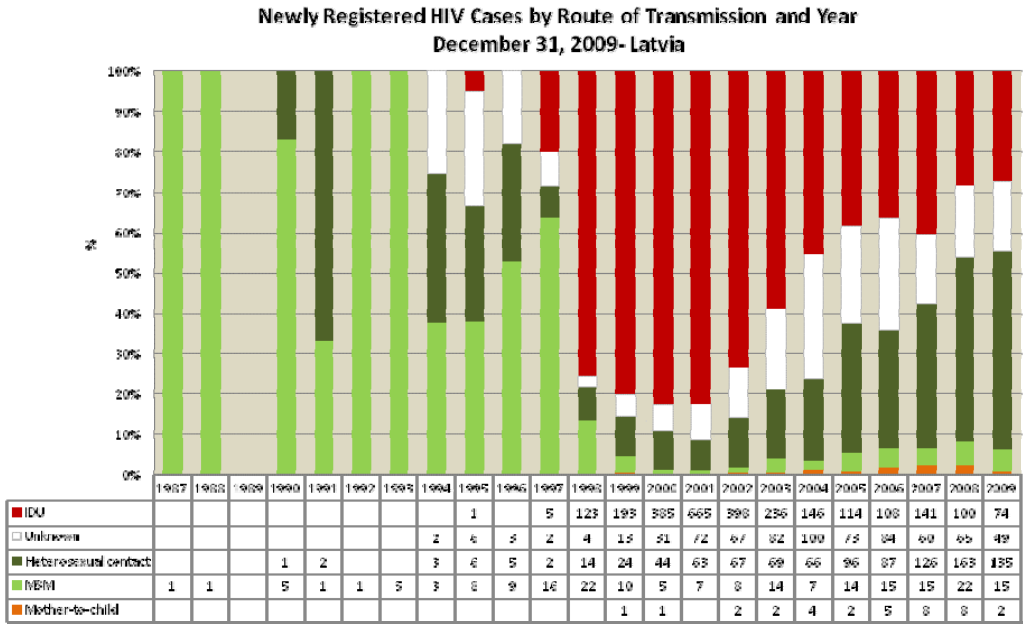






Source: ICL

Figure 6: Newly diagnosed HIV cases by route of transmission and year



	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
IDU									1		5	123	193	385	665	898	236	146	114	108	141	100	74
Unknown								2	6	5	2	4	15	51	72	67	82	100	75	84	60	65	49
Heterosexual contact				1	2			3	6	5	2	14	24	44	63	67	69	66	96	87	126	163	135
MSM	1	1		5	1	1	3	3	8	9	16	22	10	5	7	8	14	7	14	15	15	22	15
Mother-to-child													1	1		2	2	4	2	5	8	8	2

Source: ICL

While in Latvia transmission through injecting drug use is the prevailing route for HIV spread, it has been declining, and heterosexual transmission increasing slightly. It seems likely that so far most of the heterosexual spread is affecting "bridging groups" – sex partners of IDUs, sex workers and clients – rather than the general population.

However, the epidemiological data presented in Figures 5 and 6 reflects only general trends and requires future analysis, before conclusions are drown. Therefore, in-depth studies such as BBS among risk groups are necessary.

These studies help to establish and follow real HIV infection prevalence among groups-at-risk as well as link the infection rates with behavioural factor. This information is important to plan and undertake issue focused interventions among groups-at-risk as well.

Some growth in homosexual transmission observed 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 2001 increased from around 0.9% to above 5.5% in 2007-2009. Latvia needs to pay timely attention to this group. However, most behavioural issues related to MSMs, the size and geographic distribution isn't known.

As of December 31, 2009 totally 314 HIV cases have been registered among pregnant women (22.9% of all female cases) and there were 35 HIV infected children born to HIV infected mother in Latvia. (Table 4)

Table 4. HIV cases among pregnant women and mother-to-child transmission

Year	Number of HIV-positive women	Number of HIV-positive pregnant women	Number of confirmed vertical transmissions of HIV infection
1994	**1**	**1**	**0**
1995	**2**	**0**	**0**
1996	**3**	**1**	**0**
1997	**0**	**0**	**0**
1998	**39**	**5**	**0**
1999	**63**	**5**	**1**
2000	**112**	**15**	**1**
2001	**180**	**27**	**0**
2002	**163**	**32**	**2**
2003	**132**	**32**	**2**
2004	**115**	**43**	**4**
2005	**105**	**31**	**2**
2006	**113**	**31**	**5**
2007	**118**	**32**	**8**
2008	**124**	**32**	**8**
2009	**104**	**27**	**2**
Total	**1374**	**314**	**35**

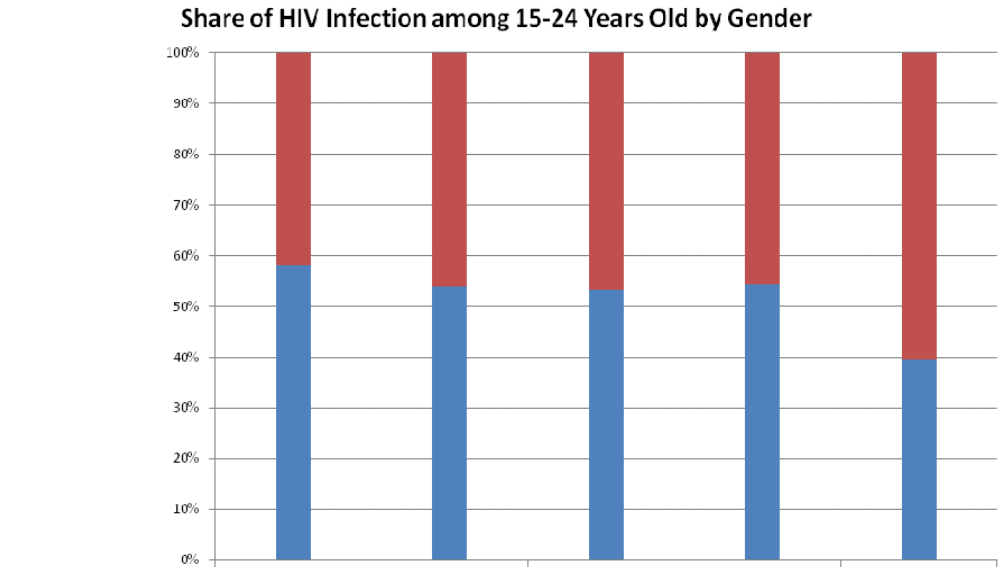
Source: ICL

On average four cases of vertical HIV transmission is reported in Latvia every year, which amounts to 20 cases per 100.000 newborns. In addition, annually about 30 HIV positive pregnant women are detected. Out of all HIV cases among pregnant women 60% are reported due to sexual transmission and in 22% cases has a history of drug injecting. HIV cases among pregnant women in Latvia are mostly found among mothers that avoided adequate prenatal care.

Over the last years the numbers and proportion of “unknown route of transmission” for newly diagnosed HIV cases increased and reached 17-18% in 2007-2009 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.

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 moving into female population, and in 2009 females contributed 60% of cases found among people 15-24 years, while in 2001 this group only accounted for 24% of HIV positive cases (Figure 7). Similar trend is seen among people older than 25 years (Figure 8).

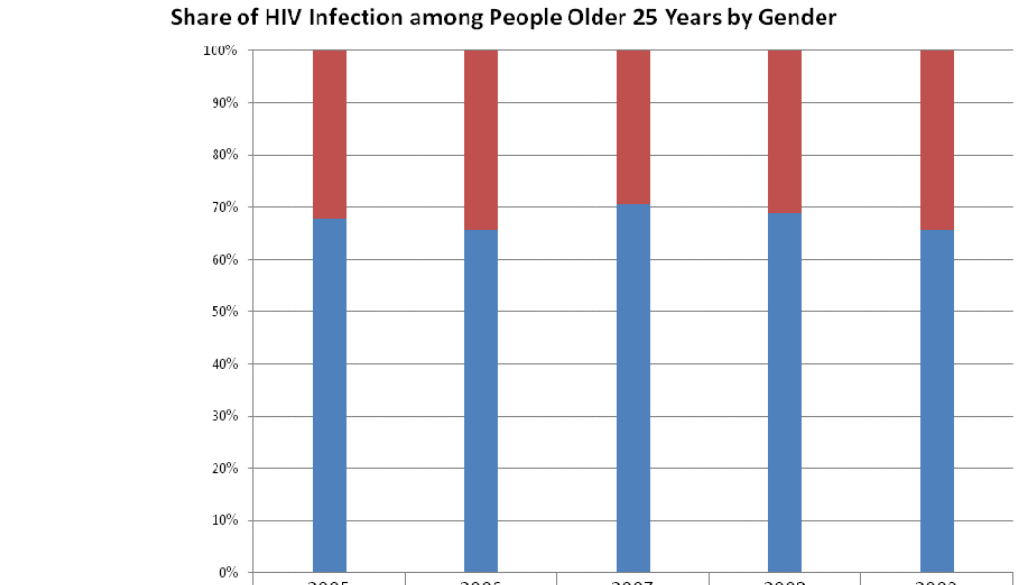
Figure 7: Share of HIV infection among 15-24 years old by gender



	2005	2006	2007	2008	2009
Female 15-24 years old	42	46	47	46	60
Male 15-24 years old	58	54	53	54	40

Source: ICL

Figure 8: Share of HIV infection among people older than 25 by gender



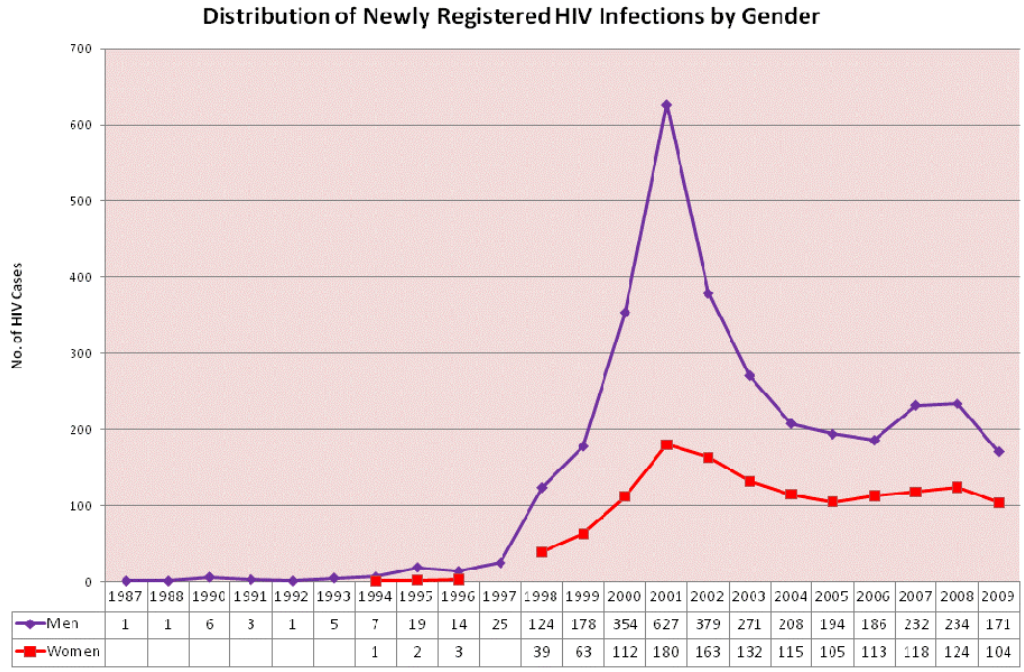
	2005	2006	2007	2008	2009
Female Older than 25 years	32	34	30	31	34
Male Older than 25 years	68	66	70	69	66

Source: ICL

Generally, since peak in 2001 the number of new HIV infections detected among men each year has declined, whereas the number of new infections detected among women

each year has remained more or less static (Figure 9). This pattern is typical of a concentrated epidemic related primarily to injecting drug use.

Figure 9: Distribution of newly registered HIV infections by gender

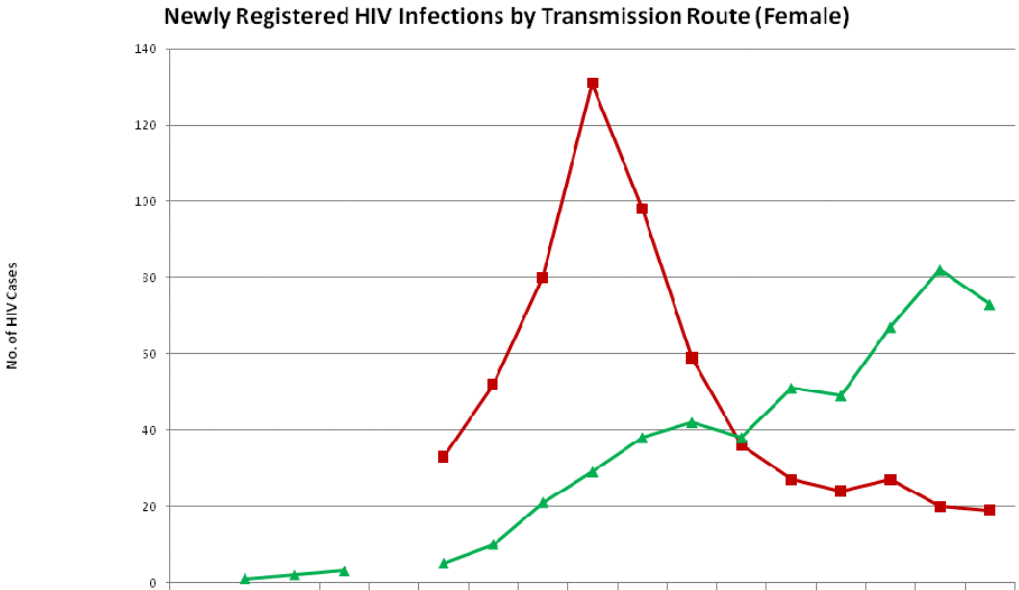


	1987	1988	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Men	1	1	6	3	1	5	7	19	14	25	124	178	354	627	379	271	208	194	186	232	234	171
Women							1	2	3		39	63	112	180	163	132	115	105	113	118	124	104

Source: ICL

Men become infected as a result of injecting drug use and an equal number of women are infected as a result of sex with these men (Figure 10). However, this does not signify that the epidemic is becoming generalized or that its fundamental nature is changing. Rather, it is the natural course of such an epidemic. It would be more accurate to describe the route of transmission for these women as sex with an IDUs rather than just heterosexual transmission.

Figure 10: Newly registered HIV infections by transmission route (female)

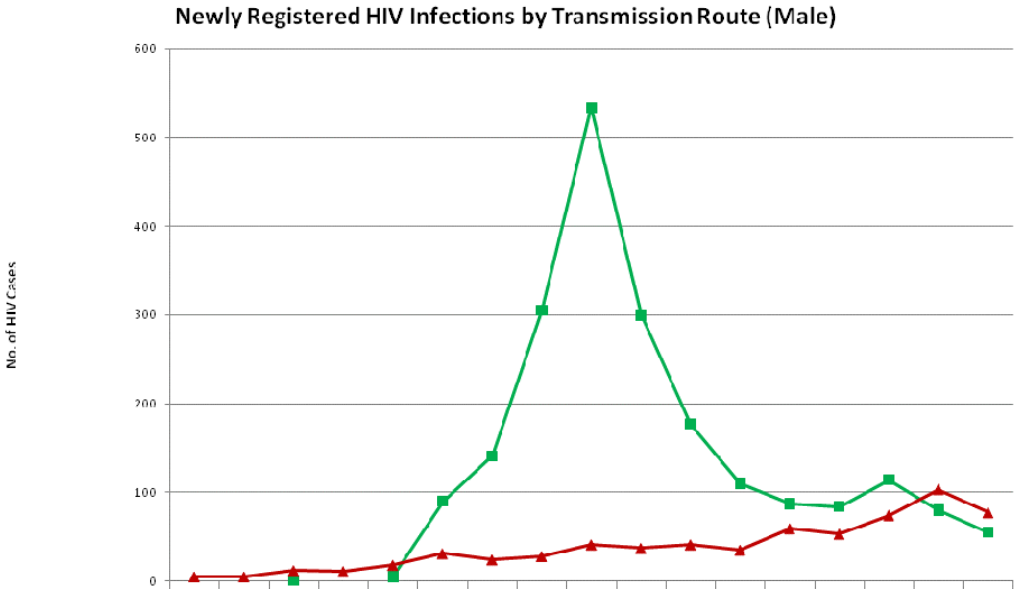


	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Injecting drug use						33	52	80	131	98	59	36	27	24	27	20	19
Sexual contact		1	2	3		5	10	21	29	38	42	38	51	49	67	82	73

Source: ICL

A complexity of the HIV epidemic in Latvia is that, although the epidemic is primarily affecting male IDUs and their female sex partners, there have also been a significant number of women infected through injecting drug use (see Figure 10), and some men have been infected as a result of sex with female IDUs (Figure 11). Again, these infections would more accurately be categorized as sex with IDU partners and not just as heterosexual transmission.

Figure 11: Newly registered HIV infections by transmission route (male)



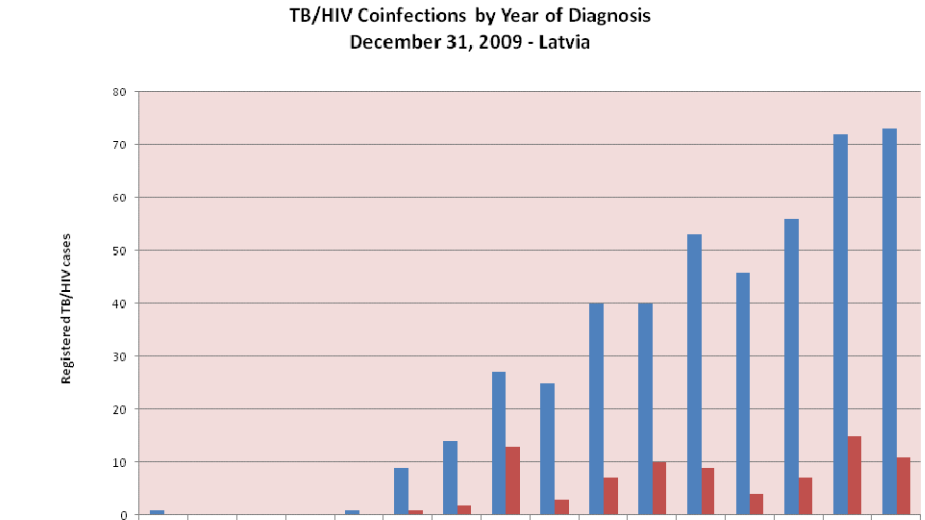
	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Injecting drug use			1		5	90	141	305	534	300	177	110	87	84	114	80	55
Sexual contact	5	5	12	11	18	31	24	28	41	37	41	35	59	53	74	103	77

Source: ICL

A truly independent, sexually-transmitted HIV epidemic would go beyond women infected by sex with male IDUs. The first sign of such an independent transmission cycle would be more and more men becoming infected with HIV without any evidence of other high risk such as reported sex with a female IDU or infection with hepatitis C or B. There is currently no such evidence of generalization of the epidemic, e.g. men becoming infected, who have not injected drugs and have not had sex with a female IDU or with men.

HIV confections (TB, HCV, HBV, STIs). Latvia has experienced an increase of TB morbidity together with the appearance of drug resistant and MDR-TB since 1991. In 1991, the incidence of TB was 291/ 100 000, in 1998- 74/ 100 000, and 37/ 100 000 in 2009. Since the first patient was registered with TB/HIV co-infection in 1994, the number of patients diagnosed with both infections continues to increase. (Figure 12)

Figure 12: TB/HIV coinfections by year of diagnosis (December 31, 2009



	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
No. of TB/HIV cases	1	0	0	0	1	9	14	27	25	40	40	53	46	56	72	73
Including MDR-TB						1	2	13	3	7	10	9	4	7	15	11

Source: ICL

8% IDUs in Riga reported ever having TB[4]. The prevalence of latent TB was 23%. People who have TB infection without HIV coinfection have a 5-10% lifetime risk of developing TB disease, whereas in PLWHA there is 5-10% annual risk of developing TB disease.

Hepatitis, particularly HCV infection, are quite common in population of IDUs and are transmitted through sharing of injection equipment and unprotected sex. ENCAP survey results in Riga indicated that 31% of IDUs had shared syringes and needles in last four weeks. IDUs are sexually active: 42% of them had several partners in last six months. Sexual risk behaviour (not using condoms and sharing syringes with sexual partners) is common. Sexual partners of IDUs are the bridging population of infections to the general population.

Prevalence of HIV, HCV and syphilis infections among IDUs and their sexual partners indicates risk of further spread among IDUs and their sexual partners. (Table 5)

Table 5. Serosurvey results for IDUs and their sexual partners: prevalence of HBV, HCV, HIV and syphilis infections markers

Group	Sample size	Infection markers prevalence			
		Anti-HBV-core	Anti-HCV*	Anti-HIV	Syphilis
IDUs	407	227 (55.7%)	302 (74.2%)	92 (22.6%)	18 (4.4%)
Sexual partners	64	17 (26.5%)	14 (21.8%)	8 (12.5%)	0

[4] Study report „Prevalence of HIV and other infections and risk behaviour among injecting drug users in Latvia, Lithuania and Estonia", ENCAP, 2009.
http://ec.europa.eu/eahc/documents/projects/highlights/BalticHIV.pdf

*Sample size: n=406

Source: ICL

Notwithstanding the relative stabilization of HIV prevalence among IDUs in Latvia, there exist associated risk for future spread of HIV and other blood-borne infections by sexual transmission to the sexual partners of IDUs and to the wider population.

Healthcare systems must consider the increasing need for HIV and hepatitis treatment and care, and prepare for the possible TB epidemic among IDUs, especially among HIV infected ones.

IV. NATIONAL RESPONSE TO THE AIDS EPIDEMIC

Since 1993 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 and in close collaboration with and the assistance of UN agencies (UNDP, WHO, WB, UNICEF, UNODC).

The national HIV/AIDS policy is based on the national Public Health Strategy and four consecutive national programs to limit spread of HIV/AIDS in Latvia. During the period January 2008 – December 2009 Latvia implemented interventions according Interim Plan (2008) after the previous (3rd) Program (2003-2007) has expired in 2007. The new Program covering period 2009-2013 has been developed, agreed and formally adopted by Government in May, 2009.[5] The Program (2009-2013) 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 (2009-2013) 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 (2009-2013):

- Reduce new HIV cases among main groups-at-risk (IDU, prisoners) through targeted HIV prevention activities and through promoting changes in HIV risk related behaviour;
- 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.

Measures to reorganize MoH structures have been taken in 2009 to avoid duplication of functions, ensure more effective coordination, rationale planning and use of funding.

Before these structural changes, as a result of the historical development, HIV treatment, TB treatment and treatment of drug addiction were all handled by different providers. For example, PLWHA needs to attend TB clinic (TLDSA) for investigation and treatment of TB. This cannot be handled at the ICL. Taking into account Latvia's rapidly increasing rates of TB/ HIV co-infection, and high recorded rates of MDR-TB the developing of mutually integrated HIV and TB surveillance, prevention and treatment strategy was a key priority.

- In accordance with CoM orders, ICL took over the functions of reorganized Public Health Agency (PHA)[6] for HIV, STI surveillance, monitoring,

[5] State Decree Nr 43, adopted by CoM on 30 June 2009
[6] State Decree Nr 412, adopted by CoM on 19 June 2009

reporting and methodological leadership on HIV/ STI prevention. AIDS Program Department within ICL is responsible for these issues. Previous TLDSA was integrated in the structure of ICL[7]. Currently ICL is responsible for HIV and TB case management and provides services:

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

The ICL also participates in clinical trials in the area of HIV/AIDS treatment. Diagnosis and treatment of hepatitis is available in the centre although there are cost-sharing mechanisms which limit uptake of the services. Patients with hepatitis B or C are not routinely offered HIV testing. ICL has established collaborative mechanism with penitentiary system to provide ART for those.

One of the most notable successes of the national HIV/AIDS response in Latvia is the introduction of harm reduction programs for IDUs. Evidence from other countries shows that HIV transmission through injecting drug use can be controlled by effective harm reduction interventions. These measures not only protect those who inject drugs but also the entire population. The reduced number of men infected annually through injecting drug use, since the peak in 2001 and stabilization of prevalence rates are evidence that these measures are beginning to have a positive effect in Latvia.

Since 1998 the injecting drug use is a driving force for concentrated HIV epidemic among IDUs in Latvia. A pilot needle-exchange program was opened by the AIDS Prevention Centre (a former state's institution under MoH) in Riga at the end of 1997 as an early response to the emerging HIV outbreak among IDUs. This project was aimed at establishing a primary contact with the hidden IDUs population and interrupting chains of new infections at their start. In the next stage of the project (1999) street outreach activities were introduced. Previous drug users (ex-users), familiar with the natural environment of IDUs, were employed as street workers. The street work proved to be particularly efficient and the capacity of the program increased manifold. The program expanded its operation beyond the initially expected syringe and needle exchange and was transformed into LTCs offering low-threshold services for IDUs.

[7] State Decree Nr 562, adopted by CoM on 17 August, 2009

Since 1999, injecting drug use and HIV infection started to spread in other localities of Latvia, where no secondary HIV prevention programs have been set due to a lack of capacity and resources. The implementation of the project "Development of the Network of Outreach/ Counselling Centres (OCCs) for Intravenous Drug Users" (2002-2004) by assistance of UNDP and Norway government has bridged the gap. During 2002-2003 LTCs for IDUs were established in 10 selected municipalities more affected by drug use and HIV infection.

By the end 2009 the network of 18 LTCs is operational in capital city area (3) and other local municipalities (15). (Figure 4)

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. State realizes management and methodological leadership, ensuring skills, capacity building for LTCs staff, and supplies these centres with injecting equipment, disinfectants, information materials and HIV tests procured by the state. LTCs provide diversified low-threshold services in combinations aimed to meet the different needs of their target audience: needle exchange, outreach, VCT, disinfectants, group and individual risk reduction information, education, counselling. LTCs are successful in motivating their clients to enter treatment (OST, ART) programs. These measures will also contribute to a reduction in sexual transmission of HIV and other STIs particularly if combined with elements of "positive prevention" and partner management of HIV positive IDUs both male and female.

Previous experience to implement and manage HIV prevention programs for IDUs on the country level allowed to extend project activities to neighbouring countries (Lithuania, Estonia, Finland and Bulgaria) forming a comprehensive and expanding transnational network. On July 1st, 2006, a new EC financed project ENCAP with participation of Latvia, Lithuania, Estonia, Finland and Bulgaria started. The project leader was AIDS Prevention Centre (Latvia).

The project aims to prevent transmission of HIV and other infections (hepatitis B, C, STIs and tuberculosis) among IDUs and bridging population, ant 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) were implemented, all stakeholders involved had possibility to exchange the best practices, to learn and raise their capacities. Implementations of project activities were joint and solemn responsibility of all project partners and were divide accordingly. ENCAP partners have led certain work packages according to their professional strength and experience. For example, Lithuania (AIDS Centre) led public relation work package, Estonia (National Health Development Institute) led research activities, and Finland (National Public Health Institute) provided trainings. Latvia's (AIDS Prevention Centre) responsibility was 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 LTCs standards.

During the implementation of this project innovative approaches have been introduced. The large scale nationally representative surveys have been conducted in three Baltic states during 2007-2008 to estimate the prevalence of HIV and risk factors related to HIV infection among IDUs in the capital cities – Riga (Latvia), Tallinn (Estonia) and Vilnius (Lithuania) using standardized methods. The results served as data sources for the core national- level indicators.

The Integrated BBS "Study of the prevalence of HIV and other infections and risk behaviour among injecting drug users in Latvia, Lithuania and Estonia" was a cross-sectional survey of active IDUs (those who have injected over the preceding two months) from non-treatment settings (LTCs). Participants for the study have been recruited by RDS methodology[8].

[8] http://ec.europa.eu/eahc/documents/projects/highlights/BalticHIV.pdf

V. MAJOR CHALLENGES AND ACTIONS NEEDED

The impact of the recession on Latvia's economic is characterised by a decline in gross domestic product (GDP), week entrepreneurship and strict fiscal policy. One economic sector that has been particularly affected by cuts in budget spending is the health sector. According to an agreement with the social partners, the financing of healthcare in 2009 has decreased by 21% in comparison with 2008.[9]

Limited, inadequate funding available for the implementation of the Program (2009-2013). In line with the health budget cuts, the overall funding of prevention and treatment for HIV/AIDS has been reduced. For example, the health care budget allocations to ICL for ARV drugs and ART monitoring have been reduced in 2009 as compared to 2008 by 26% and 17% respectfully. So the state budget allocated for the treatment covers approximately 50% of all those who need ART.

The estimated Program (2009-2013) budget for 2009 is around 2.2 million LVL (3.1 million EUR). Of this, more than half (57%) is allocated to ARV drugs and treatment monitoring. Just over a quarter (27%) is allocated to treatment and rehabilitation of IDUs. Consequently, other important preventative and related services are allocated a relatively low share of the total budget. Some activities receive no funding in 2009 from the state budget, including various trainings for professionals, awareness raising activities, the development of different guidelines, funds to promote NGO involvement.

Most (85%) of the HIV/AIDS funding from the state budget is allocated to MoH. The Program (2009-2013) services areas financed in 2009 by the state's health budget include ARV and hospital treatment for PLWHA (2553.733 LVL / 3633.655 EUR), surveillance and some specific prevention activities (43.027 LVL / 61.222 EUR). 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. Moreover, 16 municipalities provide additional funds from municipal budget willingly for operation of LTCs network, e.g., in 2008 in the amount of 150.000 LVL (213.000 EURO). So the serious threat for the LTCs network sustainability exists while lines of responsibility between central government and municipalities over funds are unclear and unregulated.

Although the implementation of the Program (2009-2013) 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 well as a reduction in funding, the health sector is also undergoing significant reorganization, with large scale job losses, reduced services and the merging of institutions. On 29 July, the Regulation of the Cabinet of Ministers on the

[9] www.eurofound.europa.eu/eiro/2009/08/articles/lv0908019i.htm

reorganisation of state administration institutions subordinated to the MoH was issued.[10]

The reforms in the health care sector have been introduced to lower costs. As the result of the structural changes that was implemented since September 2009, the number of employees in the MoH and its institutions has decreased by 43% (from 1.375 to 603).

It is estimated that this cost-cutting measure will result in a saving of LVL 88.000 (about EURO 125.214 as at October 12, 2009) in 2009 and of LVL 596.000 (EURO 848.037) in 2010. Nevertheless, experts argue that the efficiencies produced by reduced administrative costs are low, and that additional financing will be necessary for the provision of healthcare services. Moreover, experts have accused the state of incompetence, lost of capacity and of adopting a linear spending cuts policy.

So under the regulation[11], the Public Health Agency was to undergo complete reorganisation by September 1, 2009. Its' unit AIDS and STI Prevention Centre (12 employees), responsible for monitoring and surveillance of epidemic and methodological leadership on HIV prevention issues was integrated within ICL as AIDS Program Department (5 employees). A linear spending cuts and insufficient, inadequate funding for prevention activities may substantially affect the further development and long-term outcomes of response to HIV/AIDS epidemic in Latvia.

Limited involvement of NGOs particularly in service provision for key vulnerable populations (IDUs, MSM, CSW, prisoners). In principle, the importance of involving NGOs in effective national response to HIV/AIDS is recognized in Latvia. However, there may not be consensus on precise roles for NGOs or the reasons why NGOs are best-placed to perform those roles. Suggested roles for NGOs include low threshold centres, needle exchange services, counselling and ART adherence support. NGOs may be better able to provide these services than government because they are more trusted by service users.

The civil society and NGOs participation in the national HIV/AIDS response is limited in particular areas of service provision to vulnerable population groups (IDUs, MSM, CSW, prisoners) mainly due to lack of resources. 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. Consequently targeted prevention measures for MSM and CSW were missed in Program (2009-2013).

Mechanisms for challenging government funds to NGOs are not developed. As a result, funding flows to NGOs are unpredictable and this hampers their organizational development. NGOs are funded mainly on a project basis with funding mainly from international donors. NGOs need to be financially supported from state and local budget. Thus, finding ways to finance and involve civil society in the national AIDS response becomes important under the Program (2009-2013).

Weakness of prison health system. HIV and other infections (TB, STIs, and HCV, HBV) is significant problem in Latvian prisons. There are about 7000 people in 12 prisons. 1155 cases or 25% of all newly diagnosed HIV cases (N=4614) are being reported from prisons by December 31, 2009. This rate may be due to the large scale

[10] State Decree Nr 509, adopted by CoM on 29 July 2009
[11] State Decree Nr 509, adopted by CoM on 29 July 2009

testing being performed for this population, since HIV test is routinely offered to all people entering the prison system. However, it is still unclear whether the HIV infection had been contracted before or during detention and imprisonment. HIV prevalence among all prisoners is about 6.6%.

Based on data from MoH for 2008-2009, it appears that there are a total of 400-450 PLWHA in prisons. Of these 85% are men and 15% are women. Almost all (95%) of people living with HIV in prisons have a history of injecting drug use.

In principle, prisoners are entitled to free HIV/AIDS and TB treatment. However, they are requested to pay the full price for certain types of care and drugs, including treatment of opportunistic diseases. Although ART is available in prisons to those in need, it appears that very few (about 5% of PLWHA in prisons) receive this, in practice.

Reasons for relatively low uptake of ART in prisons are varied, including limited funds for ART and a lack of knowledge among HIV infected prisoners. There are also problems with availability of support services required to ART. Financial issues mean that, in 2009, HIV testing on entry into the prison system was suspended. Services for IDUs, such as the provision of methadone and/ or sterile injecting equipment, are not available in Latvian prisons. Moreover, prisoners face interruption in their methadone because of arrest and non-availability of methadone in the criminal justice system. However, a plan to begin a pilot project of OST at least in one prison is included in Program (2009-2013).

Health care services for prisoners are managed directly by the Prison Administration (MoJ), not the MoH. Reform of this system has been proposed with MoH taking responsibility for health services in prisons. However, this proposal has not been implemented so far. Such a move might save money overall, it would require additional spending by MoH and would result in that ministry becoming responsible for an area known to be problematic and challenging. Money available for health care in prisons system in 2009 has been reduced from 2008 levels because of the financial crisis, and the prisons system will no longer have enmarked funds for health.

As a result, HIV prevention activities in prisons are fragmentary but harm reduction activities (needle/ syringe exchange, OST) are not available at all. Shortage of resources and staff limits prisons health care system capacity to provide adequate level of testing, treatment and care of detainees. Latvia faces need for policy reforms to ensure health care services in prisons equal to services provided to society. One option is integration by involvement of respective institutions that receive funding from budget to deliver HIV/AIDS, TB, hepatitis, STI testing, treatment, care and prevention services in prison. 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 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.

Since 2006 UNODC is implementing in Baltic States a four-year project "HIV/AIDS prevention and care among injecting drug users and prison settings in Estonia, Latvia and Lithuania". The overall goal of the project is to assist Estonia, Latvia and Lithuania to halt and reverse the HIV/AIDS epidemics among injecting drug users and in prison settings.[12]

The need to expand ART and support services for PLWHA. Latvia has introduced highly centralized ART free of charge since 2006. Now country faces need for expanding the provision of ART to all in need. HIV treatment and care is on area of concern bearing in mind the current financial crisis in the country and the limited resources available for the health sector. This was reviewed by WHO/UNODC through the AIDS Strategy & Action Plan (ASAP) mechanism.[13]

The serious capacity constraint concerning the provision of ART in Latvia is the concentration of services in a single institution in Riga, the ICL. As a result, three quarters (75%) of those on ART live in Riga or the Riga region.

Scale up access to ART can be achieved by decentralizing treatment outside of Riga through involving infectious diseases specialists of regional medical centres, involving NGOs in the provision of adherence support and coordinating more closely with essential services for IDUs, such as the provision of OST.

The system at the moment is slowly changing towards a more decentralized approach, e.g. the treatment regimen still can be guided at the ICL, while medicines can be prescribed by the infectious diseases specialists throughout the country and available in major cities. Moreover, negotiations with GPs have started so that GPs can prescribe medicines making treatment more accessible throughout the country.

The most recent developments in the field of HIV treatment suggests that as of January, 2010 the medicines used in treatment were included in the list of compensation medicines. Within the new compensation system a price is set as negotiated with pharmaceutical companies and is generally lower (3rd lowest in EU) than that paid by tendering the medicines in previous years. The new system sets that patients are prescribed a recipe for receiving their medicines once a month in a drug store of their choice, while for the patients with good adherence a recipe can be prescribed once every three months.

As of December 31, 2009 a total of 4614 people living with HIV had been registered in Latvia. Around two thirds or 67% (3082) are registered with the ICL, of which 824 were in AIDS phase. Around two thirds or 67% of those registered with the ICL are IDUs.

ICL data on treatment suggests that 439 patients received ART, while it is estimated that between 700 and 1200 people are in need of ART, and this number is likely to

[12] http://www.unodc.org/unodc/en/baltics/index.html
[13] WHO / UNODC. Kees de Joncheere et.all "Evaluation of the access to HIV/AIDS treatment and care in Latvia", May 2009
http://www.unodc.org/documents/balticstates//Library/Other/Report_ART_Latvia.pdf

increase in the future. The state budget allocated for the treatment covers less than 50% of all who need treatment.

The review[13] revealed relatively high costs of ART in Latvia and other obstacles for access to treatment, particularly in prison settings and for IDUs. Ways need to be found to reduce the cost of ART.

The ICL Guidelines for the treatment of HIV infection promote a highly individualized approach for each patient. As a result the ICL currently uses more than 67 different ART treatment regimes. This has significant cost implications and would require revision of the national guidelines in accordance with the WHO European Region clinical protocols on HIV/AIDS Treatment and Care. More training of health professionals is required focused on consistency of practice and efficient use of resources.

Procurement systems are relatively poorly-developed. It has not been possible to maintain this unstructured provision with available financial resources and several times over the last years ART has shot interruptions. It is clear that measures need to be taken to rationalise procurement and provision of ART to ensure the optimal use of resources available for this purpose, considering potential cost benefits of more standardized treatment regimes.

Considerable savings could be achieved by greater uniformity in prescribing practice, reducing the number of different regimes offered and keeping people on first line regimes longer. However, there also needs to be reductions in price paid for ART by various mechanisms:

By simplifying and clarifying regulatory systems for ART, e.g. by ensuring that all drugs in treatment guidelines are included in the national reimbursement list;

By direct price negotiations with pharmaceutical companies based on international benchmarking.

There are specific concerns about the access of IDUs to ART in Latvia. Although the majority of those living with HIV were infected through injecting drug use, less than a third of those receiving ART have a history of injecting drug use. There is evidence of significant barriers to IDUs in receiving ART both in the community and, particularly, in prisons. These barriers include stigmatising attitudes of health staff and very limited access to OST. Two OST programs are operating in Latvia: Methadone program (financed from a state program since 1996) and Buphrenorphine program (available as a paid service since 2008). Till 2008 methadone maintenance treatment was available only in capital city Riga. Since 2009 with the support of UNODC (project “HIV/AIDS prevention and care among injecting drug users and prison settings in Estonia, Latvia and Lithuania”) the methadone program has been expanded, and at the end of 2009 operated already in three towns. In 2009 necessary arrangements were preformed to start OST service providing in more seven towns in 2010. However, as before RCPAD is responsible for prescribing of OST with methadone and training of medical doctors providing OST with methadone. Scaling-up OST by the broadening the network of service providers including regions is a substantial step towards the influence of twin epidemics of drug injecting and HIV. Notwithstanding, the collaboration between RCPAD and ICL is insufficient so far.

Consequently ART and OST are non-integrated and provided in various locations, and there is need for co-location of ART and OST.

Greater integration of government services with those provided by NGOs, e.g. on ART adherence, would be necessary. Adherence support for PLWHA in general, and IDUs in particular is very limited so far. Although NGOs provide information on ART on their websites and in information sheets, they are currently not directly involved in educating and supporting IDUs to take ART.

There is need for expanding the provision of ART to all in need by developing multiple entry points to ART through LTCs network, expanding low threshold services for hard to reach groups, building up the counselling and support capacity of these services for facilitation of a better adherence to ART.

Psychological support is important for PLWHA, particularly in relation to initiating and adhering to ART. Some psychosocial support is available to PLWHA in Latvia, particularly through support groups and consultation with psychologists. However, these services are currently limited in scale and the linkages to ART provision could be stronger. 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.

VI. MONITORING AND EVALUATION ENVIRONMENT

The development of one agreed country-level Monitoring and Evaluation (M&E) framework for Latvia is necessary to satisfy completely “Three Ones” principle, monitoring the progress of implementation of the Program (2009-2013), evaluation its impact and outcomes, uncovering the implementation weaknesses, advocating for the needed decisions at the level of ministries on corrective/ improvement measures. Latvia was missing one M&E plan within the previous Program (2003-2007) and Interim Action Plan (2008).

Indicators used in the Program (2003-2007) were process, performance and coverage indicators. There were no defined indicators for measuring the impact (prevalence) and outcome (behaviour) of both particular parts (activity and service areas) and the Program (2003-2007) as a whole.

Under the new Program (2009-2013) the agreed set of indicators according UNGASS on HIV/AIDS Monitoring and declaration of Commitment on HIV/AIDS “Guidelines on construction of core indicators, March 2009” will be used when mid-term and final evaluation of the Program (2009-2013) will take place during 2011 and 2013 respectively to identify weaknesses and success of implementation, and if necessary, adjustments will be made during mid-term of.

AIDS Program Department under ICL – the responsible entity to collect data and information in accordance with the M&E plan for Program (2009-2013) will compile proposed indicators and prepare draft reports for national and international consumption.

The NCC under the MoH is responsible for overall coordination of the Program (2009-2013) implementation. The committee will review and submit the evaluation reports to the CoM of the Republic of Latvia in 2011 and 2013.