I. STATUS AT A GLANCE

The HIV epidemic in Latvia has so far followed trends and patterns which it shares with other Eastern European countries. The introduction of easily available heroin in Latvia in 1998 coincided with a dramatic increase in the number of newly diagnosed HIV infection cases, mostly among the population of IDUs. The trend reached its peak in 2001 and, since then, has substantially decreased (Figure 1).

Figure 1.
Trends in newly diagnosed HIV infections and AIDS cases by year of reporting.
November 30, 2005

Source: State HIV/AIDS case reporting database, AIDS Prevention Centre

Sexual transmission, mostly among MSM had been the dominant mode before 1998. A very few cases were reported and HIV was stayed contained in this particular population.

Thus in an early stage in Latvia HIV epidemic showed similarities with the initial stages of the epidemic in most Northern European countries with homosexual contacts, as the major transmission route and HIV-1 subtype B was shown to dominate in this population².

The rapid increase of HIV-1 infection among IDUs in Latvia fellows similar local explosive outbreaks of infection with HIV-1 subtype A and A/B recombinant variants in the several regions of the former Soviet Union, including southern part of the Russian Federation, Ukraine, Belarus and Kaliningrad. From the molecular

1 http://www.aids.gov.lv (home page, AIDS Prevention Centre)
epidemiology studies it became clear, that the Latvian HIV-1 epidemic among IDUs was related to epidemic in the former Soviet Union countries. One lineage among the Russian HIV-1 subtype A1 variants appears to have established the outbreak in Ukraine and Latvia. It is difficult, however, to establish the direction of transfer between these countries, because there are several introductions and routes of drugs entering.

Importantly, that there are signs of spill-over and spread of dominating A1 variant from IDUs to other population groups. This indicates that possibility exists for further spread of HIV infection from high risk population groups by “bridging population” (IDUs sexual partners) into the general population.

Year 1993 was a turning point for development of the national response to the HIV/AIDS epidemic in Latvia. Riga hosted the meeting of Ministers of Health and Finance of Central and Eastern Europe countries on HIV/AIDS “Investment in Health”, April 1-2, 1993. The policy document “The Riga Initiative” has been adopted to express commitment to invest in HIV prevention. This document aimed to keep low HIV prevalence in the region. Nevertheless, the situation was changed dramatically and in few years Eastern Europe became a region with the fastest growing rates of HIV infection in the world.

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 the Ministry of Welfare (the Ministry of Health since 2003) and in close collaboration with and the assistance of UN agencies (UNDP, WHO, WB, UNICEF) and programs (WHO/ GPA, UNAIDS). Since 1999, as a UN leading agency in Latvia, UNDP coordinated support to the government in HIV/AIDS response.

The national HIV/AIDS policy is based on the National Public Health Strategy and three consecutive national programs to limit spread of HIV/AIDS in Latvia. The State Coordination Committee for Limiting the Spread of STDs and HIV Infection oversees the implementation of above-mentioned documents. In 1993, alongside the growing threat of HIV/AIDS epidemic, the Ministry of Welfare created the AIDS Prevention Centre. Since 1997 the AIDS Prevention Centre became the leading national HIV/AIDS coordinating authority, managing and coordinating the National AIDS Prevention Program.

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8 Regulation No. 206 of the Cabinet of Ministers (July 18, 1995) “The Framework for the State Coordination Committee for Limiting the Spread of STDs and HIV Infection”
9 Regulation No. 71 of the Cabinet of Ministers (February 11, 1997) “The Framework for the AIDS Prevention Centre”
Acknowledging that non-discrimination legislation and protective laws create a supportive legal and political environment for the success of public health development and national HIV/AIDS prevention efforts, the Latvian Government has revised legislative infrastructure and adopted new regulations to improve the policy framework. Following basic legislative acts – the Law on Medical Treatment (July 1, 1997), the Law on Epidemiological Safety (December 11, 1997), the Law on Sexual and Reproductive Health (February 19, 2002), the Regulations No 328 of the Cabinet of Ministers “Regulations on Human Immune Deficiency Virus (HIV) Infection and AIDS Spread Control” (September 23, 1997) ensure the following:

- That every member of society, including PLWHA, is entitled to access to information and education on health, HIV/STI prevention programs, VCT as well as he or she has equal rights to health and social services;
- That ARV-treatment for PLWHA is available free of charge.

II. OVERVIEW OF THE HIV/AIDS EPIDEMIC

The monitoring of HIV/AIDS in Latvia is the responsibility of the AIDS Prevention Centre under the Ministry of Health. The key surveillance instrument for monitoring the HIV epidemic in Latvia is HIV case reporting that is completely adapted to meet all requirements of the EuroHIV surveillance programme. The number of HIV tests performed annually for diagnostic purposes is around 300 per 10^4 population. 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, IDUs, sex workers, STI patients, 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.

From January 1, 1987 to November 30, 2005 a cumulative total of 3311 (143,95 per 100 000 population) HIV infections were registered in Latvia (population around 2.3 million)^10, of these 378 have developed AIDS and 94 have died. However, the actual number of HIV-infected people may be higher than this. For example, international agencies estimated that there were 7,600 people living with HIV in Latvia at the end of 2003^11. According to UNAIDS, Latvia has the third highest estimated HIV/AIDS prevalence rate in Eastern Europe (0.6% of adult population 15-49 years old)^12.

HIV infection is distributed unevenly through the regions of Latvia. Riga, the capital and the largest city in Latvia, and its surroundings (940,6 hundred inhabitants)^13 appeared to be a central scene, where most infections – 84% (2788/3311 with the incidence rate of 285 per 100 000 population) occurred and were exported to other parts of Latvia (Figure 2).

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^10 Number of residents in Latvia to 01.01.2005 according to the National statistics database
^11 [http://www.unicef.org](http://www.unicef.org)
^13 Number of residents in capital city area to 01.01.2005 according to the National statistics database
IDUs clearly dominate the current Latvia’s epidemic and account for 70% of all registered cases, heterosexual transmission – 4%, mother-to-child transmission – 0.27%.

Since 2001 the number of newly diagnosed HIV cases among IDUs and the proportion of IDUs among new cases has decreased gradually (Table 1, Figure 3). In 2001 there were 665 cases registered as a result of IDU (82%), in 2003 – 235 cases (59%), in 2005 – 99 cases (36%).

14 http://www.aids.gov.lv (home page, AIDS Prevention Centre)
Table 1.

Newly diagnosed HIV cases by year and transmission group in Latvia

Source: State HIV/AIDS case reporting database, AIDS Prevention Centre

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>IDUs</td>
<td>1</td>
<td>-</td>
<td>5</td>
<td>123</td>
<td>193</td>
<td>385</td>
<td>665</td>
<td>398</td>
<td>235</td>
<td>145</td>
<td>99</td>
</tr>
<tr>
<td>Homosexual</td>
<td>8</td>
<td>9</td>
<td>16</td>
<td>22</td>
<td>10</td>
<td>5</td>
<td>7</td>
<td>8</td>
<td>14</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td>Heterosexual</td>
<td>6</td>
<td>5</td>
<td>2</td>
<td>14</td>
<td>24</td>
<td>44</td>
<td>63</td>
<td>67</td>
<td>67</td>
<td>66</td>
<td>84</td>
</tr>
<tr>
<td>Mother-to-child</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Unknown</td>
<td>6</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>13</td>
<td>31</td>
<td>72</td>
<td>67</td>
<td>83</td>
<td>101</td>
<td>79</td>
</tr>
</tbody>
</table>

Correspondingly the proportion of newly diagnosed heterosexual cases has steadily increased from 7.8% in 2001 to 17% in 2003 and 30% in 2005, while the number of people reporting that they acquired HIV heterosexually has changed unessentialy since 2001.

Figure 3.

Distribution of newly diagnosed HIV cases by transmission group

Source: State HIV/AIDS case reporting database, AIDS Prevention Centre

The case reporting data collection system does not distinguish between those infected through buying or selling sex, sex partners of IDUs or members of the general

15 http://www.aids.gov.lv (home page, AIDS Prevention Centre)
16 http://www.aids.gov.lv (home page, AIDS Prevention Centre)
population. 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.

The number and proportion of new HIV cases reported among MSM remains low (2003 – 14 cases, 2005 – 16 cases) and stable (3-5%). Over the past years the numbers and proportion due to “unknown”, unidentified transmission mode has increased and reached 21% in 2003, and 28% in 2005. The main reason for this increase is attributed to shortcomings in pre- and post-test counselling, and the failure of HIV test providers to assess and document individual risk factors. In Latvia it is mandatory that physician who submitted the sample for testing, send anonymous notifications of confirmed positive HIV test results to the AIDS Prevention Centre, and is aimed to supply additional information, such as probable route of transmission, risk behaviour.

50% of reported HIV cases are young people aged 15 – 24. Males account for 73% of all cases and they dominate in all age groups. Females more frequently (52%) than males report heterosexual transmission route, and it is especially noticeable in the youngest age groups: 69% in the age group 20-24, 82% - in the age group 15-19 (Figure 4).

Figure 4.
Cumulative number (n=450) of heterosexually transmitted HIV cases by age and sex (November 30, 2005)
Source: State HIV/AIDS case reporting database, AIDS Prevention Centre¹⁷

A slight increase of female proportion among newly registered HIV cases from 30% in 2002 to 35,2 % in 2005 has been observed. This trend towards “feminisation” of

¹⁷ http://www.aids.gov.lv (home page, AIDS Prevention Centre)
the HIV epidemic in Latvia would eventually have an influence on HIV mother-to-child transmission rates. Totally 171 HIV cases among pregnant women have been registered (19% of all female cases) and 12 cases of HIV vertical transmission confirmed (Table 2).

Table 2.

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of HIV-positive women</th>
<th>Number of HIV-positive pregnant women</th>
<th>Number of mother-to-child HIV transmission (confirmed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td>39</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>1999</td>
<td>63</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>2000</td>
<td>112</td>
<td>14</td>
<td>1</td>
</tr>
<tr>
<td>2001</td>
<td>180</td>
<td>27</td>
<td>-</td>
</tr>
<tr>
<td>2002</td>
<td>163</td>
<td>31</td>
<td>2</td>
</tr>
<tr>
<td>2003</td>
<td>132</td>
<td>32</td>
<td>2</td>
</tr>
<tr>
<td>2004</td>
<td>115</td>
<td>41</td>
<td>4</td>
</tr>
<tr>
<td>2005, November 30</td>
<td>97</td>
<td>17</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>901</td>
<td>171</td>
<td>12</td>
</tr>
</tbody>
</table>

It is an obligation of maternity service providers to offer VCT to all women during the 12th and 29/30th weeks of pregnancy, while preventive ART is available free of charge.

Particular concern for Latvia is prisons. 921 cases (28%) of all newly diagnosed HIV infections are being reported from the prisons. This rate may be due to the large scale 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.

The study of drug use among prisoners in Latvia has discovered the following:
- 31% of prisoners used drugs while in prison;
- 24% of prisoners had injected drugs before imprisonment, 14% of prisoners injected in prisons;
- 82% of prisoners that inject drugs, share needles and syringes.

Notwithstanding the results of the survey, the prisons in Latvia do not provide access to harm reduction programs (provision of sterile needles and syringes, drug substitution therapy) so far.

Separate studies of HIV prevalence among key vulnerable population groups (IDUs, MSM, sex workers, prisoners) have been conducted since 1997 (Table 3).

<table>
<thead>
<tr>
<th>Date</th>
<th>Vulnerable population</th>
<th>HIV prevalence</th>
<th>Data source</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>IDUs</td>
<td>6/ 194 (3.1%)</td>
<td>Ferdats et al.(^{20}), AIDS Prevention Centre</td>
<td>Clients of methadone programme, Riga</td>
</tr>
<tr>
<td></td>
<td>Sex workers</td>
<td>0/ 198</td>
<td></td>
<td>FSSW, Riga</td>
</tr>
<tr>
<td></td>
<td>MSM</td>
<td>5/ 207 (2.4%)</td>
<td></td>
<td>Visitors of gay clubs, Riga</td>
</tr>
<tr>
<td></td>
<td>Prisoners</td>
<td>0/ 389</td>
<td></td>
<td>Inmates in two prisons, Riga</td>
</tr>
<tr>
<td>1999</td>
<td>Sex workers</td>
<td>1/ 196 (0.5%)</td>
<td>Survey report(^{21}), NGO “Latvian Association for Safer Sex”</td>
<td>Intimate service and street sex workers</td>
</tr>
<tr>
<td></td>
<td>MSM</td>
<td>13/ 242 (13.7%)</td>
<td>Survey report(^{22}), NGO “Latvian Association for Safer Sex”</td>
<td>Visitors of gay clubs, Riga, Liepaja</td>
</tr>
<tr>
<td>2001</td>
<td>Sex workers</td>
<td>6/ 78 (7.7%)</td>
<td>Survey report(^{23}) AIDS Prevention Centre</td>
<td>FSSW, Riga</td>
</tr>
<tr>
<td>2002</td>
<td>Sex workers</td>
<td>15/ 92 (16%)</td>
<td>Survey report(^{24}) AIDS Prevention Centre</td>
<td>FSSW, Riga</td>
</tr>
</tbody>
</table>

Commercial sex is recognised as a serious concern in Latvia, as street sex work is clearly linked to injecting drug use. In 2002 bio-behaviour survey\(^{25}\) among 92 FSSW in capital city area was done, and it was discovered that:
- 16% of FSSW are HIV positive by biological (salivary) test;
- 93% of HIV positive FSSW are IDUs;

- 62% of FSSW injected drugs in the last month and 89% named heroin as the first drug of choice;
- 27% of FSSW IDUs shared injecting equipment in the last month;
- 98% of FSSW used condoms during the most recent sexual intercourse with client.

From the data available, it appears that Latvia has a significant concentrated HIV epidemic particularly among IDUs which is also affecting MSM and “bridging groups”, e.g., sex workers and their clients, sex partners of IDUs, and prisoners, while general population groups are likely to have had very little exposure to HIV so far.

Since 2001 the network of OCCs for IDUs has been established in 10 municipalities, more affected by drug use and HIV infection (Figure 2). OCCs are considered as settings for provision of targeted harm/ risk reduction and VCT services and as focal points for continuous biological and behavioural surveillance. Since 2001 regular HIV biological and behavioural surveys among IDUs – clients of the OCC network in capital city area has been conducted by AIDS Prevention Centre (Table 4).

| Table 4. HIV prevalence among IDUs – clients of OCCs in capital city area by year |
|---------------------------------|----------------|----------------|-----------------|
| Source: OCC programme monitoring database, AIDS Prevention centre |
| 2001   | 2002        | 2003          | 2005, November 30 |
| Routine VCT | 185/168  | 122/832 (13,5%) | 68/447 (15,2%) | 11/261 (4,2%) |
| (17,3%) |
| Biological survey | 36/261 (13,7%) | 52/250 (21%) | 45/205 (22%) | 52/200 (26%) |

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

The prevalence rates estimated from special biological survey has increased and remained high and relatively stable, notwithstanding, that newly diagnosed and reported HIV cases related to IDUs have substantially (by 87%) declined since 2002.

Currently 22 – 26% of clients of the OCCs in the capital city area are HIV positive. Around 90% of clients reported, that they has already been tested for HIV before survey. There is surprising coincidence between HIV prevalence estimates from biological survey and “self-reporting” data (Table 5).
Table 5.
HIV prevalence among IDUs – clients of OCCs in capital city area by biological test and “self reporting”

<table>
<thead>
<tr>
<th>Source: OCC programme monitoring database, AIDS Prevention Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biological survey</td>
</tr>
<tr>
<td>2003</td>
</tr>
<tr>
<td>45/ 205 (22%)</td>
</tr>
<tr>
<td>Self reporting: have been (ever) tested for HIV before survey</td>
</tr>
<tr>
<td>180/ 205 (87,8%)</td>
</tr>
<tr>
<td>Know (positive) HIV test result*</td>
</tr>
<tr>
<td>39/ 180 (21,7%)</td>
</tr>
</tbody>
</table>

* “self reported” HIV prevalence

Relatively high and stable HIV prevalence rates (22 – 26%) since 2003 together with high (>90%) “HIV test seeking” behaviour among IDUs could present an evidence that concentrated epidemic has reached the “saturation phase” and prevalence rates could decrease in following years.

III. NATIONAL RESPONSE TO THE HIV/AIDS EPIDEMIC

The principal multisectoral document of Latvia’s national response to HIV/AIDS is the Program for Limiting the Spread of HIV/AIDS in Latvia, 2003-2007 (hereafter the Program) approved by the Cabinet of Ministers. The objectives of the Program is to limit the number of newly diagnosed HIV cases and AIDS spread in Latvia and to lessen their impact on individuals, social groups and public at large.

The Program identifies two priority groups – IDUs and young people, and five areas of interventions, namely:

1. HIV/AIDS epidemiological monitoring;
2. Prevention with an emphasis on reaching the IDUs population;
3. Health care of PLWHA, including free provision of ARVs;
4. Training of HIV/AIDS professionals;
5. Research activities.

Services financed by central government include ARV treatment for PLWHA, epidemiological surveillance (HIV testing) and some focused prevention services. In particular, specific prevention and surveillance are funded (around 167 000 LVL or 283 000 USD) from the state health budget (the Ministry of Health) sub-program “HIV infection spread control” and is allocated to the AIDS Prevention Centre. Health care, including the provision of HAART is funded (around 1,4 mln LVL or 2,37 mln USD yearly) from the sub-program “Infectious, sexually transmitted and contagious skin disease diagnostics and treatment” and is allocated to the ICL. So far no state funding has been made available for HIV/AIDS prevention activities to institutions in other sectors and NGOs.

There are other state funds which contribute to the response to HIV/AIDS but are not covered specifically by the Program budget, e.g. salaries and costs for infrastructures,

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27 LVL (Lats), national currency; ratio: 1 USD = 0,59 LVL
diagnosis and treatment of STIs, TB treatment in PLWHA, prevention and control of drug use etc. In addition ten municipalities provide funds from municipal budget for operation of OCCs network, e.g. in 2004 in the amount of 94204 LVL or 159667 USD.

To ensure the management, coordination and monitoring of the implementation of the Program, the Coordination Commission on Limiting Spread of STD and HIV Infection was re-established in its current representation with revised mandate in 2004.

During the period from January 2003 to December 2005 the following activities have been carried out to improve the legislative basis directly and indirectly pertaining to the prevention and treatment of HIV:

- The framework and guidelines for organising the activities to limit the spread of HIV and AIDS have been determined, i.e.: epidemiological surveillance, treatment of HIV infected persons and AIDS patients, medical and social rehabilitation, awareness raising and education of the general public in HIV/AIDS prevention.
- Accordingly to the Law on Treatment the Cabinet of Ministers determines standards for the safety and quality of the obtaining, testing, processing, storing and distributing human blood and its components.
- The responsibilities of administration and medical staff in general education, vocational training and pre-school establishments have been supplemented with the role of carrying out the work to prevent smoking, alcohol and drug abuse, as well as preventing STIs.
- Patients receiving health care services for certain transmissible diseases (including HIV) are exempt from the patient’s fee. The state budget covers the cost of health care services, and the state budget covers the cost of HIV tests in out-patient settings.
- The State Program for Limiting and Controlling the Spread of Drugs and Drug Dependency (2005. - 2008) includes the development of treatment and rehabilitation programs for prisoners, including HIV-positive individuals.

One of the most notable successes of the national HIV/AIDS response in Latvia is the introduction of harm reduction programs for IDUs. The harm reduction programs allowed achieve decline of the rate of newly registered HIV infections among IDUs in the country.

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28 The Direction No.128 of the Ministry of Health (July 26, 2004) “On Establishing the Coordination Committee on Limiting Spread of STD and HIV Infection” issued in accordance with the Regulations of the Cabinet of Ministers Nr. 286 (April 13, 2004)
30 Amendment to the Regulation No. 279 of the Cabinet of Ministers (July 2, 2002) "The Organization of Availability of First Aid and Preventive Health Care in Education Establishments" (Regulation No. 49 of the Cabinet of Ministers, January 18, 2005)
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 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 an OOC offering low-threshold services for IDUs.

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” (Task Force, Ministry of Health, UNDP, 2002-2004) has bridged this gap. The project can serve as an example of the best practise and model of the state – municipal collaboration. During 2002 and 2003 operational OCCs were set in 10 selected municipalities (Figure 2). Currently the operation of all OCCs is funded through the municipal budget, however the AIDS Prevention Centre supplies these centres with injecting equipment, disinfectants, information materials and HIV tests procured by the state. All OCCs 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. OCCs are successful in motivating their clients to enter treatment (drug substitution treatment, ARV-treatment) programs. Therefore OCCs have been able to become a valuable amendment to the existing municipal social services.

Estimates on most-at-risk population sizes by approved methods never have been carried out at the national level in Latvia. The first attempt to use treatment multiplier method to estimate the number of opiate users in Riga (the benchmark of these estimates was used from the State register of drug dependence and substance abuse, State Addiction Agency) resulting in approximate estimate of opiate users to be 4447 (range from 4108 to 4786). Since the “last year prevalence of opiate use” according the survey among IDUs (OCC clients in Riga was 28.9% (approximate number – 4447), the estimated overall IDUs population in Riga would be 15387 (range from 14214 to 16560). Taking into account that HIV prevalence among clients of Riga OCC is 22%, the estimated number of HIV positive IDUs in Riga is 3385 persons (range from 3127 to 3643). Certainly this is very rough estimation and its confidence intervals are wide and do not cover entire country. The scope of the work done and

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population reached indicates that the operation of the OCCs network must have made a contribution to a substantial reduction of new HIV infections since 2002. Since July 1999 totally 11670 IDUs (new clients registered within OCC) or 76% (11670/15387) of the particular IDUs population have been reached by the OCCs activities in capital city area. The estimated coverage of IDUs by OCC activities is varying by year and needs to be expanded (Table 6).

Table 6.
Coverage of IDUs population* by OCCs activities in capital city area

<table>
<thead>
<tr>
<th>Source: OCC programme monitoring database, AIDS Prevention centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
</tr>
<tr>
<td>Number of new clients</td>
</tr>
<tr>
<td>Number of regular clients**</td>
</tr>
<tr>
<td>Number of all clients***</td>
</tr>
<tr>
<td>Coverage</td>
</tr>
</tbody>
</table>

* estimated IDUs population in Riga 15 387
** are visiting OCC at least once in week
*** new clients + regular clients = approximate number of all clients

Percentage of IDUs exposed to basic OCCs services (safer injection practices, VCT, peer education) is relatively high (Figure 5).

Figure 5.
Percentage of IDUs (OCCs network clients in capital city) reached with HIV-prevention programmes

Source: Survey Report (2005), AIDS Prevention Centre


16
Figures 6, 7 show knowledge and behaviour outcomes based on 2005 survey results among OCCs clients in Riga.

**Figure 6.**

Percentage of IDUs (OCCs network clients in Riga) who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

*Source: Survey Report (2005), AIDS Prevention Centre*  

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37
Figure 7.

Percentage of IDUs (OCCs network clients in Riga) who have adopted behaviours that reduce transmission of HIV, i.e. who both avoid sharing injecting equipment and use condoms

Source: Survey Report (2005), AIDS Prevention Centre

The project “Coordinated Support to Young People’s Health and Development” (UNDP, Ministry of Education and Science, 2002 – 2004) is another example of good practice of collaboration among various institutions – the Ministry of Education and Science, the Ministry of Health, AIDS Prevention Centre, NGOs, schools and health care services. The project was aimed to create a comprehensive HIV prevention program targeting in- and out-of-school youth. The project implementation was based on interrelated components: peer education, life-skills based health education in the schools and provision of youth friendly health services. Sustainable network of organizations and specialists has been established within the project. The project succeeded in capacity building of various HIV/AIDS prevention professionals: 298 peer educators were trained, 18 youth NGOs implemented peer education programs reaching out to more than 16 000 young people, more than 670 teachers and 60 health service providers were trained on life-skills based HIV/AIDS education and on delivery youth friendly services. The project was extended for 2004-2005, and it succeeded to involve 20 NGOs and youth organizations, and 268 peer educators.

boys and 170 girls) reached out in the programs to more than 6,895 young people during 2005.

The set of questions about the essential HIV transmission facts has been included in the population-based survey conducted by Latvia’s Association for Family Planning and Sexual Health (LAFPSH) “Papardes zieds” in 2003: majority of respondents aged 15-24 correctly identified ways, how HIV can be avoided, while misconceptions about HIV transmission were widely spread among young people (Figure 8).

Figure 8.

Percentage of young people aged 15-24 who correctly identify ways of preventing the transmission of HIV and who rejected major misconceptions about HIV transmission

Source: population-based survey report

Free ARV treatment for PLWHA is other aspect of Latvia's response to HIV/AIDS which has to be outlined. ICL is responsible for the care and treatment of PLWHA, therefore the treatment and care is centralized. The centralized administration of ARV-treatment is appropriate for a small country like Latvia as it allows concentrating the relevant expertise, and tools effectively. The ICL offers a range of the most advanced first line and second line HAART regimens, more than 60 drug combinations, adjusting these for individual patients.

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However it must be noted that the state budget allocated for the treatment covers approximately 50% (233 persons) of all those who need treatment. At the same time all who currently are not enrolled in the treatment program either are not registered with the ICL or are exempted from the program due to their inability to follow treatment regimes (70% of PLWHA are active drug users). Also, the current funding is highly insufficient to provide treatment to all who need and would be willing to receive the treatment it in nearest future.

IV. MAJOR CHALLENGES FACED AND ACTIONS NEEDED TO ACHIEVE THE UNGASS GOALS/ TARGETS

The key challenges that the national HIV/AIDS response has faced and that are hindering Latvia’s ability to reach the UNGASS Declaration goals, include the following:
- Limited, inadequate financial resources available for the implementation of the Program;
- Limited involvement of NGOs, particularly in service provision for key vulnerable populations;
- Limited coverage and the need to expand the low threshold services for the key vulnerable population;
- Weakness of the M&E of the Program as a whole and its separate service areas.

So far neither stand-alone national HIV/AIDS account, nor a financial plan integral to the Program has been established. The services financed and sustained exceptionally by the state’s health care budget (Ministry of Health) include ARVs and hospital treatment for PLWHAS, HIV tests within the state’s surveillance network and some specific prevention activities. There is an obvious disproportion among the budget funds used for treatment (2,4 mln USD) and those used for prevention (0,28 mln USD). Moreover, the funds allocated for treatment have risen recently, while the budget for the prevention has not changed since 1999. The states priority in dealing HIV/AIDS issues has been health-focused, rather than aimed at prevention for the reason of limited financial resources. Although the implementation of the Program requires the involvement of other national stakeholders, e.g. the Ministry of Education and Science, the Ministry of Defence, the Ministry of Justice and the Prison Administration, the direct budget allocations are not foreseen for these stakeholders through the Program. As a result HIV prevention activities in prisons are fragmentary and ad hoc, but harm reduction activities (needle exchange, substitution therapy) are not available at all. Other Program’s activities and services, particularly those provided by NGOs, are funded on a project-by-project basis with funding mainly from international donors and foundations. Latvia’s accession to the European Union has restricted the availability of international funding, in particular the funding sources for NGOs working in the area HIV/AIDS. Consequently the NGOs participation in the national HIV/AIDS response is limited in particular in areas of the low threshold service provision to vulnerable population groups and to PLWHA. The continuity and sustainability of the services are threatened and their capacity restricted.
Although the development of the network of OCCs for IDUs is one of the Program’s achievements and covers 10 municipalities most affected by drug use and HIV, there are serious gaps, e.g., Daugavpils (the second biggest city in Latvia, close to the Russian border) and Ventspils (a harbour city with the highest HIV prevalence rate after Riga) due to the lack of local municipality commitment (Figure 2). Another serious gap of the Program is restricted access to condoms, since the state does not provide funding for condom procurement. So far there are no condoms’ social marketing programs in Latvia.

Methadone-based substitution therapy is only available through the State Addiction Agency program and currently 50 people receiving this service in Latvia.

The provision of care and psychosocial support to PLWHA is insufficient in comparison to the availability of ARV-treatment. Greater emphasis should be placed on providing psychosocial support for PLWHA through the network of low threshold centres, and the support to NGOs involved in providing such services should be increased. Consideration should be given to further fund this work from the state budget.

Transforming OCCs for IDUs into low-threshold centres, offering a wide range of services not only for IDUs but also for other key vulnerable population groups could be a positive long-term solution. This is particularly important in the light of potential increase of HIV heterosexual transmission.

V. SUPPORT REQUIRED FROM COUNTRY’S DEVELOPMENT PARTNERS

Latvia up to now has received substantial support from UN Family organizations for the national response to HIV/AIDS. The total investment of UN Family organizations and mobilized donor funding through UNDP Latvia projects in the area of HIV/AIDS in the period 2000 – 2005 was 1.127.474 USD.

With EU accession and closure of UNDP Latvia in 2005 the funding from the traditional donors sharply decreased. An opportunity is open to access EU horizontal financial instruments, while institution capacity to work with EU funds are limited due to little knowledge of the procedures and rules of preparing competitive proposals.

Latvia is needed strengthened support within the framework of concerted EC level actions on HIV/AIDS in following action areas:
- Expanding and capacity building of integrated low-threshold service networks for specific vulnerable groups (IDUs, prisoners, MSM, sex workers);
- Finding out adequate way of funding and involving civil society organizations in the national AIDS response;

- Expanding the provision of ARV to all in need by developing multiple entry points to ARV-treatment, 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 ARV-treatment, negotiating affordable lower prices of ARVs with pharmaceutical companies.

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

VI. MONITORING AND EVALUATION ENVIRONMENT

The Coordination Committee for Limiting the Spread of STDs and HIV Infection and the Ministry of Health are responsible for supervision and monitoring of the Programme's implementation.

It must be noted that the Monitoring and Evaluation (M&E) plan is not an integral part of the Program (2003 – 2007).

The Plan of Action, which is a part of the Program, includes activity or service areas, e.g. surveillance, prevention, treatment and support for PLWHA, training for HIV/AIDS professionals, research with annual targets, target indicators and stakeholders that are responsible for implementation, monitoring and reporting of particular area or activity. The Ministry of Health compiles reports from responsible institutions and prepares annual reports of the Programme implementation for the Cabinet of Ministers.

Many indicators used in the Program are process, performance and coverage indicators. There are no defined indicators for measuring the impact (prevalence) and outcome (behaviour) of either particular parts (activity areas, service areas) of the Program and the Program as a whole.

Consequently the M&E for the national HIV/AIDS response is currently fragmented and weak, and needs to be strengthened to make it more operational. The following actions are proposed:

1. Develop M&E plan based on the national composite policy index and include it as an integral part of the National AIDS Program;
2. Set up functional M&E unit for the development of the M&E plan, for collecting, analysis and dissemination of data, and secure stable funding for the development and implementation of M&E activities;
3. Identify clearly the impact (prevalence) and outcome (behaviour) indicators and appropriate coverage indicators at goal level for clearly defined service delivery areas.