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Title	**National Program for limiting spread of HIV and AIDS in** Latvia **2008- 2012**
Submitted by	**Ministry of Health of Latvia**
Summary / Note	The program has been developed in accordance with the Declaration of Intended Activities of the Cabinet of Ministers of Latvia and the directions set out in this document aim at improving public health and limiting HIV/AIDS spread and identify national policy priorities for the next planning period (2008-2012)
Requested action	For information

National Programme for limiting spread of HIV and AIDS in Latvia 2008–2012

December 24, 2007

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Abbreviations

AIDS	–	Acquired immunodeficiency syndrome
ARV	-	Antiretroviral treatment
BBS	-	Bio-behavioural survey
CSW	-	Commercial sex workers
EC	-	European Commission
EU	–	European Union
HCISA	–	Health Compulsory Insurance State Agency
HIV	–	Human immunodeficiency virus
HPC	-	HIV Prevention Centre (provides low threshold services for IDUs and bridging population)
ICL	-	Infectology Center Latvia
IDU	-	Injecting Drug User
LALRG	–	Latvian Association of Local and Regional Governments
LG	–	Local Government
LGAA	–	Local Government Affairs Administration
LPA	–	Latvian Prison Administration
LPH	–	Latvian Prison Hospital
MDR-TB	–	Multi-drug-resistant tuberculosis
MMT	–	Methadone Maintenance Therapy
MoCFA	–	Ministry of Children and Family Affairs
MoES	–	Ministry of Education and Science
MoH	–	Ministry of Health
MoI	–	Ministry of the Interior
MoJ	–	Ministry of Justice
MoW	–	Ministry of Welfare
MsM	_	Men who has sex with men
NGO	–	Non-governmental organisations
NTP	–	National tuberculosis programme
OST	–	Opioid Substitution Therapy
PHA	–	Public Health Agency
PMTCT	_	Prevention of mother-to-child transmission
RCPAD		Riga Centre of Psychiatry and Addiction Disorders
RDS	_	Respondent Driven Sampling
SATLD	–	State Agency of Tuberculosis and Lung Diseases
ST	–	Substitution Treatment
TB	–	Tuberculosis
UN	–	United Nations
UNODC		United Nations Office on Drugs and Crime
VCT	_	Voluntary testing and counselling
WHO	–	World Health Organization

1 Introduction

The spread of HIV/AIDS has become a long-term problem in Latvia. This problem implies serious consequences – i.e. poses threat to public health, social welfare, and national economy. As of January 1st, 2007, there were 3,631 cases of HIV positive and 447 AIDS patients registered in Latvia. Almost 0.31% of the reproductive age population (15-49 year old)[1] is affected by the infection. Besides, WHO and UNAIDS estimate that the actual numbers could be twice higher then official figures[2]. The number of new HIV cases uncovered annually, while remains stable during past two years, further increases the size of affected population. Therefore, the epidemiological situation calls for continuous attention on the part of the government and society as a whole.

HIV epidemic does not concern only Latvia, but to the whole European Union. During the Council Meeting of the EU ministers of employment, social policy, consumer affairs and health, the decision was made to develop uniform policy and action to fight HIV/AIDS in the EU and neighboring countries[3]. Up until 2007, Latvia's efforts against HIV/AIDS were guided by the national program, which expires this year. Therefore, it is essential to identify national policy priorities for the next planning period (2008-2012) that will help implement activities aimed at containing HIV epidemic. The new program 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[4]. In addition, this program has to focus on integrated issues related to both HIV and tuberculosis (TB) infection.

Consequently, this program has been developed taking into account the epidemiological situation of Latvia and is in line with international declarations to which Latvia is the signatory (Dublin[5], Vilnius[6], Bremen[7]) as well as EU policy[8], UN General Assembly[9] and WHO documents[10].

This program has been prepared with financial support from the Government of France through WHO Latvian Representation and Dutch Government and the World Bank through UNODC, involving foreign and local consultants.

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[1] Data: state agency „Sabiedrības veselības aģentūra" (Public Health Agency)

[2] HIV/AIDS country profiles for the WHO European Region// HIV/AIDS IN EUROPE. Moving from death sentence to chronic disease management; WHO Regional Office or Europe; Denmark 2006

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

[4] Vai turam solījumu? Pētījums par paveikto UNGASS Saistību deklarācijas ieviešanā HIV/AIDS jomā Latvijā. (*Are we keeping our promises? Progress study on implementing UNGASS commitment declaration in HIV/AIDS area in Latvia)* Panos Institute (London) report, 2005http://www.panosaids.org/latvia.htm

[5] *Dublin declaration on partnership to fight HIV/AIDS in Europe and Central Asia;* February 24, 2004

[6] Vilnius Declaration on Measures to Strengthen Responses to HIV/AIDS in the European Union and in Neighbouring Countries, September 17, 2004

[7] Bremen declaration on responsibility and Partnership — Together Against HIV/AIDS (Bremen, March 13, 2007

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

[9] Declaration of Commitment on HIV/AIDS, UN Assembly General, June 25-27, 2001 Declaration of Commitment on HIV/AIDS, UN Assembly General, June 25-27, 2001 (hereinafter — „UNGASS declaration")

[10] Prison Health as a part of Public Health, Moscow, October 24, 2003

2 Program Framework vis-à-vis Approved Policies and Governmental Priorities

The program has been developed in accordance with the Declaration of Intended Activities of the Cabinet of Ministers[11] and the directions set out in this document aim at improving public health and limiting HIV/AIDS spread.

In addition, this program builds on and contributes to following policy and programmatic documents of the Government of Latvia:

- Long-term strategy of the Latvian Parliament "The Growth Model for Latvia: Man Comes First"[12].
- For the "Public Health Strategy"[13] which aims at reducing infectious disease spread including reduction of new HIV cases. More specifically this program contributes to achieving following goals:
    - "By 2010, the differences in health indicators among various socioeconomic groups in Latvia should be reduced by one fourth by significantly improving the health of those groups currently in the most unfavourable situation" (Goal 2);
    - "By 2010, the effectiveness of infectious disease control in Latvia should reach the average EU level" (Goal 7);
    - "By 2010, the lifestyle of the population of Latvia should become more healthy" (Goal 11);
    - "By 2010, the public health care system in Latvia should become result-oriented, i.e. aim at the improvement of health indicators" (Goal 17);
    - "By 2010, the expertise of public health and public health-related specialists working in other sectors in Latvia has to increase" (Goal 19);
- Latvian National Development Plan[14], section 6.1 "Healthy People in Sustainable Society" which calls for improved accessibility to health care services in the communities, building public awareness about healthy lifestyle, promoting importance of preventive measures, encouraging cooperation between Government and non-governmental organizations (working with families, children, youth, socially marginalized risk groups including HIV infected persons);
- Strategy of the Ministry of Health[15], section 2.1, which calls for promotion of healthy life style and reproductive health, limiting HIV infection spread and provision of adequate treatment to HIV infected people and AIDS patients.
- "National report on Strategy for Social Protection and Social Inclusion (2006-2008)"[16], which intends improving access to services in education, employment and health care for children and socially marginalized youth, through promotion of social integration.
- The program for "Human Resources and Employment"[17], which includes measures for developing special assistance system for HIV infected people.

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[11] Prime Minister Aigars Kalvitis

[12] Approved during Parliamentary meeting on October 26, 2005

[13] Approved during Cabinet Meeting No. 10 on March 06, 2001 (Minutes No. 10, § 43)

[14] Latvian National Development Plan (2007—2013) Approved with Cabinet Order No. 564 (July 04, 2006) „Concerning Latvian National Development Plan (2007—2013)"

[15] Approved with Cabinet Order (November 15, 2006) No. 888 "Concerning Action Strategy of the Ministry of Health for 2007-2009")

[16] Cabinet took note no September 26, 2006 (Minutes No. 49, § 30)

- "State program for limiting and controlling dependence on narcotic and psychotropic substances (2005-2008)"[18] *inter alia* includes measures aimed at preventing HIV infection among IDUs and in places of detention.
- "National program for the Elimination of TB 2008–2012" which directly focuses on TB and HIV interaction and proposes specific interventions and targets to decrease TB as well as HIV spread, AIDS morbidity and death.
- The "National Tolerance Program"[19], which, among other issues, focuses on preventing HIV spread and improving quality of life of those, affected with HIV infection.

3 Epidemiological Context and Lessons Learned

3.1 Current epidemiological situation

Latvia belongs to the countries in EU, where HIV infection rates are very high. With 129.6 cases per million population, Latvia has double the EU-average rate, but remains below Estonia, Portugal, UK and Luxemburg. The major HIV increase in Latvia was seen during 2001. Since the numbers declined and stabilized during 2005-06 (see Table 1). While new cases reveal stabilizing trend, it may not reflect real picture of epidemic, therefore more efforts are required to contain HIV infection growth and limit its spread.

Table 1 HIV and AIDS Statistics 2002-2006

Indicator	2002	2003	2004	2005	2006
Number of new HIV cases per 100,000 population	23.1	17.4	14.0	13.0	13.1
Absolute Number of new HIV cases	542	403	323	299	299
New AIDS cases per 100,000 population	2.4	3.2	3.3	3.1	2.3
Absolute number of new AIDS cases	56	75	77	72	53
AIDS related deaths per 100,000 population	0,2	0,6	0,8	1,0	0,6
Absolute number of AIDS related deaths	4	14	19	22	14

Source: Public Health Agency

Regions of Latvia are differently affected by the infection. Riga shows the highest HIV prevalence figures (329 cases per 100 000 residents) along with Ventspils (285 cases per 100 000 residents), while Ludza, Alūksne and Madona regions have the lowest figures (see Figure 1). Therefore, geographical focus of anti epidemic measures is essential to target resources in the geographical areas that are most at risk for epidemic spread.

Affected Population Groups

The majority of HIV infected people are male injecting drug users, who were infected through sharing of needles and syringes[20]. The HIV prevalence among IDUs was estimated at 26.3% during 2005[21] and 36% of all new cases detected during 2006 were among IDUs. For countries, where

[17] Approved at the Cabinet of Republic of Latvia on October 3, 2006

[18] Approved with Cabinet Order No. 559 (August 17, 2005) „Concerning the National Program on Limitation of the Spread of narcotic and psychotropic substances (2005—2008)"

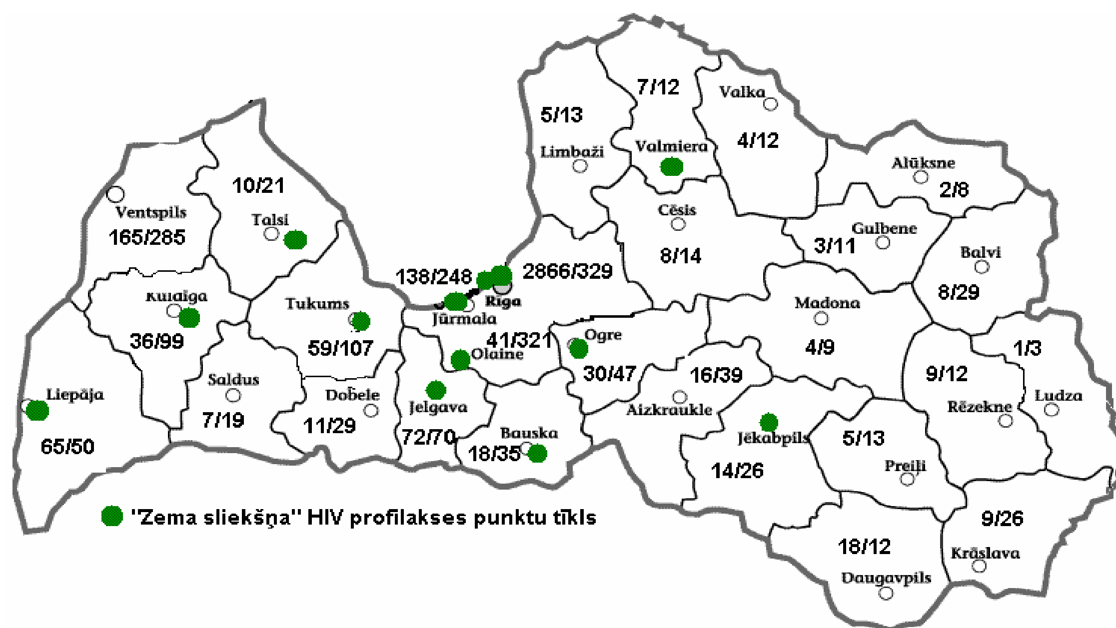
[19] Approved by the Cabinet Order (August, 25, 2004) No. 584 "National Tolerance Programme"

[20] WHO/EURO (2005): HIV/AIDS and TB interventions in Estonia, Latvia and Lithuania - Economic, health financing and health system implications. Version 12/10 2005

[21] Latvia UNGASS Country Progress Report for 2005.

IDU transmission prevails, UNAIDS recommends[22] interventions that help control HIV among IDU, and these interventions should be the cornerstone of HIV prevention strategies. Unsafe injecting practices among IDUs account for most of Latvia's HIV/AIDS cases. Decreasing the number of unsafe injections among active IDUs, increasing use of condoms, reducing illegal drug consumption can prevent spread of HIV and other infectious diseases. Successful policies include a multi-pronged approach, which aim to reach sufficient availability and community penetration with *Voluntary Counselling and Testing* (VCT), with harm reduction interventions, with information, supplies Substitution Therapy. Availability of both information and supplies must be sufficient to meet the minimal scale necessary for the epidemic prevention.

Figure 1 HIV and AIDS by geographic locations (as of December 31st, 2006)



Another contributor to new HIV cases is the prison system. In 2006, prisoners contributed 16% of all new HIV cases, which used to be 30-33% during 2000-2003 respectively. Decline in the share of new HIV cases found in penitentiary system can be attributed to declining number of individuals tested by the prisons. If in 2000 the prison system tested 8,722 individuals these numbers declined to 2,600 in 2006 (new entries per year approx. 3,500). Since 2000, due to lack of financial resources and outdated infrastructure the number of HIV-tests has been reduced over time due. Therefore, the likelihood to detect HIV-cases on admission to prison has been reduced. The incidence of HIV in prison is 36 times higher than in the community. Therefore, the situation within penitentiary system remains challenging and still poses risk for the HIV spread. Such risks are due to the fact that approximately 6.1% of prison population (Dec 31, 2006) is HIV positive.

The study among prisoners (2003) revealed that 24% of prisoners injected drugs before imprisonment, 14% continued to inject drugs in prisons. More than 80% of the detained, who used intravenous narcotic substances share syringes and/or needles[23]. Furthermore, TB and especially Latvia's high MDR-TB rates are a serious threat to the Latvian prisons and to the society at large. Together with a comparable high HIV-rate among prisoners, increasing HIV and MDR-TB co-

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[22] UNAIDS (2005): HIV/AIDS Prevention, Treatment and Care among Injecting Drug Users and in Prisons. Ministerial Meeting on "Urgent response to the HIV/AIDS epidemics in the Commonwealth of Independent States" Moscow, 31 March to 1 April 2005

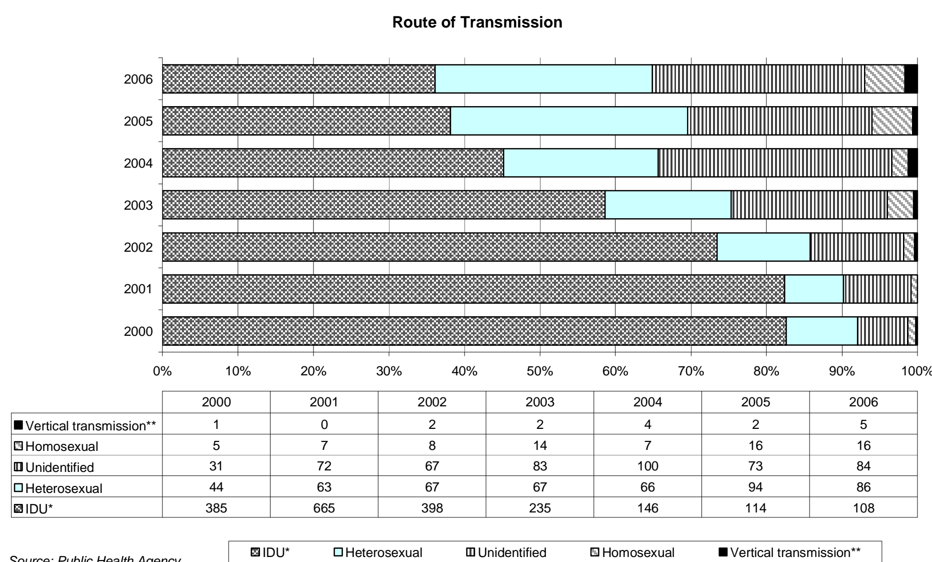
[23] Resident survey on the spread of drug use/ Drug use in Latvia; Centre of Philosophy and Sociology, University of Latvia; Centre of Drug Addiction; Riga, 2003

infections can be noticed. People with HIV-infections become infected with TB far more often then healthy individuals[24]. Therefore, the chances of HIV spread within the penitentiary system are high.

Due to a lack of TB control equipment the number of TB-cases in prisons decreased also in the last 7 years (from 361 cases in 1999 to 73 in 2006). Latvia belongs to the top 14 countries of MDR-TB, and the likelihood of these cases also to be found among the key target group of IDUs, who often were homeless and living on the streets before imprisonment, is relatively high. The risk of undetected TB (or even MDR-TB) is also very high when the equipment for detection is missing.

While in Latvia transmission through intravenous drug use is the prevailing route for HIV spread, it has been declining and heterosexual transmission increasing gradually. However, the epidemiological data presented in Figure 2 requires further analysis, before conclusions are drawn. Available information through routine reporting is not sufficient and or adequate to draw conclusions. Therefore, in-depth studies such as *Integrated Bio-Behavioural Survey* (BBS) among risk groups are necessary. These studies help understand the infection spread among groups at risk as well as link the infection rates with behaviour factors. This information is important to plan and undertake issue focused interventions among groups-at-risk.

Figure 2 Route of HIV Transmission 2000-2006



	2000	2001	2002	2003	2004	2005	2006
Vertical transmission**	1	0	2	2	4	2	5
Homosexual	5	7	8	14	7	16	16
Unidentified	31	72	67	83	100	73	84
Heterosexual	44	63	67	67	66	94	86
IDU*	385	665	398	235	146	114	108

Source: Public Health Agency

Furthermore, routine HIV reporting system in Latvia does not capture well HIV cases among individuals involved in prostitution (male and female) and/or using services of prostitutes. Neither allows monitoring the infection rates among those, who are sexual partners to IDUs. Thus, growth in heterosexual transmission is hard to explain without thorough research. This growth could be driven by several factors: commercial sex, through sexual relationship with IDUs or ex-prisoners, or by simple heterosexual means of transmission. Growth in unknown route of transmission obviously affects observed trends and points to weakness in surveillance system employed by Latvia. Nevertheless, with the current level of epidemic development in Latvia it is most likely that epidemic yet remains within groups-at-risk and bridging population, though the risk of epidemic spread beyond these groups exists and therefore requires effective anti-epidemic measures[25].

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

[25] Vai turam solījumu? Pētījums par paveikto UNGASS Saistību deklarācijas ieviešanā HIV/AIDS jomā Latvijā. (Are we keeping our promises? Progress study on implementing UNGASS commitment declaration in HIV/AIDS area in Latvia) Panos Institute (London) report, 2005http://www.panosaids.org/latvia.htm

Growth in homosexual transmission observed on Figure 2, also calls for attention. While yet absolute numbers of HIV cases among MSM are low, as a share of new HIV cases it is growing and since 2000 increased from around 1% to above 5% in 2006. In Western European countries homosexual transmission is the predominant mode for HIV spread, therefore Latvia needs to pay timely attention to this group. However, most behavioural issues related to MSMs, the size and geographic distribution is not known, which impedes program planning. Therefore, in-depth research of MSMs is the first obvious step to implement under the national program and based on the obtained information plan adequate interventions within this group.

On average around four cases of vertical transmission is reported in Latvia every year[26], which amounts to 20 HIV cases per 100,000 newborns. In addition, annually ≈30 HIV positive pregnant women are detected. As of January 1st, 2007 there were 17 HIV infected children born to HIV infected mother in Latvia. Out of all HIV, cases among pregnant women 49% are reportedly due to sexual transmission and in 23%, the woman has a history of drug injecting. While in the last two years, only two HIV cases were detected among pregnant IDUs, in the three preceding years there were 9-10 cases per year. These figures resemble Ukraine a few years back, where 21% of HIV positive tests among pregnant women between 1996 and 2001 reportedly concerned women with a history of drug injecting. However, further analysis of cases of children born to HIV infected mothers showed that in 53.4% the mother had previously injected drugs, while many of the others had partners who inject drugs. HIV cases among pregnant women in Latvia are mostly found among mothers that avoided adequate prenatal care as well. This may suggests that pregnant IDUs are not adequately reached by HIV testing during pre-natal care services in Latvia. Therefore, in order to avert vertical transmission[27] primary HIV prevention along with prevention of unwanted pregnancy among HIV positive women is necessary.

HIV infection by age and gender

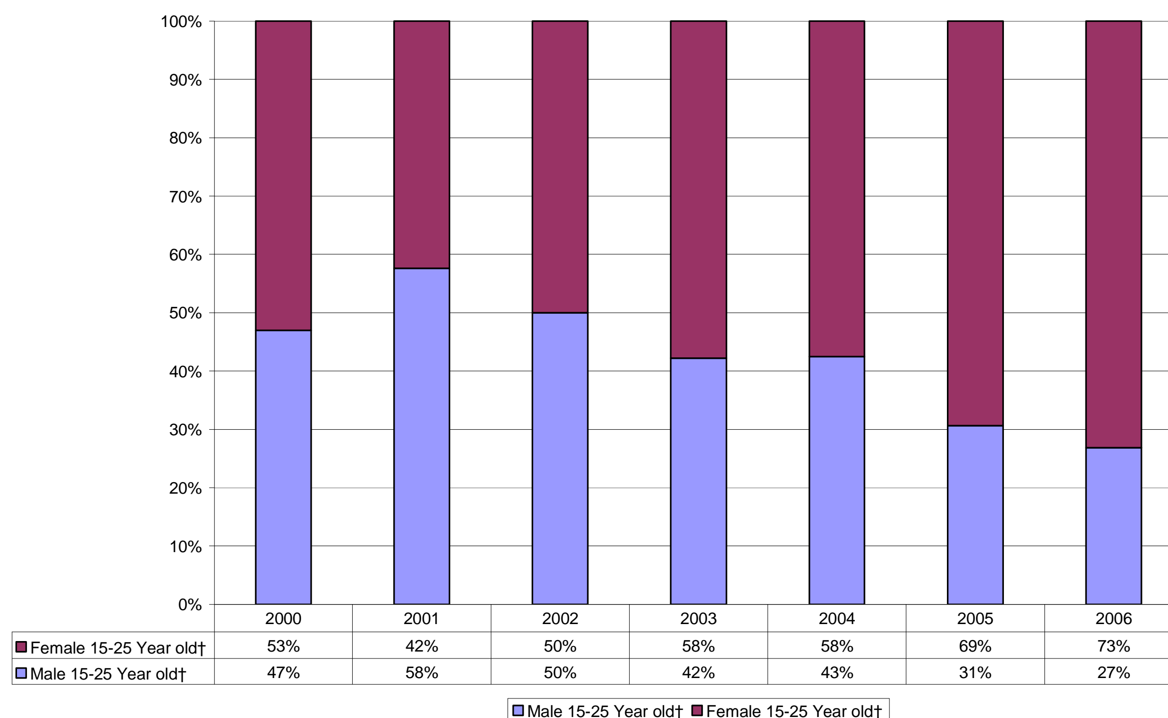
At the outset of HIV epidemic during 2000-2001, males were more affected. However, over the course of recent years, infection is probably moving into female population and in 2006, females contributed 73% of cases found among people 15-25 years, while in 2000 this group only accounted for 53% of HIV positive cases (see Figure 3) similar trend is seen among people older then 25 years (see Figure 4). One explanation to the observed changes could be declining number of HIV cases detected in prisons and lower tests performed among HPC clients, which historically contributed HIV positive cases among males. However, further research is important to understand epidemic transition from males into females and to better plan response measures.

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

[26] Data: State Agency „Public Health Agency" (on January, 2007) Epidemiological Bulletin No. 3 (961) January 15, 2007

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

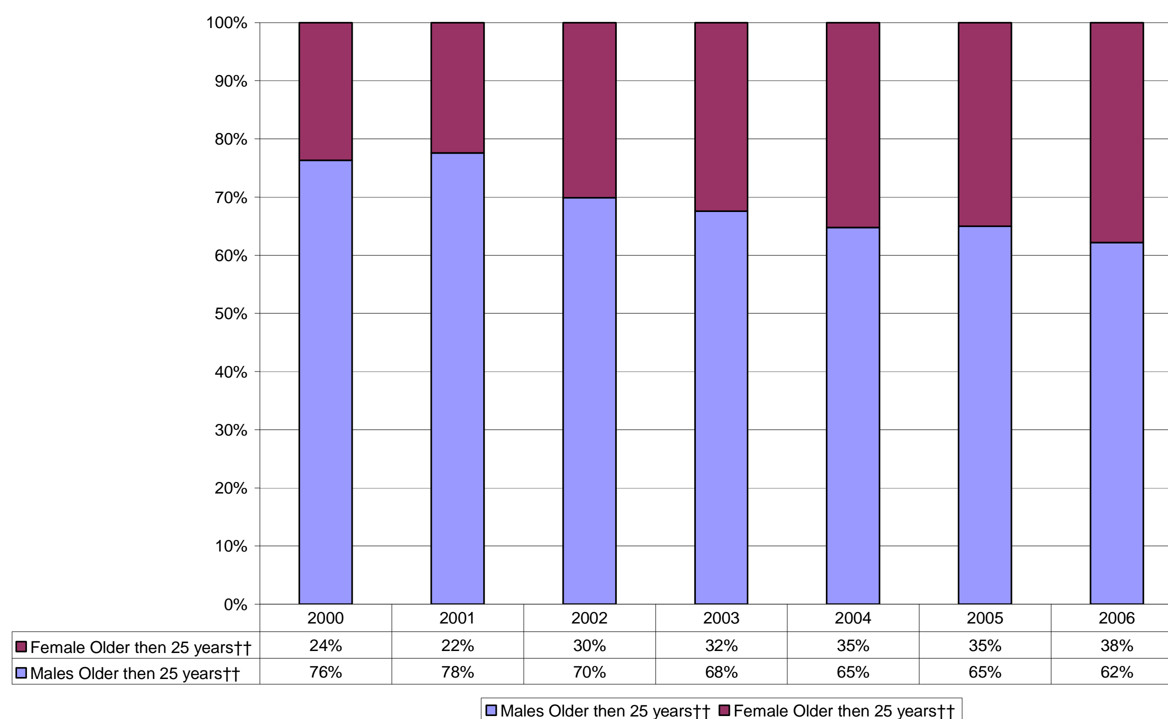
Figure 3 Share of HIV Infection among 15-25 old by gender †



	2000	2001	2002	2003	2004	2005	2006
Female 15-25 Year old†	53%	42%	50%	58%	58%	69%	73%
Male 15-25 Year old†	47%	58%	50%	42%	43%	31%	27%

† The share of population is derived from 15-25 year old
Source: Public Health Agency

Figure 4 Share of HIV Infection among people older 25 years by gender †



	2000	2001	2002	2003	2004	2005	2006
Female Older then 25 years††	24%	22%	30%	32%	35%	35%	38%
Males Older then 25 years††	76%	78%	70%	68%	65%	65%	62%

†† The share of population is derived from 25+ year old
Source: Public Health Agency

HIV Infection by Ethnic Background

HIV is differently spread among various ethnic groups residing in Latvia and mainly affects Russian speakers and Roma population. While Latvians comprise about 60% of the population,

only 20.4% of HIV cases are registered among Latvians. Russian speakers comprise 27% of the total population, however they contribute 48% of HIV cases and 6% of HIV cases are found among Roma, through their share in the total population is only 0.4%. More then half of HIV positive pregnant are Russian or Roma descent. This is explained by unsafe practices of injecting drugs among Russian speakers and Roma. Second generation HIV surveillance among IDUs in Latvia (2005) suggests that more than half of IDUs are Russian speakers, almost six percent are Roma and less than a third are Latvians. Furthermore, 90% of the methadone patients are non-Latvian ethnic origin. Therefore, the problem of injecting drug seems to have been clustered among non-Latvian population, which determines higher rate of HIV cases in these population groups. Latvia is committed to fostering a society based on social inclusion. Therefore, the national program includes practical objectives and activities targeting the population at increased risk of HIV and other morbidity associated with drug injecting.

Non-AIDS mortality among PLWHA who inject drugs

PLWHA who inject drugs die mostly before receiving a clinical AIDS diagnosis in Latvia and they die five times more often from non-AIDS related causes than from HIV/AIDS (see table 2). As in other European countries[28], in Latvia drug overdose is an important cause of death among HIV positive IDUs. Studies from the USA suggest that HIV positive IDUs may be more at risk of overdose.[29] Therefore, interventions should be developed that aim to reduce the incidence of overdose among HIV^+ and HIV^- IDUs alike.

Table 2. Cumulative number of HIV/AIDS and Non-AIDS related deaths reported on 31 December 2006

Transmission route:	**Total HIV/AIDS DEATHS***	**Total Non-HIV/AIDS DEATHS****	**Rate**
Injecting drug use	25	125	**1:5**
Male-to-male sex	4	10	1:2.5
Heterosexual contact	6	20	1:3.3
Mother to child transmission	1	1	
Other	0	0	
Unknown	4	21	**1:5.25**
TOTAL:	**40**	**177**	

Source: WHO/Europe Survey on HIV/AIDS and antiretroviral therapy, 2006.
* *Include only HIV/AIDS related deaths, not people diagnosed with HIV or AIDS who died from other causes*
* *Include only deaths among PLWHA from causes not related to HIV/AIDS, e.g. overdose, liver disease, accidents, suicide etc.*

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

Primary target groups include:

1. Intravenous drug users
2. Prisoners

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[28] EMCDDA Annual Report 2007: Highlights.

[29] Wang C, Vlahov D, Galai N, Cole SR, Bareta J, Pollini R, Mehta SH, Nelson KE, Galea S. The effect of HIV infection on overdose mortality AIDS 2005;19:935-942.

3. Commercial sex workers
4. Men who have sex with men

Secondary target group is comprised of:

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

3.2 Past Achievements and Lessons Learned

Key achievements under the National Strategy until December 2007include following:

- ♦ Latvia established *Low Threshold Centres* for IDUs in 11 municipalities and one under Public Health Agency. These centres served 11,670 IDUs since July 1999. All these sites 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. These centres are motivating their clients to enter treatment (drug substitution treatment, ARV-treatment) programs. Therefore, HPCs have been able to become a valuable addition to the existing municipal social services. However, the number of clients reached by HPC has declined from 2,525 in 2003 to around 1,000 in 2007 and there is a need to increase the client base and to expand coverage of IDUs through establishing new HPC sites in the new municipalities[30] and increasing the number of clients served. Therefore, it is necessary to increase support to HPCs, increase the scale of cost-effective services and reach-retain large enough proportion of the IDU population, which is necessary to have an impact on the spread of HIV. In addition, it is important to involve NGOs in development of the HPC network therefore NGOs should be (financially) supported by the government. Training is necessary to help HPCs achieve their primary goal of HIV prevention among as many IDUs as possible and finally, new HPC sites should be established in new municipalities with significant IDU populations. HPC have to become gender sensitive and offer services that are necessary for female IDUs to timely prevent unwanted pregnancies and vertical transmission.
- ♦ Funding of healthcare services in the prison system is very low and infrastructure outdated. As a result testing of prisoners has declined and consequently number of HIV cases detected in prison decreased. The lack of X-ray equipment in prison does not allow timely detection of TB and MDR-TB, and further increase the threat of TB and HIV spread in this system. Shortage of funds limit prison health care system to provide adequate levels of testing, treatment and care to prisoners and Latvia faces the need to increase and link with the public health care system the funding and treatment/care provision within the penitentiary system.
- ♦ Latvia has to reach MSM (and “contextual MSM” in prisons) and CSW population. According to international experience these groups are best reached by NGOs, therefore effective engagement with non-governmental sector is important. However, past and current funding for non-governmental sector is minimal, which does not allow NGOs to expand the coverage and/or offer services on a sustainable basis. Thus, finding the ways to finance and involve civil society in the national AIDS response becomes important.
- ♦ Two *Opioid Substitution Therapy* (OST) programs are operational in Latvia: *Methadone* since 1996 and *Buprenorphine* since 2003. During 2000-2006, total 684 individuals were served by

[30] Latvia 2006 UNGASS report.

this program[31]. Public perception of the MMT has been very negative; therefore, the programs did not attract high numbers of drug users. However, Latvia needs to increase IDU numbers that are on substitution therapy and plans to expand number of clients under the new program should be developed. According to Latvia's present drug strategy (a new strategy must be developed in 2008), substitution treatment should be expanded to all regions in the country and several other settings such as prisons. The current regulations have to be amended in early 2008 in order to scale up MMT and make the treatment available in seven regions. However, under the amended regulations unnecessary restrictive measures (i.e. mandatory hospitalization for seven days in Riga) should be eliminated to facilitate scaling up substitution treatment to effective levels. Therefore, scaling up MMT to levels that influence the *Twin Epidemics* of drug injecting and HIV should be prioritized under the new program. Development of regulations for MMT should be guided by patient needs, scientific evidence, international best practice, and UN guidance documents. The effects of treatment should be evaluated through involvement of external institutions and/or agencies (e.g. university research groups) to improve the quality ST and offer sound evidence for policy development. The Riga Centre of Psychiatry and Addiction Disorders should play a key role and should become a national center of expertise (resource center) that fosters the development of new modalities for MMT and ST. There is no OST program in prisons although isolation can be use for reaching positive results,

- ♦ Latvia developed counselling and testing services for HIV/AIDS through establishing *Low Threshold Centres* (HPCs), 22 laboratories are involved in HIV epidemiological surveillance system, two specialized STI facilities, and thirty-two specialized TB facilities provide medical services. In addition, one non-governmental organization provides VCT services to the population at risk. It is mandatory for health staff to offer HIV test to all TB patients, pregnant women, IDUs, sex workers, STI patients and to prisoners at entry to prison system. Consequently, number of tested individuals annually ranges at around 150,000 per year (including 68 000 blood donors). All laboratories have to report detected HIV cases and send samples for confirmation tests to national lab. Such system provides valuable information for monitoring HIV epidemic in Latvia. However, over time the quality of reported epidemiological data deteriorated i.e. share of unknown route of transmission has increased, which indicates about poor quality of offered VCT services. Thus, improving quality of VCT is important and therefore, proposed national program will address these weaknesses.

- ♦ Latvia conducted national bio-behavioural studies in 2002 among street and bar prostitutes in Riga and Riga region. Since 2001, regular surveys took place among IDUs clients of HPCs in Riga and Riga region. However, the quality of Bio-Behavioural Surveys could be questioned as the rates of HIV detected through BBS in 2005 was comparable to rates routinely detected among the clients of HPCs, which suggests that the study probably sampled only few respondents beyond the clients of the HPC. Therefore, there is a need to implement surveys among groups at risk in order to identify HIV prevalence and behaviour patterns and to better plan preventive interventions.

- ♦ Latvia introduced treatment with antiretroviral therapy for people living with HIV and as of December 31st, 2006 total 301 patients were on treatment out of 2,442 HIV/AIDS patients[32]. ARV treatment has been established, but now country faces the need for expanding the provision of ARV to all in need. Therefore, Latvia needs to develop multiple entry points to ARV-treatment integrating it into (or linking with) HPCs, with the objective of reaching more HIV positive IDUs. In addition, Latvia needs to build counselling and support capacity of these

[31] Latvian National Focal Point (2007) 2007 National Report (2006 data) to the EMCDDA by the Reitox National Focal Point. Latvia: new development, trends and in-depth information on selected issues. Riga: Public Health Agency.

[32] Latvia, WHO/Europe Survey on HIV/AIDS and antiretroviral therapy 2007.

services and facilitate better adherence to ARV-treatment; it has to negotiate affordable (lower) prices for ARVs with pharmaceutical companies[30]. Furthermore, the rates of co-infection with Hepatitis B and C are high and therefore treatments are required. However, cost sharing (i.e. patients are required to cover 25% of the cost of treatment, which amounts to ≈400€) becomes significant financial access barrier for patients and the numbers treated thus far remain to be low. In order to increase number of treated patients with co-infection (mainly hepatitis C) it is essential to revise policies and reduce the rate of cost sharing and/or negotiated the lower price for drugs.

- Significant advances were made in introducing the 'Three Ones' principle of UNAIDS:
  - Latvia developed one National HIV Program (2003-2007) which helped coordinating the work of various partners. However, Monitoring and Evaluation (M&E) plan was not an integral part of the Program (2003 – 2007).
  - Within MoH Latvia established the National Coordination Committee for HIV and STI Prevention, assumes responsibility for coordinating national response to HIV/AIDS. This committee also includes members from other line ministries (MoCFA, MoIA, MoD, MoES, MoJ and MoW) and from NGOs, but its functionality needs further strengthening.
- As stated above, Latvia is yet missing one National country-level Monitoring and Evaluation plan and system, which has to be developed to satisfy completely 'Three Ones' principle. Many indicators used in this National Program are process, performance, and coverage indicators. Therefore, it is critical to develop comprehensive M&E plan under the new National Program and use it for monitoring, and for mid-term and final evaluation of the national program prior to developing the next national program.

4 Program Goal and objectives

The Goal of this program is to **limit the spread of HIV infection and reduce its negative impact on individuals and society at large**.

To reach this Goal five strategic objectives were identified:

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

In order to attain stated strategic objectives the program will focus its interventions on the target groups identified earlier.

5 Implementation Principles

The program implementation will be based on following principles:

- All activities will promote, protect and respect human rights and assure gender equality;
- Implementation will be based on principles of cooperation with the non-governmental and private sector, as well as on the principles of transparency, partnership and mutual confidence;

- HIV prevention will be differentiated and locally adapted to the relevant epidemiological, economic and socio-cultural context in which they are to be implemented. In Latvia, this includes taking into account the decentralization process, ensuring that the programs are designed at the municipal level, with activities tailored to the needs of local populations (including ethnic minorities), using activities, messages and channels based on community knowledge and culturally sensitive to community beliefs;
- Reduce access barriers (i.e. legal, geographical, financial, cultural) to preventive, curative, support or care services and scale up services delivered to those in need.
- Peer driven models will be widely used in order to promote a supportive and enabling environment for vulnerable groups and help them engage if and benefit from the interventions planned under the national program. The concept of a supportive and enabling environment will recognize that "*the most effective responses to the epidemic grow out of people's action within their own community and national context*."[33]
- HIV prevention will be supported with evidence, based on what is known and proven effective from all available data, and the generation and use of the evidence base will be expanded and strengthened;
- HIV preventive interventions will achieve coverage, scale, and intensity necessary for making critical difference in controlling the epidemic spread.

6 Programmatic Activities and Expected Results

The proposed programmatic activities are grouped around five strategic objectives listed in the Section 4 and are aimed at reaching the target groups identified earlier. The brief description of the planned activities and expected results are provided in this section. However, more details per each activity are available in the relevant annexes.

Strategic Area 1. Avert new HIV cases among most-at-risk population

Under this strategic area, the focus will be on delivering preventive services to IDUs, Prisoners, CSW and MSM.

6.1.1 Activities targeted at IDUs

An important goal of the national program will be to develop *best practice* and *evidence-based* policies and interventions for IDUs. Therefore, all interventions proposed hereby have shown effect or promise in managing IDU driven concentrated HIV epidemics. The purpose of the work among IDUs will be *increasing the scale and quality of drug treatment and other health and prevention services to best practice levels, in order to fully realize 'universal access' for this sentinel population.* This will be achieved through following interventions:

1. Scale up the provision of harm reduction supplies,[34] information about HIV and VCT to reach and retain in service up to 45% of injecting drug users at the end of year five of the national program. Therefore, the support will be provided to HPCs to use peer driven interventions that will help reaching and retaining a proportion of the IDU population large enough to have an impact on the spread of HIV. *Gender sensitive* (i.e. women-friendly) programming will be developed in HPCs, which will combine HIV prevention with elements of family planning and

[33] Handbook for Legislators on HIV/AIDS, Law and Human Rights. Geneva, UNAIDS/IPU 1999.

[34] Harm reduction supplies for injecting drug users can include needles and syringes, disinfectants, alcohol pads, ascorbic or citric acid, cotton filters, single use 'cookers' and antibiotic ointments (for damaged veins).

contraception. Therefore, along with harm reduction, reproductive health and PMTCT services will be routinely provided to female clients. Early interventions for young female IDUs and pregnant IDUs will be developed. In order to reach the scale with preventive services, NGO involvement will be essential. NGOs will help furthering the reach of HPCs and will help increase involvement of peers and IDU networks in the delivery of HIV prevention messages and supplies. Therefore, NGOs will be financially supported from state and local budget. Trainings will be offered to HPC and NGO staff in order to help them to reach as many IDUs as possible. In addition, these interventions will also focus on reaching out Russian speaking and Roma population.

2. Scale up *Methadone Maintenance Therapy* (MMT) and other substitution treatment (e.g. buprenorphine) and develop evidence-based drug treatment modalities for amphetamine injectors. Scaling up OST to levels that influence the twin epidemics of drug injecting and HIV requires broadening the network of service providers. Trainings and development of regulatory framework for OST should be guided by patient needs, by scientific evidence, international best practice, and UN guidance documents. Patient-centred services have to be developed, whereas access barriers to therapy are minimized, various services are integrated and delivered to the individual. Capacity for treatment evaluation has to be developed to evaluate the reach and quality of OST. Involvement of external institutions or agencies (e.g. university research groups) can improve the quality of these studies and make necessary evidence available that will inform policy decisions. The Riga Center of Psychiatry and Addiction Disorders should play a key role in the development of the service provider network and should become a national center of expertise (resource center) on drug treatment. It should try to bring ST services as close in the community as possible. Tailored drug treatment and HIV prevention interventions should be developed to serve the needs of *amphetamine injectors*. Best practice examples from e.g. Czech Republic, the USA, and other countries should be adapted to the Latvian context for this purpose. In order to improve the quality of MMT it is important to develop independent treatment evaluation capacity (e.g. within university system, or Public Health Agency, and/or NGO research groups). For this purposes funds will be made available and tendered on a competitive basis to contract and engage independent groups in the research.
3. Develop expertise and implement best practice for overdose prevention in order to reduce the prevalence of lethal drug overdose. These activities are aimed at investing in overdose reduction programs, both in the community and as part of prison release programs. Best practice overdose programs are being developed around the world and Latvia will study and adopt the ones, which best suits its need. Under the national program, Latvia will aim to involve HPC and NGOs in overdose prevention activities.

Expected results from these activities are following:

- Increased number of HPCs that effectively use peer driven methodologies and NGOs and reach out higher number of IDUs and distribute adequate number of syringes through peer-based strategies (secondary exchange) and other harm reduction materials and information;
- Well-trained program staff (at HPCs, NGOs and other IDU projects) equipped for working with out-of-treatment IDUs;
- Increased and stable involvement of opiate addicts in OST and other ST who receive patient tailored prescription regimes;
- Best practice approaches to amphetamine problems adapted to the Latvian context and implemented in HIV prevention and drug treatment services;
- Quality of MMT will be evaluated and scientific evidence necessary for planning will become available;

- Regional shared care agreements between state, municipal and NGO counterparts involved in care to IDUs in order to deliver ARV along with OST.

The overall impact of the effective implementation is expected to be significant decrease in unsafe injecting practices, and stabilization of HIV prevalence and reduction of HIV incidence among IDUs and their sexual partners.

6.1.2 Activities targeted at Prisoners

Following activities are planned to prevent HIV cases among prisoners:

1. Improve testing and diagnosis of HIV/AIDS and linkage to other infectious diseases (TB, Hepatitis, STIs). *The issues related to treatment and care of prisoners are addressed under strategic area 3.*
2. In order to prevent HIV spread within prisons system it is essential to increase the knowledge, competencies, and skills of the prison staff and prisoners about HIV/AIDS and other infectious diseases through providing training with the manual "Risk Reduction for Drug Users in Prisons" and other media.
3. Initiate harm reduction and *Opioid Substitution Therapy* (OST) in prison system and involving sizable number of IDUs. Effective prevention of HIV spread among IDUs, especially in prisons, mainly is performed by harm reduction programs (provision of substitution treatment, needle exchange programs) to make the intravenous drug users stop injecting and stop sharing needles. Therefore, it is important to introduce and scale-up such services in order to keep up with the dynamic of infectious diseases and drug use. Political leadership and legislative and policy reforms will be essential first step for such services to emerge in the prisons of Latvia.
4. The global experience shows that prisoners as well as groups-at-risk are best served when outside agencies (governmental and NGOs) are involved in delivering HIV-prevention and curative services. Involvement of such agencies is an assurance of confidentiality and anonymity. Additionally, in Latvia prison system is short of resources and staff therefore involving public health agencies such as ICL, SATLD - State Agency of Tuberculosis and Lung Diseases of Latvia, and PHA that receive funding from public budget will deliver HIV/AIDS, TB, hepatitis, STI testing and prevention services in prisons and will help provide equivalent services to the community. For this purposes it is proposed to use "Triangular Clinics" as a medical response to the spread of three major threats: the spread of HIV/AIDS (and other blood borne viruses such as hepatitis), opioid (and other drug) addiction, and TB. Tackling all these interrelated challenges along with the problems of financial und human resource shortage in the prison system, through mobilization of the medical support of external agencies seems to be the only promising approach.

Expected results from these activities are following:

- Increased awareness among prison staff and prisoners about the transmission and prevention of blood-borne infections that will help lower risk-behaviour;
- Increased 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;
- Harm reduction and OST services become available to prisoners therefore risk of HIV spread within prison system will be lowered and new cases of infection averted;
- Prisoners will receive comparable health care services to the rest of Latvian population and their confidentiality will be guaranteed that will help increase the trust in providers and most likely will improve outcomes of offered treatment.

6.1.3 Activities targeted at CSWs and MSM

While prevention of HIV spread among these groups is important, at this stage very little is known about their behaviour and size/location. Therefore, under the national program it is planned to undertake special study that will help estimate size of these groups, their behaviour and will provide necessary information for future planning. Hence, after implementation of the stated study, detailed planning will take place and interventions will be reflected in the amended national program, which is expected to occur during 2009-2010.

In order to undertake such study international assistance will be solicited and local outreach channels will be used such as:

- Existing network of services for gay men in Riga, including bars, night clubs, websites and a gay hotel that provides HIV testing two nights a week for its clients.
- Some expertise in working with (drug injecting) sex workers is available in Latvia through local NGOs that ran a project for street sex workers funded by the British embassy. They also participate in EU funded sex work networks. Therefore, it is planned that *Rapid Assessment and Response* (RAR) will be used to rapidly develop a national response to HIV among sex workers. Part of this will be a *Respondent Driven Sampling* RDS-BBS study to determine extent and nature of the SW population and their health and social problems.

Strategic Area 2. Implement wider prevention strategies among general population

Under this strategic area, the national program will focus on preventive interventions among general population and, more importantly, among schoolchildren, among pregnant to avert vertical transmission, among professionals who are at most risk (i.e. health care workers, police officers, fire-fighters and rescue workers[35]). *Voluntary Counselling and Testing* (VCT) for HIV will be expanded as a means of increasing population awareness as well as detecting HIV infected, safe blood supply will be assured through testing of 100% of donor blood and blood-products. Timely and quality post-exposure prophylaxis (PEP) will be provided to the needy individuals. In order to outreach these groups following interventions are planed under the national program:

1. Increase awareness of public about HIV Transmission and means of prevention through organizing annual information and educational campaigns within the framework of the World AIDS day, focusing educational messages on youth and children and making diverse information about HIV transmission and prevention measures available through Internet (PHA web site) and other targeted media.
2. While drug injecting mostly clusters in marginalized groups, non-injecting drug use is spread more widely through all social classes in most European countries, including Latvia.[36] In all major cities throughout the EU drug use has become a conspicuous feature of nightlife. Latvian school surveys suggest that about 5% of students have experience with drugs such as amphetamines, heroin, or cocaine—all of these substances can be injected. Therefore, the problems of drug injecting and HIV cannot be disconnected within schoolchildren; the *Twin Epidemic* extends it reach as long as Latvian youth engagement into drug injecting continues. Therefore, it is necessary to focus messages not only on HIV but also on needle-HIV interconnectedness in order to avert *Twin Epidemic* spread and reduce HIV infection rates. Peer programming in this groups will be considered to help the spread educational messages among those that interact with drug users in a social settings.

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[35] Interventions aimed at prison staff is described under Strategic Area 1.

[36] Latvia EMCDDA country report, 2007 (check ref)

Two projects will be piloted under the national program to test approaches and obtain experience and afterwards will be scaled up nation wide.

3. Activities aimed at preventing vertical transmission of HIV will be implemented during next 5-years that will assure adequate supply of HIV express tests to maternity wards and provision of preventive therapy against HIV vertical transmission (mother-child) in accordance with guidelines for HIV infection treatment. In order to avert vertical transmission primary HIV prevention along with prevention of unwanted pregnancy among HIV infected women will be carried out and more importantly young women most at risk, those injecting drugs, involved in sex work or sexual partners to IDUs will be targeted. For young female injectors special harm reduction interventions that combine elements of HIV prevention with family planning will need to be made available through existing services, such as HPC described earlier under *Strategic Area 1*.
4. Universal precautions will be promoted among health care workers and selected professions (policemen, fireman, rescue workers and prison staff) through developing and posting information about universal precautions on the PHA website; organizing special annual seminars/lectures for these groups;
5. VCT services will be expanded and the quality improved through developing and approving new VCT guidelines; introducing these guidelines in the postgraduate training curricula and training sufficient number of health care workers; Assuring supply of the HIV laboratory surveillance network with adequate quantities of HIV test-kits to meet the demand of increasing VCT;
6. Testing of donor blood for HIV to assure safe blood and blood product supply throughout the country will continue;
7. HIV post exposition prophylaxis (PEP) to all that have been exposed to the risk of HIV transmission will be provided.

Expected results from these activities are following:

- Increased awareness among general public and more importantly among schoolchildren about HIV transmission and drugs, which could help minimize epidemic spread and help decrease the number of new drug users emerging from younger age groups;
- Preventing and decreasing the number of cases when HIV infections is transmitted from mother to child;
- Preventing new cases of HIV among people that professionally are at-risk of HIV infection and also preventing HIV among those who were exposed to the risk of HIV transmission;
- Improved quality and availability of VCT testing and increased number of people that received information about HIV and were tested;
- Higher degree of safety of the available donor blood and blood products.

Strategic Area 3. Provide health and social care to PLWHA and eliminate stigma & discrimination

Under this strategic area, the national program will focus on improving quality and reaching more people with treatment, care, and social support. This strategic area builds on commitment made by Latvia in the "Political Declaration on HIV/AIDS" reflected in the Resolution adopted by the UN General Assembly on June 2nd, 2006 to overcome legal, regulatory or other barriers that block access to effective HIV prevention, treatment, care and support, medicines, commodities and services. Therefore, following interventions have been planned under the national program:

1. New guidelines and treatment protocols for treating HIV infected people and AIDS patients (including the diagnosis and treatment of the so-called indicator diseases accompanying AIDS) will be developed and disseminated throughout the health care network;
2. Combined ARV treatment for HIV infected individuals will be expanded and quality of this therapy (including resistance to ARV drugs) will be monitored. In addition, diagnosis and treatment of the opportunistic diseases will be assured for those in need. For this purposes sufficient financial and human resources will be deployed by the health care system to increase the number of treated individuals and reduce and/or remove financial, geographical or cultural access barriers to care, which currently exists in the country. Importance will be placed on scaling up ARV treatment for IDUs through providing patient-centred integrated services for HIV positive (injecting) drug users. Collaboration between different specialists will be at the core of curbing the HIV epidemic among IDUs. There are many best practice examples (e.g. integrated model of service provision where MMT and ARV treatments are offered from one place; patient case management is an effective and inexpensive method to increase the coordination of care offered to IDU patients with multiple health (and social) problems, etc) that will be reviewed, adopted, and used in Latvia. Success at controlling HIV in this sentinel population will determine the future course of the HIV epidemic in Latvia. This program proposes to scale up both OST and ARV treatment, targeting the same population;
3. ARV and TB treatment along with treatment for co-infection will be offered to prisoners through financing and involving the public health agencies (i.e. Latvia Infectology Center and State Agency of Tuberculosis and Lung Diseases of Latvia) and establishing "Triangular Clinics" as a medical response to the spread of three major threats within the prison system. NGO participation in the delivery of care and support will be facilitated through provision of sufficient funding from the state budget and through removal of any legal or other barriers for their engagement;
4. As the number of patients increase, the need for palliative care for AIDS patients is growing. Therefore, national guidelines for such care will be developed and service providers will be established/strengthened and funded by the state. It is hoped that during coming 5-year period all patients, who are in need of these services, will be reached;
5. The focus will also be maintained on improving access to social services and to the type of services for HIV infected. This would require sufficient budget allocations from municipal budget to fund and deliver such services to the people in need. Engaging NGOs in social service provision to HIV infected will receive priority;
6. To help people in need of treatment, care and support to navigate the national system and timely receive information about available state funded benefits and services, AIDS hotline will be maintained and operated by ICL. ICL will also ensure psychological support to HIV infected persons and their families.

Expected results from these activities are following:

- Increased availability of treatment, care and social support services to HIV infected and AIDS patients in public as well as in prison system; Availability of patient-centred services for IDUs where ST and ARV treatment are combined and offered to the patient from the same location;
- Improved quality of services and access through reduction of financial or geographical access barriers to treatment, care and support;
- Higher number of HIV infected and AIDS patients being able to reach and receive the treatment, care, and support they need.

Strategic Area 4. Generate and use evidence for response planning and implementation management

Having objective information about the HIV infection and spread of drug use among different population groups is important to track the epidemic as well as to monitor the program implementation and its impact. Therefore, this strategic area focuses on those interventions that can help improve the type and quality of information necessary for adequate response to the epidemic:

1. Public Health Agency will continue to maintain HIV case-based reporting system and will compile database of HIV/AIDS cases according to European CDC and WHO European Regional Office guidelines. Case notification and HIV and AIDS registries will be maintained by the agency and routine analysis and reporting will be assured to national and sub-nation bodies and international organizations;

2. The *"Three Ones"* principles, endorsed by the Government of Latvia, helps achieve the most effective and efficient use of resources, and ensures rapid action and results-based management. Latvia yet satisfies two principles out of this three. It has *One agreed HIV/AIDS Action Framework* that provides the basis for coordinating the work of all partners in the country and *One National AIDS Coordinating Authority*, with a broad-based multisectoral mandate. The third principle - *One agreed country-level Monitoring and Evaluation System* is yet missing. Therefore, under the new national program for HIV/AIDS this monitoring and evaluation framework will be developed and used to monitor overall implementation of the national program and evaluate its impact. Because of this work, the set of indicators proposed in this document will be expanded and will become part of the *agreed country-level Monitoring and Evaluation System.* The information generated by this system will be used for mid-term and final evaluation of the national program that will take place during 2010 and 2012 respectively.

3. As stated earlier in this document information pertaining CSW and MSM is lacking in the country and does not allow planning of interventions for these groups. Hence, it is critical to undertake study and estimate size of most at risk population in Latvia for CSW and MSM. The study will use *Respondent Driven Sampling* (RDS) as standard methodology for *Integrated Bio-Behavioural Survey* (BBS) and other research methods proposed for "hidden populations" and will produce reliable population size estimates by combining the RDS and Capture-recapture methods. **This information will be used to plan interventions for CSWs and MSM and reflect them in the amended national program.**

4. Besides the stated study, regular *Integrated Bio-Behavioural Survey* (BBS) among prisoners, IDUs, CSWs, and MSM will be necessary. These studies will help monitor the infection spread among groups at risk as well as link the infection rates with behaviour factors. This information will be important to plan/adjust interventions among groups-at-risk as well as will generate information about HIV prevalence that will inform *National Monitoring and Evaluation System.*

5. Limited information about migrant population is available in Latvia. While migration numbers are yet low, anecdotal evidence suggests that some migrants are trafficked and forced into risky behaviour. It is planned that with the help of UNODC Latvia will plan and undertake special study focusing on migrants and obtained evidence will inform the national planning process.

6. Where possible and when opportunities emerge different studies implemented in Latvia (like: European school survey on alcohol and drug use among European 17–18 year old students, etc.) will be piggy-backed to study school children knowledge, attitude and practice regarding HIV/AIDS.

7. The information emerging from studies, form routine HIV and AIDS monitoring will be made available freely in a public domain to improve access to this information, assure transparency and broader involvement of those interested in monitoring the epidemic spread, and undertake independent evaluations/studies.

Where possible implementing agencies will link with the European research networks and funding to implement these studies and or solicit technical and financial assistance from bi-lateral or multi-lateral agencies (i.e. WHO, UNODC, etc.).

Expected results from these activities are following:

- Latvia will have *One National Monitoring and Evaluation System* to rack the epidemic and national response effectiveness.
- Routine system of HIV and AIDS surveillance will function and produce necessary information;
- The quality, availability and diversity of information related to risk-groups (i.e. their size, HIV prevalence, risk behaviour etc.) will improve;
- The impact of the national program will be evaluated and if necessary adjustments will be made during mid-term review. Final evaluation will inform next round of the national program for 2013-2017.

Strategic Area 5. Strengthen national coordination and capacity to respond to HIV and AIDS

Effective implementation of the National response to epidemic requires close collaboration and effective coordination among different ministries, among governmental and non-governmental sectors, among different vertical programs and health care services, collaboration among different projects supported by EC and other multilateral agencies like WHO, UNODC, etc. Therefore, under this strategic area following interventions are planned:

1. Functions of the National STD/HIV Prevention Coordination Committee will be expanded and will also include TB issues, will effectively involve civil society in national planning, program implementation and service delivery for HIV and AIDS;
2. Necessary resources in the national and municipal budgets will be allocated for NGO involvement and contracts will be tendered for NGOs to deliver services in the community and on national level;
3. Cooperation between institutions working on HIV and TB surveillance will be strengthened through developing integrated HIV and TB surveillance, prevention and treatment guidelines;
4. Participation in various donor funded projects will be assured:
    a. EC international cooperation project 2005302 (Expanding Network for Coordinated and Comprehensive Actions on HIV/AIDS Prevention among IDUs and Bridging Population)
    b. UNODC international cooperation project XEE/J20 “HIV/AIDS prevention and care among IDUs and in prison settings in Estonia, Latvia and Lithuania” AD/XEE/06J/20
    c. The Government of Latvia, through Ministry of Welfare will consider accessing the “European Social Fund” in order to finance and support access to employment and social inclusion of yet marginalized groups, for fighting discrimination and for developing better public services.

d. Though the Biennial Collaborative Agreements (BCA) between the MOH and WHO Regional office for Europe

Expected results from these activities are following:

- Well-coordinated multisectoral national response to HIV and AIDS, which assures timely and effective implementation of the interventions planned under the national program.

7 Implementation Timelines and Responsible Institutions

Implementation timelines, responsible institutions and collaborating agencies are described in detail in the Annex 1.

8 Required policy changes

In order for Latvia to implement planned activities and counteract epidemic spread, it is necessary to amend and enact new policies that will create conducive environment for the national program implementation. Proposed changes are as following:

- ♦ Develop funding mechanisms and allocate sufficient funds to finance NGO involvement in preventive, treatment and care activities planned under the national program;
- ♦ Revise laws and regulations with the aim to provide equal health care services for prisoners and public and assure equal financing of the service provision through better integration of public and prison health care service provision systems. Therefore, it is necessary to integrate and bring into the prison system the services of public health care system services (State Agency of Tuberculosis and Lung Diseases of Latvia, Latvia Infectology Centre, addiction treatment centres in Riga and other cities), by involvement of respective agencies and NGOs. Such integration should be aimed at developing and delivering confidential, competent, anonymous, and coordinated prevention, care, treatment, and support to those in the prisons.
- ♦ Revise laws in order to assure introduction of harm reduction measures, like *Opioid Substitution Therapy* (OST) and syringe exchange programs in the prisons and in the community;
- ♦ Reduce financial access barriers (i.e. the rate of cost-sharing) for those that require treatment for HIV co-infection, mainly for Hepatitis "C";
- ♦ Develop and implement patient-centred preventive and health services that could be delivered to the groups at risk.

9 Existing Funding and Necessary Financial Resources

The total cost of HIV and AIDS interventions for the national program 2008-12 is estimated at LVL 53.9 million (see *Annex 2 – Funding Requirement for more details*). These estimates are based on the critical assumption that preventive and curative services will be scaled-up to the levels that are necessary to counteract HIV growth/epidemic. Therefore, these estimates assume going to scale for IDUs and CSWs at 60%, covering all prisoners at the end of 2012 and awaiting more solid planning fundament for the response to MSM. STI interventions are important to reduce vulnerability for HIV infections, but have not been explicitly incorporated in the national program yet and are only part of cost components of interventions aimed at Most-At-Risk-Population. Data for home-based care was not available at the program planning stage and consequently are not included in the costing.

The majority of resources i.e. 62% or LVL 33.2 million will be necessary for HAART treatment. These estimates are based on the expected number of patients provided by Infectology Center of Latvia. At the end of 2007 ICL treated 380 patients with HAART and since many more are eligible to receive HAART. Therefore, doubling of HAART patients estimated for 2008 up to 800 patients. The following years 200 new patients (net) are added per year. It is evident that treatment costs are quite high LVL 5200-6400 per year per person. With the further growth in HIV infected these costs will increase significantly. Therefore, focusing on prevention pays off, because cost of preventive services is lower as well as it helps prevent new HIV infection and therefore helps to minimize funding requirement for HAART for future. Preventive activities are estimated at LVL 200-500 on average to provide HIV prevention for most-at-risk populations in Latvia[37].

In addition, Latvia spends the highest amount for HAART, when comparing costs of the first regimen and second regimen ARV drugs. The cost of monitoring the HAART treatment is significantly higher in Latvia than in Estonia, Georgia and Ukraine[37]. Therefore, negotiating better prices with drug suppliers and trying to reduce the cost of monitoring could be helpful strategy to balance the funding requirement with the available resources.

The second most important part of the resources are targeted for prevention among three priority interventions aimed at IDUs: a) increase number of IDUs reached through peer-driven interventions, b) increase OST and c) increase services to prison IDU population. These estimates are based on the plans to scale-up the present relatively limited methadone programme to include from 200 persons in 2008 to 1,500 IDUs in 2012. However, even these targets are modest compared to what is needed for Latvia. Further increase in the target number of IDUs to be reached with OST at the end of the program should be considered if funds and capacity permit.

Comparison of the estimated cost of the national program with the available resources for 2008 indicates on the significance of the existing resource gap. The resource gap builds on estimates from 2005 (2005 running prices)[38] compared with 2008 (2008 prices), which does not make a perfect comparison but provides guidance to the size of the resource gap that is necessary to finance the Latvian national Strategy 2008-12.

In 2005 the prevention area 1 covering prevention of most-at-risk population included HPCs only and did not include resources for MSM; peer-driven IDU interventions; interventions for FSW injecting drugs; and only some limited training on HIV in prisons. In 2005 youth were a significant proportion of general prevention interventions: LVL 55000 for mass media targeting youth and LVL 67000 for awareness campaign. Since youth is not at risk per se (only youth with unsafe behaviours present the risk for epidemic spread), these interventions are not included in the HIV Strategy 2008-2012.

The prevention area 2 covering general prevention interventions such as safe blood, HIV tests, and VCT had more resources allocated in 2005 than being proposed in the HIV Strategy 2008-2012. This is mainly due to the resources spent on youth awareness and mass media campaigns. The figures from 2005 include staff and running costs for relatively few VCT interventions but it is assumed that the budget lines are covering other services as well. The 800 VCT proposed for 2008 being scaled up to cover 5200 VCT in 2012 have much lower costs attached for significant higher numbers of VCT.

The costs of providing HAART only include the drugs for 2005 – the cost of providing drugs in the planning period includes both drugs and monitoring. The total costs allocated to HAART are driven by the price of drugs – especially second regimen drugs. Therefore, negotiating better prices could be the solution to minimize the gap.

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[37] Alban A., Miezitis A. 2007. Estimation of costs of HIV Strategy 2008-2012 for Latvia.

[38] Latest available data

Very limited resources were allocated to evidence based activities in 2005, which provides a significant gap of the LVL 175,000 – almost the total budget for 2008 for this target area. The resources allocated for national coordination in the HIV Strategy 2008-2012 relates to a percentage of prevention and care. In Latvia, this will include activities in the Infectology Center, all activities in the HIV Prevention Center and coordination in the relevant ministries and across all partners in HIV and AIDS.

Table 2 Financing the HIV Strategy 2008-2012: Estimated resource gap 2005-2008

Activity	2005	2008	2009	2010	2011	2012	Resource gap Between 2005-08
Prevention, area 1							
FSW		139,448	278,897	418,345	557,793	697,242	
FSW&IDU*		24,999	49,998	74,997	99,996	124,995	
MSM*		10,000	15,000	20,000	20,000	20,000	
IDU-OR	204,024	178,008	311,514	578,526	734,283	778,785	
IDU(OS)		101,974	254,936	458,885	611,847	764,808	
IDU-PDI*		25,000	87,875	263,624	483,310	702,996	
Condom promotion		5,200	7,800	18,200	27,300	33,800	
Prisoner	3,273	79,241	158,483	264,138	369,793	528,275	
Sub-total, prevention, area 1	***207,297***	***563,871***					**356,574**
Prevention, area 2							
Mass Media**	55,439	112,045	112,045	112,045	112,045	112,045	
Blood safety	163,100	174,750	186,400	186,400	186,400	186,400	
VCT***	53,113	12,000	18,000	42,000	63,000	78,000	
HIV test kits	99,537	86,000	87,700	90,300	92,200	93,700	
STI							
PMTCT		17,500	21,000	24,500	28,000	35,000	
Youth awareness	67,727						
Sub-total, prevention, area 2	***438,916***	***290,250***					**-148,666**
Care & treatment, area 3							
HAART	2,134,308	4,998,678	6,447,167	6,090,418	7,313,388	8,358,157	
Palliative care*			9,603	19,206	28,809	38,411	
HBC*							
HIV-TB							
AIDS hotline*		24,000	25,500	27,000	28,500	30,000	
Sub-total, care, area 3	***2,134,308***	***5,022,678***					**2,888,370**
Evidence based plan., area 4							
Capacity building****	5,000	50,000	50,000	50,000	50,000	50,000	
Operational research / BBS		130,000	150,000	150,000	100,000	100,000	
Sub-total, area 4	***5,000***	***180,000***					**175,000**
National Coordination, area 5							
Coordination incl. M&E	NA	894,727	1,206,962	1,299,237	1,609,224	1,882,892	
Sub-total. Area 5		***894,727***					**894,727**
TOTAL	**2,785,521**	**7,067,171**	**9,482,703**	**10,191,870**	**12,520,162**	**14,620,007**	**4,281,650**

** HIV services unavailable in 2005*
*** Mass media only includes youth campaign*
**** Fairly high budget figures for staff, and running costs are included for VCT that do not match the activities (no. of VCTs) – it is assessed that the staff and running costs have alternative uses?*
***** The figure for capacity building in 2005 includes only some training*
Note: The yellow marks indicate that the HIV interventions are not provided in the given period

In conclusion: The resource gap to carry out the proposed HIV interventions in 2008 is estimated at LVL 4.3 million increasing over the years due to the extra cost necessary of scaling up interventions year by year. Average increase of LVL 2 million per year is mainly driven by the number of people accessing HAART. However, the resource gap has a range of uncertainties attached to it as described in the Alban and Meizitis 2007 report[39], therefore require cautious interpretation.

10 Program Monitoring and Evaluation

The National Coordination Committee for HIV and STI Prevention established by the MoH will carry out overall coordination of the *National Program* implementation. This committee includes members from other line ministries (MoCFA, MoIA, MoD, MoES, MoJ and MoW) and from NGOs. The decisions of the Coordination Committee will be informed by programmatic and epidemiological information collected by the *Public Health Agency.* The committee will review, decide, and submit recommendation to the Ministry of Health that has ultimate responsibility to monitor and evaluate outcomes of the *National Program* and submit annual (and evaluation) reports to the Cabinet of Ministers of the Republic of Latvia.

Public Health Agency will be responsible entity to collect data and information in accordance with the monitoring and evaluation plan for the *National Program,* compile proposed indicators[40] and prepare reports for national and international consumption[41,42].

Information on HIV/AIDS epidemiological situation in Latvia (in regions and in towns) will be included in the „Epidemiological Bulletin" and in the annual report submitted to the Cabinet of Ministers as well as posted on the PHA website for open public access.

National coordination and multisectoral response will be strengthened through moving away from information sharing to using M&E framework, monitoring the progress of implementation, uncovering the implementation weaknesses, taking decisions on corrective/improvement measures and advocating for the needed governmental decisions on the level of government or sector ministries.

Detailed output indicators and quantitative-qualitative targets for the national program are provided in the Annex 3.

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[39] Alban A., Miezitis A. 2007. Estimation of costs of HIV Strategy 2008-2012 for Latvia.

[40] According to Commitment Declaration on HIV/AIDS implementation monitoring Guidelines on Establishing Basic Indicators." UN General Assembly Special Session on HIV/AIDS „Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on construction of core indicators" July 2005

[41] UN Millennium Declaration UN Assembly General, New York, September 6-8, 2000

[42] Point 3.2 un 4.5 of the Cabinet Regulations (July 26) No. 433 "Rules on State Agency "Public Health Agency""

Annex 1: Programme activities, time lines, responsible and cooperating institutions, expected results (2008–2012)

No	Key tasks activities	IMPLEMENTATION					Institution responsible for activity implementation*		Expected Results
		Y1	Y2	Y3	Y4	Y5	Responsible institution	Cooperation institution	
1	**STRATEGIC AREA 1. AVERT NEW HIV CASES AMONG MOST-AT-RISK POPULATION**								
1.1	**Scale up the provision of harm reduction, HIV information and VCT to IDUs by HPCs with the help of outreach workers and Peer Driven Interventions**	**X**	**X**	**X**	**X**	**X**	**PHA, LG**	**HPCs, ICL, NGOs**	♦ **At the end of year five ≈45% of all IDUs will be in regular contact with HPCs and will benefit from harm reduction**
1.1.1	Scale up syringe distribution through outreach and peer driven interventions and secondary exchange; Scale up distribution of other harm reduction supplies (e.g. condoms, filters, vit. C) to IDUs	X	X	X	X	X	PHA	MoH, LGs, HPCs, NGOs	♦ ≈45% of all IDUs receive on average 1 sterile syringe a day and 2 condoms a week from HPCs
1.1.2	Provide training to HPCs and to NGOs on developing peer driven interventions.	X	X	X	X	X	PHA	Professional organizations, UNODC, WHO (Knowledge Hub on Harm Reduction), EC	♦ HPCs, NGOs sufficiently skilled, staffed and equipped to deliver peer drive interventions. ♦ Regular skills oriented trainings organized; ♦ ≈70% staff of HPCs and NGOs receive 1+ training/year
1.1.3	Develop Gender sensitive services at HPCs to serve female IDUs	X	X				PHA	HPCs, LG	♦ HPCs are equipped with skills and offer gender sensitive services to female IDU users ♦ Higher number of female IDU receive harm reduction and other preventive services
1.1.4	Develop approaches at HPCs to improve service utilization by minority drug injectors	X	X				PHA	HPCs, LG	♦ More equal representation of Russian speaking and Roma IDUs at HPC by the end of year five
1.1.5	Establish new HPC sites (in e.g. Ventspils) and two other municipalities with significant IDU populations.	X	X				PHA, LGs	NGOs	♦ Eight new HPCs established

No	Key tasks activities	IMPLEMENTATION					Institution responsible for activity implementation*		Expected Results
		Y1	Y2	Y3	Y4	Y5	Responsible institution	Cooperation institution	
1.2	**Scale up OST and other substitution treatment (e.g. buprenorphine); Improve and scale up treatment for problematic amphetamine use; Develop tailored patient-centred care**								
1.2.1	Scale up the number of patients on OST through introduction of evidence based practice in current and seven new sites.	X	X	X	X	X	RCPAD	Regional & Municipal drug treatment centres, PHA, local authorities, UNODC, HCISA	♦ At the end of year five ≈33.3% of opioid addicts receives substitution treatment ♦ At the end of year five, all Substitution Treatment programs are 100% Evidence Based.
1.2.2	Scale up number and proportion of amphetamine IDUs receiving evidence based addiction treatment	X	X	X	X	X	RCPAD	Regional & Municipal drug treatment centres, PHA, local authorities, HCISA	♦ 250 amphetamine injectors at the end of year four in evidence based treatment for amphetamine dependence.
1.2.3	Develop patient centred care arrangements on a regional and/or local level, where drug treatment is decided and prescribed locally (not in Riga).	X	X				RCPAD, ICL, PHA	Regional & Municipal drug treatment centres, PHA, local authorities, other health services, HCISA	♦ Patient centred care arrangements are established ♦ OST prescription decisions are decentralized out of Riga.
1.2.4	Develop case management to coordinate IDU patient care and collaboration at patient level	X	X	X	X		RCPN, ICL, PHA	NGOs	♦ Case managers are trained and working in regions/towns where HIV positive IDUs receive ART along with ST.
1.2.5	Increase the capacity of the Riga Center of Psychiatry and Addiction Disorders to serve as national resource center for OST.	X	X	X	X	X	RCPAD	PHA, UNODC	♦ Riga Centre for Psychiatry and Addiction Disorders provides quality support to drug treatment programs in the country in order to meet coverage targets ♦ Increase No of research publications, manuals, guidelines produced and trainings conducted by Riga Centre for Psychiatry and Narcology
1.2.6	Evaluate the quality of OST by involving external organization and/or agencies (e.g. Universities).	X		X		X	PHA	universities, NGOs, RCPAD, UNODC	♦ Independent evaluation of OST takes place and makes scientific evidence available for public
1.3	**Develop expertise and implement best practice overdose prevention programs.**	**X**	**X**	**X**	**X**	**X**	**PHA**	**HPCs, (in-patient) drug treatment centres; Prison administration**	♦ **Prevalence of lethal drug overdose is reduced**
1.3.2	Provide training to staff of HPCs and NGOs, drug treatment programs and prisons on overdose prevention/reversal with naloxone	X	X				PHA	Prison administration, RCPAD, UNODC, Centre of Emergency and Disaster Medicine	♦ HPC, NGO and prison staff are trained in overdose prevention/reversal interventions

No	Key tasks activities	IMPLEMENTATION					Institution responsible for activity implementation*		Expected Results
		Y1	Y2	Y3	Y4	Y5	Responsible institution	Cooperation institution	
1.3.3	Train IDUs in overdose prevention methods and distribute overdose reversal kits among opiate injectors (through HPCs, OST programs, prison release programs)	X	X	X	X	X	HPCs, (in-patient) drug treatment centres, Prison Administration	PHA	♦ 2500 IDUs & released prisoners receive preventive information and training on using naloxone; ♦ 5000 OD prevention kits (incl. naloxone) distributed
1.4	Improve testing and diagnostics of HIV/AIDS and other diseases among prisoners Make sure tests and treatments are funded and available from public health system - Equipped prison facilities with X-rays - Increase VCT among prisoners	X	X	X	X	X	PHA, ICL, SATLD	Prison Administration MoJ	♦ VCT for HIV, hepatitis are provided by the Public Health System ♦ TB screening and diagnostic is offered. ♦ More prisoners receive quality VCT and share of those that are tested and know their HIV status increases.
1.5	Increase the knowledge, competencies, and skills of staff and prisoners about HIV/AIDS and i.v. drug use and other infectious diseases through providing training using the manual "Risk Reduction for Drug Users in Prisons" and other media. - Train the prison staff - Train the prisoners - Establish and train the peer-group- work among prisoners	X	X	X	X	X	Prison Administration MoJ	NGOs UNODC PHA, SATLD	♦ Prisoners and prison staff know the basics about transmission and prevention of blood-borne infections. ♦ The peer-to-peer – approach is implemented and acknowledged.
1.6	Initiate harm reduction and Opioid Substitution Therapy (OST) in prison system		X	X	X	X	RCPAD, PHA and NGOs	Prison Administration MoJ, UNODC, PHA	♦ Harm reduction measures are widely understood and accepted among prison staff. ♦ Harm reduction materials and OST are available and offered to prisoners. ♦ No of prisoners benefiting from harm reduction and OST is increasing
1.7	Involve outside agencies (governmental and NGOs) to deliver HIV-prevention services in-prisons (guaranteeing confidentiality and anonymity).	X	X	X	X	X	Prison Administration Min. of Justice	PHA, ICL, NGOs	♦ Public sector services are involved in the screening, testing, diagnostic, treatment, care and support for prisoners. ♦ NGOs are involved in counselling and prevention, care and support of infected prisoners.
1.8	Engage with CSW and MSM when information			X	X	X	PHA	MoH, NGOs	♦ CSW and MSM focused interventions are

No	Key tasks activities	IMPLEMENTATION					Institution responsible for activity implementation*		Expected Results
		Y1	Y2	Y3	Y4	Y5	Responsible institution	Cooperation institution	
	necessary for programming will become available from the planned studies among these risk groups								developed and reflected in the national program starting from 2010

No	Key tasks activities	IMPLEMENTATION					Institution responsible for activity implementation*		Expected Results
		Y1	Y2	Y3	Y4	Y5	Responsible institution	Cooperation institution	
2	**STRATEGIC AREA 2. IMPLEMENT WIDER PREVENTION STRATEGIES AMONG GENERAL POPULATION**								
2.1	**Increase awareness of general public about HIV Transmission and means of prevention**								♦ **Increased awareness about HIV transmission and means of prevention among the target groups**
2.1.1	Organize annual information and educational campaigns within the framework of Global AIDS day (December 1)	X	X	X	X	X	PHA	MoH, NGO, WHO Liaison Office in Latvia and other institutions	♦ Most of Latvian press, radio and TV are discussing HIV/AIDS related issues throughout the country ♦ 2 round table discussion with policy makers takes place ♦ 2 seminars/conferences take place
2.1.2	Post street advertisements/billboards throughout the country focusing messages on youth		X	X	X	X	PHA		♦ Information about HIV/AIDS targeted to youth is available from billboards throughout the country.
2.1.3	Provide diverse information about HIV/AIDS through Internet – PHA web site	X	X	X	X	X	PHA		♦ The respective PHA home page is up to date with actual information and statistics on HIV & AIDS http://www.sva.gov.lv
2.2	**Decrease initiation into injecting drug use (IDU reproduction rate)**								♦ **Decrease in IDUs initiating non-IDUs into drug injecting at the end of year five**
2.2.1	Adjust Best Practice IDU initiation interventions to Latvian context and provide training to HPCs and NGOs.	X	X				PHA	HPCs, NGOs	♦ Best practice adjusted and HPCs/NGO staff trained
2.2.2	Implement and evaluate 2 pilot projects		X	X	X		PHA	HPCs, NGOs	♦ 2 pilot projects implemented and evaluated
2.2.3	Start scaling up interventions to five cities, based on evaluation					X	PHA	HPCs, NGOs	♦ Scaling up has commence in 5 cities
2.3	**Implement activities aimed at preventing vertical transmission of HIV:**								
2.3.1	Supply maternity wards with HIV express tests	X	X	X	X	X	PHA		♦ 300 – 400 high risk women with unknown HIV status have been tested for HIV during delivery
2.3.2	Provide preventive therapy against HIV vertical transmission (mother-child) in accordance with guidelines for HIV infection treatment	X	X	X	X	X	ICL	Health Care Network	♦ At least 90% of HIV infected pregnant women and newborns with infected mothers receive a full ARV therapy course
2.3.3	Work closely with HPCs to deliver female IDU friendly services	X	X	X	X	X	PHA	MoH	♦ Higher number of female IDU receive harm reduction and other preventive services to prevent unwanted pregnancy or prevent HIV vertical transmission
2.4	**Promote universal precautions among health care workers and selected professions (policemen, fireman, rescue workers, prison staff)**						**MoH, MoES, MoJ, MoIA**	**PHA, ICL, UoL, RSU universities, municipalities and other interested institutions**	♦ **Knowledge of universal precaution measures among health care workers and selected professions (policemen, fireman, rescue workers and prison staff) is increased**
2.4.1	Develop and post information about universal	X					PHA	MoH	♦ Information about universal precautions is readily

No	Key tasks activities	IMPLEMENTATION					Institution responsible for activity implementation*		Expected Results
		Y1	Y2	Y3	Y4	Y5	Responsible institution	Cooperation institution	
	precautions on the PHA website								available from PHA web site
2.4.2	Conduct annual lectures for promoting universal precautions aimed at identified groups: health care workers and selected professions (policemen, fireman, rescue workers and prison staff)	X	X	X			PHA	MoH, MoES, MoI	♦ Up to 600 health care workers and selected professions (police officers, fire fighter, and rescue workers and prison staff) participate in the annual lectures over the five-year period.
2.5	**Improve quality and increase number of HIV testing (VCT)**						**ICL**	**PHA, MoH HIV testing service providers**	♦ **VCT Testing is increased** ♦ **More health care providers comply with the new VCT guidelines when offering services to pubic**
2.5.1	Develop and approve guidelines for VCT		X				PHA	ICL, MoH	♦ Guidelines on VCT are developed
2.5.2	Introduce in the postgraduate training curricula new guidelines for VCT			X	X	X	Riga Stradins University	MoH	♦ Specialists trained through postgraduate education receive trainings on VCT
2.5.3	Supply primary diagnostics laboratories involved in HIV/AIDS epidemiological surveillance with HIV test-kits	X	X	X	X	X	ICL		♦ 25 laboratories involved in HIV epidemiological surveillance are adequately supplied with HIV test-systems
2.6	Perform testing of donor blood for HIV	X	X	X	X	X	State Blood Donor Centre		♦ 100% of donor blood are tested for HIV
2.7	Ensure HIV post exposition prophylaxis (PEP) to medical employees, officials with special service ranks and other persons accordingly to the national guidelines	X	X	X	X	X	ICL		♦ 100% of the medical employees, officials with special service ranks and other persons who are in need receive PEP

No	Key tasks activities	IMPLEMENTATION					Institution responsible for activity implementation*		Expected Results
		Y1	Y2	Y3	Y4	Y5	Responsible institution	Cooperation institution	
3	**STRATEGIC AREA 3. PROVIDE HEALTH AND SOCIAL CARE TO PLWHA AND ELIMINATE STIGMA & DISCRIMINATION**								
3.1	Develop and approve clinical guidelines and treatment protocols for HIV infected and AIDS patients (including the diagnosis and treatment of the so-called indicator diseases accompanying AIDS)	X					ICL	MoH, SATLD, PHA, Riga Centre of Psychiatry and Addiction Disorders	♦ National clinical guidelines and treatment protocols are available
3.2	**Ensure combined ARV treatment for HIV infected individuals, monitor quality of this therapy (including resistance to ARV drugs) and ensure diagnostics and treatment of the opportunistic diseases**	**X**	**X**	**X**	**X**	**X**	**ICL, prison hospitals, HPCs**	**MoH, MoJ**	♦ **Patients receive combined ART according to medical indications and national guidelines** ♦ **Patients receive diagnostic and curative services for opportunistic diseases**
3.2.1	Provide ARV treatment to HIV infected and AIDS patients	X	X	X	X	X	ICL	MoH	♦ Higher number of HIV positive people are on treatment
3.2.2	Provide ARV, TB and co-infection treatment along with ST to IDUs through by developing patient centred services		X	X	X	X	ICL	HPC, SATLD, RCPAD	♦ Higher number of IDU receive integrated ST and ARV treatment
3.2.3	Provide ARV, TB and co-infection treatment to prisoners through involving the agencies that serve public.		X	X	X	X	ICL, SATLD	Prison Administration MoJ, RCPAD	♦ Higher number of prisoners receive treatment for HIV/AIDS, TB co-infection and ST
3.3	**Improve the palliative care service for AIDS patients:**								
3.3.1	Develop and approve guidelines on palliative care for AIDS patients	X					MoH	ICL, MoW, SATLD	♦ Palliative care services are available to the majority of AIDS patients
3.3.2	Develop palliative care services for AIDS patients and provide services to the patients		X	X	X	X	MoH	ICL, MoW, SATLD	♦ Palliative care services are available to the majority of AIDS patients
3.4	**Improve access to social services for HIV infected**						**MoW, NGO, HPCs**	**MoH, Ministry of Regional Development and Local Government, SATLD, ICL, NGO,**	
3.4.1	Develop budget program for HIV focused social services under the municipal budgets		X				MoF	MoH, *RAPLM,*	♦ Number of municipalities allocate budget funds for social services to HIV infected increases
3.4.2	Contract NGOs to deliver the social services to the HIV infected		X	X	X	X	MoH	PHA, MoJ	♦ NGOs receive municipal funding and deliver services to HIV infected
3.5	**Maintain AIDS hotline**	**X**	**X**	**X**	**X**	**X**	**ICL**		♦ **One 24-hour free-of-charge AIDS hotline providing information on HIV/AIDS related issues**

No	Key tasks activities	IMPLEMENTATION					Institution responsible for activity implementation*		Expected Results
		Y1	Y2	Y3	Y4	Y5	Responsible institution	Cooperation institution	
3.6	**Ensure psychological support to HIV infected persons and their families**	**X**	**X**	**X**	**X**	**X**	**ICL**		♦ **HIV infected people, AIDS and HIV/TB patients receive psychological support**

No	Key tasks activities	IMPLEMENTATION					Institution responsible for activity implementation*		Expected Results
		Y1	Y2	Y3	Y4	Y5	Responsible institution	Cooperation institution	
4	STRATEGIC AREA 4. GENERATE AND USE EVIDENCE FOR RESPONSE PLANNING AND IMPLEMENTATION MANAGEMENT								
4.1	Maintain HIV case-based reporting and compile data base of HIV/AIDS cases according to *ECDC* and WHO European Regional Office guidelines	X	X	X	X	X	PHA	ICL, SATLD, HPCs, treatment institutions involved in TB treatment and labs, all medical doctors	♦ Case-based reporting introduced and central national database is available which holds all information. ♦ Semi-annual reports are produced and submitted to ECDC/WHO. ♦ National UNGASS reports are produced and are timely submitted to UNAIDS.
4.2	Develop and implement National M&E framework for HIV/AIDS		X				MoH	MoES, MoJ, NGO	♦ Monitoring evaluation plan has been developed and used in epidemic response monitoring and evaluation.
4.3	Undertake mid-term and end-term evaluation of the program			X		X	MoH	PHA, UNODC, WHO	♦ Program evaluation reports are available and inform policy development and implementation planning/management
4.4	Undertake study to estimate size of most at risk population in Latvia for CSW and MSM	X	X				PHA	Donor Agencies	♦ Estimates of MSM (in 2008) and CSW (in 2009) are available ♦ Information needed to plan interventions is obtained
4.5	Undertake Integrated Bio-Behavioural Surveys (BBS) among groups-at-risk (IDU,CSW, MSM)								♦ Study results that inform national HIV/AIDS reports and allow monitoring of national program implementation are available
4.5.1	BBS among IDUs		X		X		PHA	NGO, HPCs, Narcology Services	♦ IDU behavioural and HIV prevalence data is available
4.5.2	BBS among MSM	X		X			PHA	NGOs	♦ MSM behavioural and HIV prevalence data is available
4.5.3	BBS among CSW		X		X		PHA	NGOs	♦ CSW behavioural and HIV prevalence data is available
4.5.4	BBS among prisoners		X		X		PHA	PA	♦ Detainee behavioural and HIV prevalence data is available
4.6	Undertake special study among migrant population to estimate their size and risk with regard to HIV.		X	X			PHA	UNODC	♦ Study results are available and inform policy and planning process
4.7	Piggy-Back on the studies implemented by other services among school children to study their knowledge, attitude and practice regarding HIV/AIDS				X		PHA	Various services	♦ Information about schoolchildren's knowledge, attitude and practices related to HIV/AIDS is available and used for interventions planning
4.8	Improve access to information and results of various studies implemented in Latvia	X	X	X	X	X	PHA	PHA	♦ Study results have been posted on MoH and PHA homepages and are available in public domain

No	Key tasks activities	IMPLEMENTATION					Institution responsible for activity implementation*		Expected Results
		Y1	Y2	Y3	Y4	Y5	Responsible institution	Cooperation institution	
5	**STRATEGIC AREA 5. STRENGTHEN NATIONAL COORDINATION AND CAPACITY TO RESPOND TO HIV AND AIDS**								
5.1	Expand the functions of the National STD/HIV Prevention Coordination Committee to include TB	X					MoH	SATLD	♦ Procedures and work plan of the Coordination Committee are defined and include issues related to TB
5.2	Involve civil society in national planning, implementation and service delivery for HIV and AIDS	X	X	X	X	X			♦ Civil society participation is increased
5.2.1	Include NGO representatives in National Prevention Coordination Committee	X					MoH	NGO	♦ STD, HIV and TB National Coordination Committee includes at least 3 NGO representatives
5.2.2	Allocate necessary resources in the national and municipal budgets and contract NGOs to deliver various services in the community and on national level		X	X	X	X	MoH, MoW, PHA	NGO	♦ Municipal and national budgets have line items that is being used to contact NGOs ♦ NGOs are contracted and deliver services to the population in need
5.3	Improve cooperation between institutions working on HIV and TB surveillance	X					PHA, SATLD	ICL, MoH	♦ Reciprocal integration of HIV and TB surveillance related issues are addressed in amended regulatory acts and guidelines
5.4	Draft and approve integrated HIV and TB surveillance, prevention and treatment guidelines	X					MoH, PHA	ICL, SATLD, medical treatment personnel, WHO	♦ Integrated HIV and TB surveillance, prevention and treatment guidelines are drafted and available ♦ Cooperation between institutions involved in TB and HIV epidemiological monitoring is taking place through data exchange (at least once in 6 months) and analysis is being done
5.5	Participate in EC international cooperation project 2005302 (*Expanding Network for Coordinated and Comprehensive Actions on HIV/AIDS Prevention among IDUs and Bridging Population)*	X	X				PHA	MoH, SATLD, LAoM Private sector („ITA Konsultants" Ltd.), LT AIDS centre, *EE NVAI, FI NSVI*	♦ Strengthen regional advocacy for HIV and AIDS ♦ Uniform approaches for HPC to deliver preventive/curative services for clients are developed ♦ Staff of HPC are trained in uniform approaches

No	Key tasks activities	IMPLEMENTATION					Institution responsible for activity implementation*		Expected Results
		Y1	Y2	Y3	Y4	Y5	Responsible institution	Cooperation institution	
5.6	Participate in UNODC international cooperation project AD/XEE/06/J20 "HIV/AIDS prevention and care among IDUs and in prison settings in Estonia, Latvia and Lithuania"	X	X	X			MOH	MoJ, PHA, RCPAD, LPA	♦ Policies conducive to OST and harm reduction interventions in prisons are enacted ♦ Teaching material for HIV prevention in places of detention are developed and staff trained ♦ Number of HPCs are expanded ♦ Access to Methadone Maintenance Therapy is increased in big cities and prisons ♦ HIV prevention in prison system is initiated ♦ Professional capacity of HIV prevention and drug dependence treatment service providers increased
5.7	WHO Biannual Collaboration agreement	X	X	X			MoH	WHO EURO, UNODC, Various government agencies	♦ Solicit necessary technical assistance and support for the program implementation ♦ The national needs for assistance are reflected in the Biannual collaboration agreements
5.8	Work with European Social Fund to develop necessary programs and secure funding for facilitating national HIV program implementation	X	X				MoH	Other Ministries and European Social Fund	♦ New programs are developed and funded from European Social Fund

*HPC = Low Threshold Centres are municipal structures implementing drug related harm reduction measures to limit the spread of HIV infection and other infections transferred via blood for high risk groups The centre services include: provision of information and motivation of the client, syringe and needle exchange, HIV testing, condom distribution, providing disinfectants. In some cases, HIV service centre activities are linked to other support and assistance service activities (for instance, night shelters, health care institution and social assistance institution, etc.)

* * **abbreviations of institution names:** MoD – Ministry of Defence, MoIA - Ministry of Interior Affairs, SPA – State Prison Administration, MoES – Ministry of Education and Science, MoW - Ministry of Welfare, RSU – Riga Stradin's University, RCPAD - Riga Centre for Psychiatry and Addiction Disorders, PHA – Public Health Agency, MoJ – Ministry of Justice, MoH – Ministry of Health, NGO – Non-Governmental Organization, BBS – Biomarker Behavioural Survey, SATLD - State Agency of Tuberculosis and Lung Diseases of Latvia

Annex 2: Funding Requirement

Total cost of HIV interventions, Latvia. 2008-2012

Activity	2008	2009	2010	2011	2012	Total (LVL)	Total (EUR)
Prevention, area 1							
FSW	139,448	278,897	418,345	557,793	697,242	**2,091,725**	**2,986,983**
FSW&IDU	24,999	49,998	74,997	99,996	124,995	**374,985**	**535,479**
MSM	10,000	15,000	20,000	20,000	20,000	**85,000**	**121,380**
IDU-OR	178,008	311,514	578,526	734,283	778,785	**2,581,115**	**3,685,832**
IDU(OS)	101,974	254,936	458,885	611,847	764,808	**2,192,450**	**3,130,819**
IDU-PDI	25,000	87,875	263,624	483,310	702,996	**1,562,804**	**2,231,684**
Condom promotion	5,200	7,800	18,200	27,300	33,800	**92,300**	**131,804**
Prisoner	79,241	158,483	264,138	369,793	528,275	**1,399,930**	**1,999,100**
Prevention, area 2							
Mass Media	112,045	112,045	112,045	112,045	112,045	**560,224**	**800,000**
Blood safety	174,750	186,400	186,400	186,400	186,400	**920,350**	**1,314,260**
VCT	12,000	18,000	42,000	63,000	78,000	**213,000**	**304,164**
HIV test kits	86,000	87,700	90,300	92,200	93,700	**449,900**	**642,457**
STI							
PMTCT	17,500	21,000	24,500	28,000	35,000	**126,000**	**179,928**
Care & treatment, area 3							
HAART	4,998,678	6,447,167	6,090,418	7,313,388	8,358,157	**33,207,808**	**47,420,749**
Palliative care		9,603	19,206	28,809	38,411	**96,029**	**137,129**
HBC							
HIV-TB							
AIDS hotline	24,000	25,500	27,000	28,500	30,000	**135,000**	**192,780**
Care and prevention	***5,988,844***	***8,071,916***	***8,688,583***	***10,756,662***	***12,582,615***		
Cross-cutting							
Evidence based plan., area 4							
Capacity building	50,000	50,000	50,000	50,000	50,000	**250,000**	**357,000**
Operational research } BBS	130,00	150,000	150,000	100,000	100,000	**630,000**	**899,640**
National Coordination, area 5							
Coordination incl. M&E	898,327	1,210,787	1,303,287	1,613,499	1,887,392	**6,913,293**	**9,872,182**
TOTAL	**7,067,171**	**9,482,703**	**10,191,870**	**12,520,162**	**14,620,007**	**53,881,913**	**76,943,371**

Annex 3: The Program Indicators and Targets

Table 3 Program output indicators[43],[44]

No	Key tasks and activities	Baseline		Implementation Targets for OUTPUTS				
		Indicator	Year	2008	2009	2010	2011	2012
1	STRATEGIC AREA 1. AVERT NEW HIV CASES AMONG MOST-AT-RISK POPULATION							
1.1	**Scale up the provision of harm reduction, HIV information and VCT to IDUs by HPCs with the help of outreach workers and Peer Driven Interventions**							
1.1.1	Scale up syringe distribution through outreach and peer driven interventions and secondary exchange; Scale up distribution of other harm reduction supplies (e.g. condoms, filters, vit. C) to IDUs							
a	Number of IDUs covered by HPCs	NSP 600-800, 5,5 - 7%*	2007	1,000	1,500	3,500	5,250	6500
b	Number of syringes distributed per year	117237/TBE	2006	365,000	547,500	1,277,500	1,916,250	2,372,500
c	Number of harm reduction kits[45] distributed to IDUs per year	TBE	2007	365,000	547,500	1,277,500	1,916,250	2,372,500
d	Number of condoms distributed to IDUs per year	23,902	2007	104,000	156,000	364,000	546,000	676,000

[43] TBE = To be Established after baseline becomes available

[44] TBD = To be Determined for the purposes of setting targets in future

[45] Harm reduction supplies for injecting drug users always include needles and syringes, and other requirements for sterile preparation of drugs for injection. Such harm reduction kits mostly include disinfectants, alcohol pads (for cleaning the injection site), cotton filters. Where drug users share liquid drugs (traditionally also in Latvia), larger number of syringes and needles are provided to prevent infection transfer from syringe mediated drug sharing, a technique that can pass on viral matter from one syringe into the other. Ascorbic or citric acid is often added in European countries (where, as in Latvia, "brown" heroin base prevails to prevent eyesight problems due to fungal infections caused by the use of (spoiled or polluted)lemon juice and vinegar as acidifiers. Antibiotic ointments are frequently provided for wound care. in addition to preventive purposes, the rationale for providing a broad spectrum of supplies is to increase the number of visits of IDUs to HIV prevention services. (references at request)

No	Key tasks and activities	Baseline		Implementation Targets for OUTPUTS				
		Indicator	Year	2008	2009	2010	2011	2012
1.1.2	Provide training to HPCs and to NGOs for developing peer driven interventions.							
a	Number of HPCs using peer driven methodologies for reaching IDUs;	TBE	2007	5	8	15	18	All (20)
b	No. of IDUs involved in peer driven intervention strategies;	TBE	2007	-	500	1,500	2,750	4,000
c	Out of total number No. of syringes distributed through peer driven methods (secondary exchange)	TBE	2007	250,000	400,000	1,000,000	1,916,250	2,372,500
1.1.3	Develop Gender sensitive services at HPCs to serve female IDUs							
a	Number of HPCs that have (IDU) women-friendly services.	0/TBE	2007	2	4	8	14	All
b	Number of IDU women using women-friendly services and general HIV prevention services at HPCs	TBE	2007					30% of HPC clients
c	Number of IDU women that received reproductive health counselling and PMTCT services at or brokered by HPCs	TBE	2008					60% of female HPC clients
1.1.4	Develop approaches at HPCs to improve service utilization of minority drug injectors							
a	Number of minority IDUs included in HIV prevention, drug treatment and other IDU health services. (local: proportional to minority representation)	TBE	2008					≥60% of minority IDUs
b	Number of Russian speakers and Roma employed in outreach worker/coordinator and other HPC staff positions	TBE	2008	TBD	TBD	TBD	TBD	(staff should resemble ethnic diversity of clients)
1.1.5	Establish new HPC sites in municipalities with significant IDU populations.			2 new sites established	1 new sites established	2 new sites established	2 new sites established	1 new sites established
1.1.6	Increase number of VCTs offered to HPC clients	n/a	2007	800	1200	2800	4200	5200

No	Key tasks and activities	Baseline		Implementation Targets for OUTPUTS				
		Indicator	Year	2008	2009	2010	2011	2012
1.2	**Scale up methadone maintenance therapy and other substitution treatment (e.g. buprenorphine); Improve and scale up treatment for problematic amphetamine use; Develop tailored patient-centred care**							
1.2.1	Scale up the number of patients on OST through introduction of evidence based practice in current and eight new sites.							
a	Improve and scale up treatment for problematic amphetamine use;							
b	Develop tailored patient-centred care and prescription practice	TBE	2008	25% trained, 12% impl	50% trained, 25% impl	75% trained, 50% impl	100% trained, 75% impl	100%
c	Number of opioid IDUs receiving daily dosing of a) methadone and b) buprenorphine for at least 6 months	190, (70 MMT; 120 buprenorphine; actual rate TBE)	2007	200	500	900	1200	1500
d	Number and proportion of (opioid) IDUs enrolled in any form of drug treatment (except detoxification) for at least 30 days	537 (911 detoxes)	2006	TBD	TBD	TBD	TBD	TBD
1.2.2	Scale up number and proportion of amphetamine IDUs receiving evidence based addiction treatment							
	Number of amphetamine IDUs receiving evidence based/best practice addiction treatment	TBE	2008		50	100	175	250
1.2.3	Develop patient centred care arrangements on a regional and/or local level, where drug treatment is decided and prescribed locally (not in Riga).							
	Number of patient on tailored prescription regimes to fit various subpopulations	0.00	2007.00	10	25	50	75	100% of ST patients
1.2.4	Develop case management to coordinate IDU patient care and collaboration at patient level							
a	Number of case managers	0	2007	2	5	8	≥8	≥8
b	Number of (peer reviewed) publications, manuals, , trainings, etc. produced by the RPNC (national center of expertise)	TBE	2008	TBD	TBD	TBD	TBD	TBD

No	Key tasks and activities	Baseline		Implementation Targets for OUTPUTS				
		Indicator	Year	2008	2009	2010	2011	2012
1.2.5	Increase the capacity of the Riga Center of Psychiatry and Addiction Disorders to serve as national resource center for ST.			TBD	TBD	TBD	TBD	TBD
1.2.6	Evaluate the quality of ST.			Evaluation report available		Evaluation report available		Evaluation report available
1.3	**Develop expertise and implement best practice overdose prevention programs.**							
1.3.1	Provide training to staff of HPCs and NGOs, drug treatment programs and prisons on overdose prevention/reversal with naloxone					2 staff members of all HPCs, (all types of) drug treatment programs, prisons		
1.3.2	Train IDUs in overdose prevention methods and distribute overdose reversal kits among opiate injectors (through HPCs, OST programs, prison release programs)	0	2007		125	600	1375	2500
1.4	**Improve testing and diagnostic of HIV/AIDS and other diseases among prisoners**							
1.4.1	Number of VCTs performed in Prisons	2,600	2006	3,000	4500	5500	6000	6500
1.4.2	Number of TB tests with X-Ray	721	2006	2500	3500	5000	6000	9000
1.4.3	Number of hepatitis tests	90	2006	90	1000	2500	3000	3500
1.5	**Increase knowledge, competencies (staff and prisoners) about HIV/AIDS and other infectious diseases and drug addiction**							
1.5.1	Number of prisoners trained (*total number of prisoners ~6500)*	600	2006	2,000	2,500	3,000	3,500	4,000
1.5.2	Number of medical staff trained (*Total number in 2006 – 210 In 2007 – 311)*	40	2006	65	150	200	250	300
1.5.3	Number of other staff trained (*number of staff worked in direct contact with prisoners – 1800*)	30	2006	300	600	1,000	1,500	1,500

No	Key tasks and activities	Baseline		Implementation Targets for OUTPUTS				
		Indicator	Year	2008	2009	2010	2011	2012
1.5.4	**Number of probation service staff trained**	**100**	**2006**	**100**	**200**	**200**	**200**	**200**
a	Number of study visits to other prisons systems (15-20 participants per each study visit)	0	2006	1	3	2	2	2
b	Number of information material provided to prisoners covering topics about (STI, TB, HIV, drugs, hepatitis, etc.)	0	2006	6 materials 1,000 cop	6 materials 1,000 cop	6 materials 2,000 cop	6 materials 4,000 cop	6 materials 6000 cop
1.6	**Initiate harm reduction and OST**							
1.6.1	Number of substitution treatment cases	0	2006	0	30	50	100	100
1.6.2	Number of needles and syringe exchanged	0	2006	0	0	5,000	10,000	15,000
1.6.3	Number of condoms provided	0	2006	10,000	30,000	50,000	55,000	60,000
1.7	**Involve outside agencies in the prison system**							
1.7.1	Number of 'triangular clinics' operational	0	2006	5	10	15	15	15
1.7.2	Number of persons working in these clinics	0	2006	25	50	75	75	75
1.7.3	Number of prisoners attending this clinics	0	2006	1,000	2,000	2,500	3,000	3,500
1.7.4	Number of NGOs involved in prison system work	0	2006	1	2	2	3	3
1.8	**Engage with CSW and MSM when information necessary for programming will become available from the planned studies among these risk groups**	n/a	2007	-	-	Activities are reflected in the national program		

No	Key tasks and activities	Baseline		Implementation Targets for OUTPUTS				
		Indicator	Year	2008	2009	2010	2011	2012
2	**STRATEGIC AREA 2. IMPLEMENT WIDER PREVENTION STRATEGIES AMONG GENERAL POPULATION**							
2.1	Number of reproductive age population reached through awareness raising efforts about HIV and AIDS	1,17million	2006	1,17million	1,17million	1,17million	1,17million	1,17million
2.2	Initial two pilot projects are evaluated and recommendations for scaling up are provided to the government						Report with recommend ations is available	
2.3	No of HIV-positive pregnant women that received PMTCT prophylaxis with ARV at any point in time during pregnancy (including those received HAART for their own health).	No Data	2006	50	50	50[46]	50	50
2.4	No of HIV-positive pregnant women that received PMTCT prophylaxis with ARV only during labour.	No Data	2006	10	10	10[47]	10	10
2.5	No of pregnant women without antenatal care tested for HIV with rapid tests at the labour	350	2007	350	350	350	350	350
2.6	No persons from high risk populations tested for HIV with rapid tests (IDUs, MSM, CSW):	850 (IDUs)	2007	850	1000	2000	3000	4000
2.7	No of prisoners tested for HIV with rapid tests	0		200	200	200	200	200
2.8	Number of health care providers trained with new VCT guidelines	No Data	2007			TBD	TBD	TBD
2.9	Number of laboratories supplied with HIV/AIDS test-kits	22	2007	24	25	25	25	25
2.10	Number of test-kits distributed to laboratory network (excluding blood centres)	70,000	2007	75,000	80,000	80,000	80,000	80,000
2.11	No of VCT tests during the year[48]	82,000	2006	86,000	87,700	90,300	92,200	93,700

[46] Target should be revised during 2010

[47] Target should be revised during 2010

[48] Test for blood donors are not included

No	Key tasks and activities	Baseline		Implementation Targets for OUTPUTS				
		Indicator	Year	2008	2009	2010	2011	2012
2.12	Number of people reached when promoting universal precautions among health care personnel, social workers, prison and police staff, firemen and rescue workers	No Data	2007	200 Annually	200 Annually	200 Annually		
2.13	Number of people who received post exposure prophylaxis	60	2007	100% (70)	100% (80)	100% (90)	100% (100)	100% (110)
3	**STRATEGIC AREA 3. PROVIDE HEALTH AND SOCIAL CARE TO PLWHA AND ELIMINATE STIGMA & DISCRIMINATION**							
3.1	Total number of HIV/AIDS patients seen for care	2442	2006	2900	3100	3300	3500	3700
3.2	Number of prisoners on ARV treatment (at the end of year)	32	2006	50	60	70	80	90
3.3	No of patients on HAART (Highly Active Antiretroviral Therapy, a combination of three or more drugs)	301	2006	800	1000	1200	1400	1600
3.4	No of patients with treatment for ARV + ST (10% of all ST patients)	n/a	2006	50	90	150	200	250
3.5	No of patients with treatment for co-infection ARV + TB	27	2006	30	35	40	45	50
3.10	No of AIDS patients receiving palliative care	No data	2007	TBD	TBD	TBD	TBD	TBD
3.11	No of people receiving social services			TBD	TBD	TBD	TBD	TBD
3.12	No of people calling on AIDS hotline	12,059	2006	13,000	13,100	13,200	13,300	13,400
3.13	No of people receiving psychological support	ICL		TBD	TBD	TBD	TBD	TBD

No	Key tasks and activities	Baseline		Implementation Targets for OUTPUTS				
		Indicator	Year	2008	2009	2010	2011	2012
4	**STRATEGIC AREA 4. GENERATE AND USE EVIDENCE FOR RESPONSE PLANNING AND IMPLEMENTATION MANAGEMENT**							
4.1	HIV/AIDS case based register is available and up-to-date	Yes	2007	Yes	Yes	Yes	Yes	Yes
4.2	National M&E framework document for HIV/AIDS is prepared	Not Available	2007		Document prepared			
4.3	Undertake study to estimate size of most at risk population in Latvia for CSW and MSM	Not Available	2007	Study implemented for MSM	Study implemented for CSW			
4.4	Integrated Bio-Behavioural Surveys (BBS) among groups-at-risk (IDU,CSW, MSM) implemented							
4.4.1	BBS among IDUs	-	-		Study implemented		Study implemented	
4.4.2	BBS among MSM	-	-	Study implemented		Study implemented		
4.4.3	BBS among CSW	-	-		Study implemented		Study implemented	
4.4.4	BBS among prisoners	-	-		Study implemented		Study implemented	
4.5	Implement study among people vulnerable to human trafficking with the help of UNODC					Study implemented		
4.6	Piggy-Back on the studies implemented by other services among school children to study their knowledge, attitude and practice regarding HIV/AIDS	-	-					
4.7	Undertake mid-term and end-term evaluation of the program	-	-			Study implemented		Study implemented
4.8	Study results are posted on the PHA web site	-	-	Yes	Yes	Yes	Yes	Yes

No	Key tasks and activities	Baseline		Implementation Targets for OUTPUTS				
		Indicator	Year	2008	2009	2010	2011	2012
5	**STRATEGIC AREA 5. STRENGTHEN NATIONAL COORDINATION AND CAPACITY TO RESPOND TO HIV AND AIDS**							
5.1	Procedures and work plan of the Coordination Committee are defined and include issues related to TB	-	-	Document prepared				
5.2	At least 3 civil society representatives participate in National Coordination	Yes (2)	2007	Yes (3)	Yes (3)	Yes (3)	Yes (3)	Yes (3)
5.3	Amount of funds budgeted by ministries (MoH, MoJ, MoES) for NGOs working on HIV/AIDS issues	0.00	2007		TBD	TBD	TBD	TBD
5.4	Draft and approve integrated HIV and TB surveillance, prevention and treatment guidelines	n/a	2007	Document prepared				

Expected Results

Table 4 Program RESULTS indicators

No	Key Activities	Baseline		Implementation Targets				
		Indicator	Year	2008	2009	2010	2011	2012
1	**STRATEGIC AREA 1. AVERT NEW HIV CASES AMONG MOST-AT-RISK POPULATION**							
1.1	Percentage of IDU (BBS) who reporting use of sterile injecting equipment the last time they injected	TBE	2005		Increase by 15%		Increase by 30%	
1.2	HIV prevalence among IDU (BBS) respondents	22% (14% prelim. data)	2005 (2007)		≥20% (≥13%)		15% (10%)	
1.3	Proportion of IDU (BBS) respondents reporting being frequent agents/recipients of secondary exchange during last 30 days	TBE			15 / 30%		30 / 80%	
1.4	Share of IDU (BBS) respondent who have been tested for HIV and know their status	TBE			Increase by 15%		Increase by 30%	
1.5	Share of IDUs being on Substitution Therapy (any type)	1.3%	2007	3.3%	6.0%	10.0%	13.3%	16.7%
	PRISONS							
1.6	Increase coverage of prisoners with VCT[49]	40%	2006	46%	69%	85%	92%	100%
1.7	Increase TB screening and coverage with diagnostic services of prisoners (including natural turnover of prisoners in a year – total 9000 prisoners)	721 (with X-Ray)	2006	27%	38%	55%	66%	100%
1.8	Share of prisoners who correctly identify ways of preventing transmission of HIV	n/a	2006			Increase by 20%		Increase by 60%
1.9	Share of prison staff who correctly identify ways of preventing transmission of HIV	n/a	2006			Increase by 40%		Increase by 80%
1.10	No of prisons that introduced peer-to-peer – approach	n/a	2006	TBD	TBD	TBD	TBD	TBD

[49] Number of prison population 6,500 is used as a denominator to estimate targets

No	Key Activities	Baseline		Implementation Targets				
		Indicator	Year	2008	2009	2010	2011	2012
1.11	Share of prisons offering Harm reduction programs.	0	2006			30%		100%
1.12	Share of prisons offering substitution treatment for drug users.	0	2006		20%	40%	100%	100%
1.13	Share of IDU prisoners involved in OST (According to 2003 study 14% of prisoners inject drug while in prison and ≈50% are opioid users)	0	2006		6%	10%	22%	22%
1.14	Increase share of prisons with 'triangular clinics' that are supported by ICL, SATLD and PHA	0	2006	30%	60%	100%	100%	100%
1.15	NGOs involved in counselling and prevention, care and support of infected prisoners.	0	2006	1	2	2	3	3
2	**STRATEGIC AREA 2. IMPLEMENT WIDER PREVENTION STRATEGIES AMONG GENERAL POPULATION**							
2.1	Share of young women and men aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV					Increase by XX%		Increase by XX%
2.2	Share of general secondary schools offering courses about sexual and reproductive health					Increase by% TBD		Increase by% TBD
2.3	Share of HIV-positive pregnant women that received PMTCT prophylaxis with ARV at any point in time during pregnancy (including those received HAART for their own health).	No Data	2006			90%		100%
2.4	Number of health and social care workers, policemen, rescue workers, firemen and prison staff infected during performing of official duties	No Data	2007			Stabilized		Stabilized
2.5	Share of those tested for HIV where route of transmission is unknown	28.1%	2006			Reduce by 5%		Reduce by 5%

No	Key Activities	Baseline		Implementation Targets				
		Indicator	Year	2008	2009	2010	2011	2012
2.6	Share of at-risk population tested for HIV							
	IDUs	3.2%[50]	2006			13%		23%
	Prisoners	40%[51]	2006			50%		70%
	CSWs[52]	n/a	2007			Increase by% TBD		Increase by% TBD
	MSM[52]	n/a	2007			Increase by% TBD		Increase by% TBD
3	**STRATEGIC AREA 3. PROVIDE HEALTH AND SOCIAL CARE TO PLWHA AND ELIMINATE STIGMA & DISCRIMINATION**							
3.1	Share of HIV/AIDS patients seen for care	67.3%[53]	2006	70%	73%	76%	79%	80%
3.2	Increase coverage of prisoners with ARV treatment (estimated number of HIV infected are 6% of prison population)	8%		13%	15%	18%	21%	23%
3.3	Share of HIV/AIDS patients receiving palliative care	No data	2007	TBD	TBD	TBD	TBD	TBD
3.4	Share of HIV/AIDS patients receiving home based care			TBD	TBD	TBD	TBD	TBD
3.5	Share of HIV/AIDS patients receiving social services			TBD	TBD	TBD	TBD	TBD
3.6	Share of HIV/AIDS patients receiving psychological support			TBD	TBD	TBD	TBD	TBD

[50] Estimated number of IDUs are 11,000 for Latvia

[51] Prisoners (including pre-detention) were estimated to be 6.548 as of January 1st, 2007

[52] Indicators will become available after the study for CSW and MSM are implemented and programming takes place

[53] As of December 31, 2006 there were 3,631 HIV positive individuals registered in Latvia

No	Key Activities	Baseline		Implementation Targets				
		Indicator	Year	2008	2009	2010	2011	2012
4	**STRATEGIC AREA 4. GENERATE AND USE EVIDENCE FOR RESPONSE PLANNING AND IMPLEMENTATION MANAGEMENT**							
4.1	HIV/AIDS Reports timely submitted to EuroHIV and National Government	Yes	2007	Yes	Yes	Yes	Yes	Yes
4.2	National M&E Indicators collected and timely submitted	n/a	2007	Yes	Yes	Yes	Yes	Yes
4.3	Size of CSW and MSM population in Latvia estimated	n/a	2007	Estimates available				
4.4	ALL National M&E Indicators provided by Integrated Bio-Behavioural Surveys (iBBS) among groups-at-risk are available	n/a	2007	Yes	Yes	Yes	Yes	
4.5	Mid-term and end-term evaluation reports are available and accessible from internet on PHA web site	n/a	2007			Yes		Yes
4.6	Issues related to migrant population are understood and inform national level planning of interventions	n/a	2007			Yes		
5	**STRATEGIC AREA 5. STRENGTHEN NATIONAL COORDINATION AND CAPACITY TO RESPOND TO HIV AND AIDS**							
5.1	National Coordination Committee meets regularly, makes decisions and notes of the meetings are available.	Yes	2007	Yes	Yes	Yes	Yes	Yes
5.2	Civil society organizations received funding from the government and offer necessary services to needy population	No	2007		Yes	Yes	Yes	Yes
5.3	Cooperation and coordination among different donor funded project is assured and renders expected results				Yes	Yes	Yes	Yes