

HIV/AIDS in Russia and Eurasia

Volume 2

Edited by
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HIV/AIDS in Lithuania

Saulius Caplinskas

Lithuania, a Baltic country of approximately 3.5 million people, is marked by low HIV prevalence despite being surrounded by countries that have high HIV prevalence rates (figure 9.1). The number of HIV infections among injection drug users remains low, which contrasts starkly with neighboring countries where the incidence of HIV infection among IDUs has increased sharply in recent years (table 9.1). The influence of neighboring epidemics is impossible to assess in the long term, and therefore the window of opportunity to impact the speed and pattern of transmission in Lithuania is critical.

Systematic surveillance of HIV infection in Latvia began in 1987. The Lithuanian AIDS Center (LAC) is the main prevention, clinical, and referral diagnostic center for HIV infection. The screening network originally included mass screening programs of pregnant women and other groups from 1988 to 1993. Since 1993, significant changes in testing policy have occurred, specifically the targeting of high-risk populations. HIV tests have always been voluntary, except for mandatory testing of blood, organ, and tissue donors. Epidemiological data is stored in the LAC HIV database, which contains coded and protected epidemiological, diagnostic, and clinical information on all identified HIV cases in Lithuania.

The first HIV-positive person in Lithuania was reported in 1988. Until 1997, HIV transmission via sexual contact prevailed. Since 1997, HIV has been spread mainly through injection drug use. From 1988 to 2005, 980 HIV infection cases were identified in Lithuania, including 789 people infected via drug injection, 94 through heterosexual sex, 67 through homosexual sex, and 40 cases where the transmission route remains unknown (table 9.2).

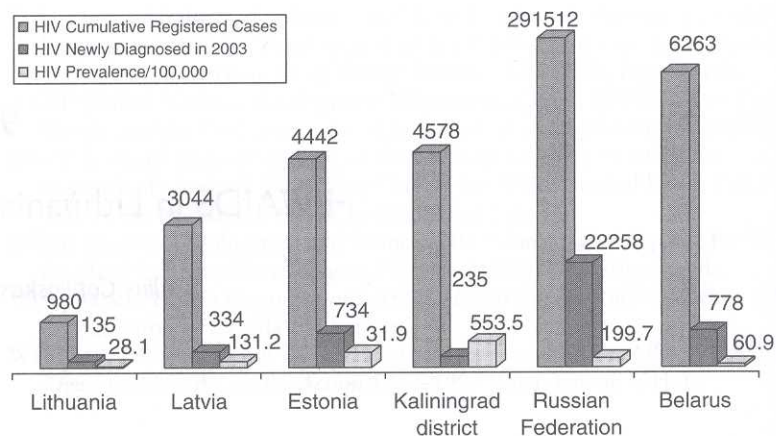


Figure 9.1 Cumulative HIV Cases in the Baltic countries, Belarus, and Russia in 2004

Source: Data from AIDS centers, January 9, 2005.

Table 9.1 The Epidemiological HIV/AIDS Situation in Lithuania and Neighboring Countries, December 31, 2004

Country	Lithuania	Latvia	Estonia	Russia	Belarus
HIV cases	980	3,044	4,442	29,1512	6,263
AIDS cases	86	320	70	1,057	168
Died	85	81	21	4,780	543
IDU	781	2,140	2,444	13,440	4,201
Prevalence per 100,000 population	28.1	131.2	319	199.7	60.9

Source: Data from UNAIDS, 2004.

Table 9.2 HIV Transmission Modes in Lithuania, December 31, 2004

Probable Route of Infection	Males	Females	Total (%)
Injection drug use	704	77	781(79.7%)
Homosexual	67	0	67(6.8%)
Heterosexual	70	24	94 (9.6%)
Blood products	0	0	0 (0%)
Mother-to-child	0	0	0 (0%)
Unknown	35	3	38 (3.9%)
Total	876	104	980

Source: Lithuanian AIDS Center, 2005.

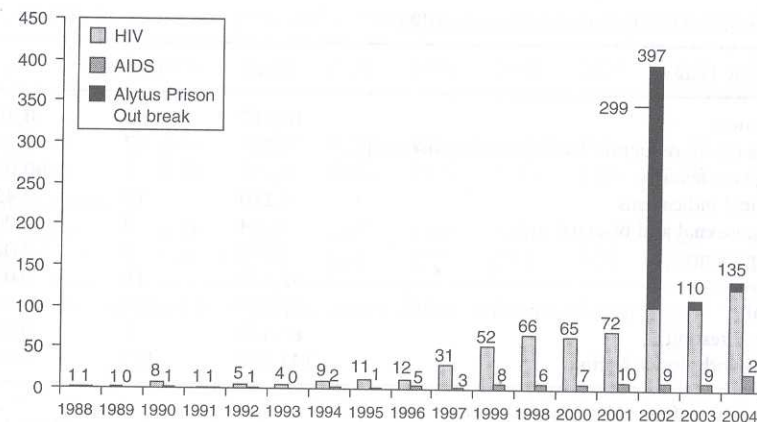


Figure 9.2 HIV/AIDS Registered Cases in Lithuania, 1988–2004

Source: Data from Lithuanian AIDS Center.

Lithuania has reason to take pride in its efforts to keep HIV at bay. Until May 2002, HIV prevalence rates in the country were among the lowest in Europe, even though Lithuania shares many social and economic characteristics with other former Soviet states where HIV had been spreading at a much higher rate. After an initial outbreak among IDUs in the seaport town of Klaipeda, Lithuania seemed to have been able to contain the spread of the virus.

Between May 1 and August 20, 2002, 397 new cases were detected, almost doubling the cumulative number of cases in less than four months to 682 (figure 9.2). Two hundred and ninety-nine cases were located in a closed correctional facility in Alytus, where residents are placed under strict control of the state. According to UNAIDS estimates, the number of HIV cases in Lithuania was 1,300 (with a maximum of 2,600) at the end of 2003 (United Nations, 2004b).

About 1.5 percent of the general population in Lithuania undergo voluntary testing annually for the presence of HIV antibodies, while the blood bank screens about 80,000 samples a year (table 9.3). From 1987 to 2004, 18 HIV-infected individuals were identified through blood donation screening. No cases of HIV transmission through blood or blood products have been reported.

HIV cases have been reported predominantly in the 20–39 age range, with 76 percent of all cases falling in that group (table 9.4). The youngest patient in Lithuania was 15 years old and the oldest was 68 at the time of HIV diagnosis. The average age according to the mode of transmission differs for sexual contact (37 years of age) and injection drug use (30 years of age).

Table 9.3 HIV Testing in Lithuania, 2004

<i>Groups Tested</i>	<i>Tested</i>	<i>HIV+</i>	<i>%</i>
Prisoners	16,617	82	0.49
IDUs (harm reduction facility, not imprisoned)	1,420	17	1.20
Pregnant females	3,587	1	0.03
Clinical indications	4,280	18	0.42
Homosexual and bisexual men	44	0	0.00
STI patients	1,798	0	0.00
Others	32,132	16	0.05
Total	59,878	134	0.22
Donor testing	85,559	1	0.00
Total with donor testing	145,437	135	0.09

Source: Data from Lithuanian AIDS Center, 2005.

Table 9.4 HIV Infection Cases by Age in Lithuania, December 31, 2004

<i>Age</i>	<i>Males</i>	<i>Females</i>	<i>IDU</i>	<i>Total</i>
15–19	36	7	37	43
20–24	142	26	148	168
25–29	229	21	209	250
30–39	297	37	279	334
40–49	120	7	85	127
50–59	27	2	9	29
60–>	9	1	—	10
Unknown	16	3	14	19

Source: Data from Lithuanian AIDS Center, 2005.

The number of female cases is on the rise. The male-to-female ratio of HIV cases was five to one in 2004 (table 9.4). The majority of reported HIV-infected females are of reproductive age, an average of 29 years old, which is very close to the average age of HIV-positive injection drug users. The number of female HIV cases includes 20 former or active sex workers. No cases of mother-to-child transmission of HIV or HIV infection in children younger than 15 years old have been reported (table 9.2). By 2005, only six pregnant women with HIV were registered, and all received ARV treatment during their pregnancies. After delivery, their newborns received preventive treatment. Considering the current trends in the HIV epidemic, counseling and voluntary testing of pregnant women has become a task of the highest importance.

Table 9.5 Incidence and Prevalence of HIV/AIDS Per 100,000 Population, 1996–2003

	1996	1997	1998	1999	2000	2001	2002	2003
AIDS								
Incidence	0.14	0.08	0.23	0.17	0.2	0.26	0.26	0.23
Prevalence	0.33	0.42	0.65	0.83	1.03	1.29	1.59	1.85
HIV infection								
Incidence	0.33	0.87	1.47	1.87	1.86	2.07	10.9	3.18
Prevalence	1.45	2.33	3.82	5.72	7.63	9.72	19.6	24.5

Source: Data from the Lithuanian AIDS Center and Health Information Center, 2005.

HIV prevalence has increased on an annual basis. HIV prevalence in the year 1996 was 1.45 per 100,000 population, gradually rising to 28 per 100,000 in 2004—still the lowest in the Baltic Sea region. HIV incidence has also increased. In 1996, HIV incidence per 100,000 population was 0.33, rising to 3.18 in 2003 (table 9.5). The relatively slow spread of the virus can be attributed to active preventive work on the part of the LAC and other institutions targeting high-risk behavior groups.

Primary research on HIV-1 molecular typification in Lithuania has shown that the predominant strain of the virus was initially subtype B. This subtype, which is the most prevalent in Western Europe, was also initially the most common subtype in all three Baltic countries as well as Russia and was originally linked to homosexual transmission (Ustina et al., 2001). After the HIV outbreak in the Alytus correctional facility in 2002, subtype A has become predominant.

AIDS Cases

The prevalence of AIDS cases per 100,000 population has increased from 0.33 in 1996 to 1.85 in 2002. Since the introduction of the HIV registry, AIDS has been diagnosed in 86 persons (table 9.6). Eighty-five deaths of HIV-infected persons have been reported, 37 because of AIDS. The mean time from AIDS diagnosis to death is 10–12 months.

Of all registered AIDS cases, 56 percent were men having sex with men, 24 percent were caused by heterosexual contact, and only 12 percent might be attributed to injection drug use. In eight percent of cases the infection route remains unknown. In 3.9 percent of cases, AIDS was diagnosed at the time of HIV diagnosis.

Table 9.6 AIDS Cases in Lithuania, December 31, 2004

<i>AIDS Cases</i>	<i>Males</i>	<i>Females</i>	<i>IDU</i>	<i>Total</i>
Number of AIDS cases diagnosed	77	9	10	86
Number of deaths	75	10	43	85
Deaths from AIDS	36	1	1	37
Other causes of death	39	9	42	48

Source: Data from the Lithuanian AIDS Center, 2005.

Government Policy

The Lithuanian AIDS Center (LAC) was established by an order of the health minister in 1989. It is a governmental organization under the aegis of the Ministry of Health. The LAC is responsible for developing and implementing the national response to HIV/AIDS, and it is the main clinical and referral diagnostic center for HIV infection.

The LAC runs various programs and services in Vilnius, including a dispensary/epidemiological surveillance unit, a reference laboratory, an HIV/AIDS hot line, anonymous HIV counseling and testing, and drop in "Consultation Spots" that provide needle exchange services for IDUs. The center also runs a public education and information unit and, somewhat remarkably for an HIV/AIDS center, a social rehabilitation program for former drug users as well as anonymous STI testing and treatment. The presence of a modernized infrastructure for both HIV prevention and drug treatment should be credited for reducing the initial outbreak of HIV infection among IDUs in the country and keeping incidence low.

The key strategic document on HIV/AIDS prevention and control in Lithuania is the "National AIDS Prevention and Control Program." The first national program was designed in 1989 after the establishment of the Lithuanian AIDS Center. In the first years of implementation, input from other sectors was rather scarce. The World Health Organization (WHO) provided significant support to implement education initiatives for the general population and especially for young people.

In 1994, the health minister approved the first Commission of AIDS Program Coordination. This panel included not only medical personnel but also experts and scientists from other government departments. In 1995–1997, the key issues in the HIV/AIDS prevention program were intersectoral cooperation and decentralization of

response. In 1996, the AIDS Prevention and Control Program was included in the list of national health program priorities.

Lithuania's first National HIV/AIDS Prevention Program was developed and implemented in 1990–1992. The later programs in 1992–1993, 1994–1996, 1996–1998, and 1999–2001 were implemented with the aim of reducing the spread of HIV in Lithuania and achieving not only medical but also social objectives.

The National AIDS Prevention and Control Program 2003–2008

In October 2003, the Lithuanian government approved the AIDS Prevention and Control Program for 2003–2008. This program included new policies based on Global AIDS Strategy principles and on UNAIDS recommendations. Its priorities were set according to the rapidly changing epidemiological situation in Lithuania and neighboring countries, changing HIV transmission modes and trends, a desire to improve the experiences of health experts and experts in other sectors, and the newest scientific breakthroughs, all while trying to assure continuity with former key program goals.

Special attention to target groups like drug users, sex workers, and prisoners is a priority. Program activities are to be carried out in conjunction with a variety of organizations involved in drug use and HIV prevention, including NGOs. A network of "low-threshold" health care sites is envisioned, as is the oversight of HIV/AIDS epidemiological surveillance and laboratory analysis. The Prevention and Control Program maps out improvements in the capacity of municipal HIV/AIDS prevention programs and in the education of politicians, police officers, military personnel, and the mass media.

HIV Prevention on the Local Level

The role of municipal health programs is very important in spurring health promotion generally and ensuring local participation in the design of health policy. HIV prevention on the local level has intensified in Lithuania since 1997, after an established budget process was approved by the Lithuanian Parliament. Municipal doctors are appointed to coordinate preparation and implementation of target programs. Success depends largely on municipal doctors' competence and understanding of the HIV/AIDS problem.

Municipalities are becoming increasingly involved in the development of local drug and HIV policies. This is not surprising, as it is at the city level where the problems associated with illicit drugs are experienced most directly. Municipal authorities are initiating local policies like needle exchange, substitution therapy, and other forms of drug treatment.

By 1998, ten Lithuanian municipalities had launched their own HIV/AIDS prevention programs, and four had launched their own STI prevention programs. Since 2001, the Lithuanian AIDS Center has organized meetings with mayors, educators, health care workers, police officers, mass media, and children's rights protection services in five regions. Seminars for teachers, schoolchildren, and social workers have been organized, and free HIV testing has been provided. These programs have been helpful in the effort to organize qualified expert groups in the municipalities.

In 2004, intersectoral boards coordinated activities in HIV/AIDS prevention, drug use, and related issues in 41 municipalities. HIV/AIDS prevention action projects were designed and enacted in 43 municipalities. Training, facilitated by the Lithuanian AIDS Center and actively supported by the Canadian Embassy, is targeted at municipal, county, and public health center experts. Due to this initiative, five more municipalities have been spurred to design their own local HIV prevention programs. The local public health centers have paid special attention to HIV and related problems.

Treatment and Care of People Living with HIV/AIDS

The Outpatient Department of the Lithuanian AIDS Center has been in operation since 1990. The major focus of this department is the organization of health services for people living with HIV and the training of medical staff on HIV/AIDS issues. HIV-positive persons are referred to the Outpatient Department for counseling, observation, and drug therapy. Secondary expert level services, including general practitioner, infectionist, gastroenterologist, gynecologist, and dermato-venerologist care, are available to everyone with HIV. Care for HIV-positive individuals is decentralized, and individuals are free to choose any health care institution to obtain follow-up and treatment services. Services are rendered not only at the Lithuanian AIDS Center in Vilnius but also in medical institutions in Kaunas, Klaipeda, and Siauliai.

ARV treatment was made available in 1992 with the registration of Lithuania's first anti-HIV drug: zidovudine. Monotherapy was followed by bitherapy of two ARVs. The annual number of patients receiving ARV treatment has varied from one to ten. Since 1998, the combination of three ARVs (HAART) has been acknowledged as standard HIV treatment.

Until 2004, free antiretroviral treatment was covered by the state only to people with AIDS. In 2004, the Ministry of Health approved a new methodology of HIV analysis and treatment. ARV treatment is now usually initiated based on clinical, immunological, and virological criteria. Thus, treatment is accessible not only to people with AIDS but also to those at great risk of disease progression. It is administered to all people with medical need, without regard to their social status.

Free ARV treatment and medical care is accessible to women with HIV during their pregnancy and delivery. Preventive ARV treatment is also administered to their newborns. By 2005, only six women with HIV had delivered babies, and all received ARV treatment during their pregnancies. Primary testing data showed that the newborns were healthy. They will be observed until 18 months of age, when a final diagnosis of HIV infection can be determined.

HIV Trends among IDUs in Lithuania

By 2004, 68,653 people with substance dependence had been registered with Lithuanian health care institutions. Among them, 5,011 were because of drug abuse. The number of men who abuse drugs is five times higher than that of women. The number of drug abusers has increased eightfold since 1991, and this figure only includes those users who have sought help at medical institutions. According to expert estimates, the population of IDUs in Lithuania might soon reach 7,000 to 11,000 (United Nations, 2004a).

Lithuania's first HIV-positive injection drug user was reported in 1994. Two years later, four HIV-positive IDUs were reported in Klaipeda. In 1997, IDUs accounted for 70 percent of all registered cases of HIV; in 2000, 72.3 percent; in 2001, 77.8 percent; in 2002, 95.5 percent; in 2003, 77.3 percent; and in 2004, 74.8 percent (figure 9.3). The exceptionally large proportion of IDU cases in 2002 was due to an outbreak in the Alytus penal facility. Screening in other penitentiaries in the same year did not reveal any new cases of HIV infection. Urgent preventive action in Alytus resulted in the localization of the outbreak. Only 15 new HIV cases were reported there in 2003, and two in 2004.

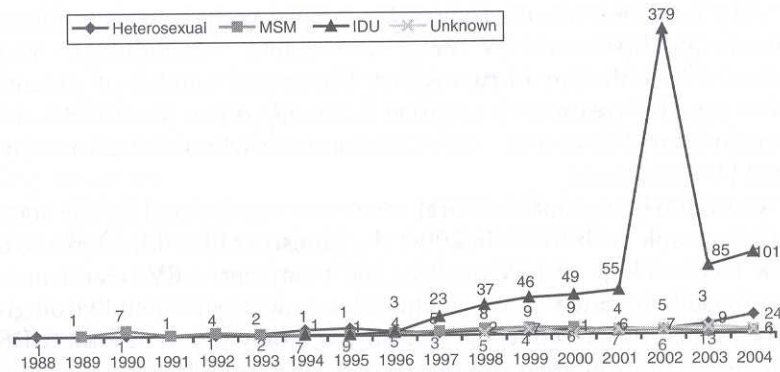


Figure 9.3 HIV Registered Cases and Transmission Mode in Lithuania, 1988–2004

Source: Data from Lithuanian AIDS Center.

In 2004, 60 percent of HIV-positive IDUs were diagnosed in closed penal facilities. All people entering a prison in Lithuania are offered a voluntary HIV test. Only a few refuse to take one. The number of drug-using inmates has increased annually. Harm reduction programs are particularly controversial in prisons. Needle exchange is generally not accepted practice in the Lithuanian penal system; however, equipment to wash needles and syringes on-site is available. Condom distribution is less controversial, and free condoms are available.

From 1997 to 2004, HIV was predominantly transmitted through contaminated needles (figure 9.3). The mean age of HIV-infected IDUs during this time period was 30, with a growing shift to younger people over time. Adolescent infection through injection drug use is increasing; the 15–24 age range made up 22.8 percent of total IDU HIV cases in 2004 (table 9.4). This shift could be explained by lower awareness of safe needle use among inexperienced IDUs and also by a recent decrease in drug prices that resulted in an upsurge of drug use.

Many drug users have no form of identification. Without papers they are not eligible for medical insurance from the state, meaning that only emergency services are available to them. Many have not developed any symptoms of HIV, since HIV has entered the community of IDUs relatively recently.

The majority of HIV-positive cases in drug users has been registered in Klaipeda. Though HIV infection has spread predominantly in the major cities, it could spread in smaller border towns due to their close proximity to regions with high HIV prevalence rates, particularly Kaliningrad and Latvia.

Availability of HIV Prevention and Drug Treatment Services in Lithuania

Drug treatment and HIV prevention activities are relatively well developed in Lithuania, particularly in Vilnius and other large cities like Klaipeda and Kaunas.

The Lithuanian AIDS Center attempted to start the first syringe and needle exchange program in 1991, before drug use was considered a national problem. IDUs were a closed and wary group, persecuted by the police. There were attempts to estimate the approximate extent of drug use and behavior of IDUs, and to send volunteers to develop contacts in the IDU community. Initial steps were taken to exchange needles and syringes, but because of the exchange site's location on the outskirts of Vilnius, it was not accessible to those in need.

The Vilnius Center for Treatment of Addictive Disorders (VCTAD) has offered a variety of services including detoxification, rehabilitation, and methadone treatment since 1995. That same year VCTAD initiated a needle exchange, which included outreach and secondary exchange.

Outside of the capital, Vilnius, the situation is more complex. In keeping with Lithuania's health care reform plans, in smaller cities and districts public health centers are responsible for the protection and promotion of public health. Public health centers have a rather substantial mandate, including the promotion of healthy lifestyles, the prevention of alcohol and drug abuse, and the prevention of infectious diseases, including HIV and hepatitis. They are also responsible for monitoring a number of health indicators, and they have modest laboratory facilities.

In 1996, the first cases of HIV were reported in the Klaipeda IDU community. In that same year, the Klaipeda Dependence Diseases Center made syringe and needle exchange available on-site. In 1997, an anonymous counseling site was established to provide syringe exchange services for IDUs. It was the first site of its kind in the Baltics and continues to be supported by the local government of Klaipeda. Services include syringe/needle exchange, condom distribution, distribution of educational publications, and consultation on safer drug use, safer sex, and HIV and hepatitis prevention. HIV testing is also provided. Since 2001, two additional consultation sites with syringe/needle exchange services have operated in Klaipeda. About 1,700 IDUs attend the low-threshold programs in this area.

Outside Vilnius, methadone treatment is offered in the Kaunas, Klaipeda, Panevezys and Druskininkai Centers for Treatment of

Addictive Disorders. There are 236 residential treatment slots in the country. The majority are maintained by NGOs, although the government funds 28 of them.

Some of these drug treatment and HIV prevention projects offer HIV testing. A number of regional hospitals with infectious disease departments offer HIV testing as well. In principle, these same facilities should be able to provide HIV treatment. Most people with HIV, however, prefer to go to the LAC in Vilnius out of fear of loss of confidentiality and the consequent social stigma.

Primary Health Care Centers (PHCCs) are present in most municipalities. These centers consist of multidisciplinary teams staffed by general practitioners, surgeons, and mental health (and addiction) specialists. VCTAD is collaborating successfully with two PHCCs in Vilnius that provide methadone treatment. In Druskininkai, the local PHCC is providing methadone detoxification and treatment as well as psychological support and HIV prevention services including needle exchange.

HIV and Related Problems in Penitentiary Institutions

There are 15 penitentiary institutions in Lithuania, including one for women, one for juvenile delinquents, and one for men with active tuberculosis.

Every penal establishment has its own health care service, managed by the Prison Department (PD) under the Health Care Service of the Ministry of Justice. A Hospital of Penitentiary Institutions with 111 beds operates in Vilnius. Since 2003, this hospital has included an HIV/AIDS prevention and treatment site. The hospital aims to provide health care services in the prison system comparable to care provided to the general population. In recent years, the majority of inmates with HIV have been serving their sentences in Alytus. Health care in penitentiary institutions is considered a part of the National Health Care System.

The majority of prisoners with HIV are usually already registered in the Lithuanian AIDS Center on an outpatient basis upon their entry to a penitentiary. However, about a third of people infected with HIV discover their HIV status in prison due to intersectoral cooperation between the Prison Department and the Lithuanian AIDS Center.

Voluntary HIV testing with pre- and post-test counseling for those incarcerated is scheduled as follows: at the time of entry, three months

Table 9.7 Percentage of Inmates who Are Drug Users in Lithuanian Penitentiaries, 2001–2004

	2001	2002	2003	2004
Number/percentage of prisoners who are drug users	1010/8.8%	1301/11.3%	1464/13.3%	1148/14.2%

Source: Data from Health Care Service of the Lithuanian Prison Department.

after entry, three months after the long-term date, and three months prior to release. All incarcerated people with HIV serve their sentences alongside noninfected inmates, but they have a right to stay isolated from others. The first HIV-positive prisoner was identified in 1992, and the second in 1996. Along with the spread of HIV in the IDU community, the number of HIV-infected inmates has been increasing since 1997. By 2004, 67 percent of all HIV cases reported in Lithuania had been identified as present or former prisoners.

The majority of prisoners with HIV are male (female cases are sporadic), and the majority are drug users. HAART is available through the penal health care system. In most cases, HIV is still in the asymptomatic stage; no cases of prisoners with AIDS have been reported so far.

The percentage of inmates who are drug users has increased annually (table 9.7). According to Prison Department data, opiates are the most popular drugs in penitentiaries. Amphetamines have become more popular as their price has fallen. More than two-thirds of narcotic substances are injected.

Inpatient care for drug users is available in psychiatric departments of penitentiary hospitals. Counseling and psychological-social rehabilitation services are not presently guaranteed to all inmates because of the lack of trained medical personnel. Dependency treatment is not supported in any of the penitentiaries. Similarly, there are no drug-free zones. Substitution therapy and harm reduction programs do not exist due to a lack of political advocacy within the prison system, even though such programs are widely accessible to the general public. In 2003, the Prison Department along with the Open Society Fund launched a pilot harm reduction project in Alytus. The National Drug Control and Drug Use Prevention Program established rehabilitation subdivisions in all correctional facilities. There are currently pending proposals to enable reviews of sentence terms and to schedule early releases for prisoners after the completion of a rehabilitation course.

Penitentiary personnel are aware that drug-dependent inmates should be provided with sterile syringes and disinfectants. The latter, as well as condoms, are available in the majority of prisons; the introduction of large-scale harm reduction programs, however, depends on political will.

HIV Transmission through Sexual Contacts

The first HIV-positive cases in Lithuania were diagnosed among men having sex with men (figure 9.3). It was estimated that the virus entered this community between 1980 and 1983. There were seven HIV-positive MSM registered in 1990. These cases were disclosed mostly by partner notification.

It is problematic to analyze retrospectively the epidemiology of the HIV situation and its evolution in the general population through heterosexual transmission, yet there are strong arguments that incidence and prevalence in the period 1988–1994 were very low. Over the past three years, HIV transmission via sexual intercourse has increased dramatically. In 2004, 24 cases of HIV acquired heterosexually were reported, twice as many as in 2002. Four people were infected via homosexual contact in the same year. There is also an increasing number of female cases of HIV infection through sexual intercourse, with nine new cases in 2004. In the entire HIV reporting period, more cases of HIV acquired heterosexually (94 cases) have been reported as compared to homosexual transmission (67 cases).

The main bridge groups of possible HIV transmission into the general population are sex workers, drug users, and their sexual partners. According to data compiled by the LAC in a recent survey of 200 sex workers, 3.8 percent are HIV-positive, and 2.5 percent are both HIV-positive and drug users. The convergence of two major risk factors makes the group a major target for prophylaxis. In 2000, the LAC surveyed 96 commercial sex workers. These findings showed high rates of alcohol and drug use, insufficient use of condoms, and high rates of STIs among the CSW population. These factors should be considered as possible precursors to the spread of HIV in the subject population. There is a need for specific interventions targeted to increase safer behavior among sex workers and their clients. Recent experience with sex workers at the Lithuanian AIDS Center proves that the STI infection rate in this group can be reduced by targeted educational initiatives (figure 9.4).

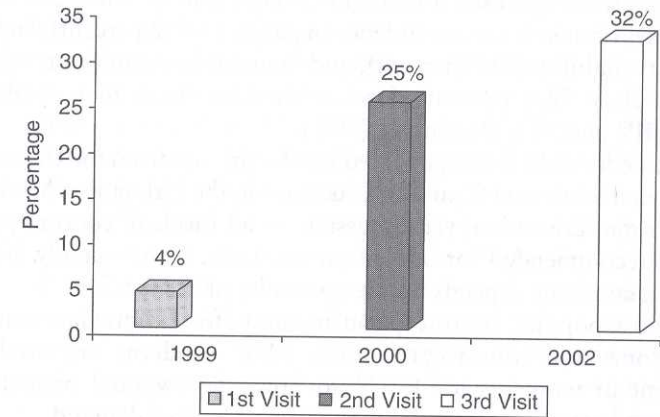


Figure 9.4 Vilnius Street Sex Workers without STIs as Diagnosed by the Social Ailments Consultation Site of the Lithuanian AIDS Center (n = 56)

Source: Data from Lithuanian AIDS Center.

Condoms

From 1995 to 2002, condom importation into Lithuania increased more than twofold (Lithuanian Statistics Department, 2003). Condoms are accessible in a wide variety of venues: supermarkets, pharmacies, gas stations, street kiosks, bars, and student dormitories. Condom vending machines have been widely installed in nightclubs, cafes, and bars. In 2002, thanks to a private initiative, condom vending machines were marked with stickers reading “Stop AIDS” in Vilnius nightclubs, cafes, and the dormitories of Vilnius University. Condom vending machines are not accessible outside the capital.

Adolescents

Adolescent sexual intercourse has become a matter of great concern in Lithuania. The number of teens with a premature sexual debut has increased. As of 2000, 10.8 percent of girls age 15 and 26.4 percent of boys of the same age already had their first sexual experience (Ustilaite, 2001). Almost half of these young-age experiences are casual (Jaruseviciene, 1998). The mean age of first sexual intercourse for those who have had sex by age 15 is 13.5 years. During their last experience, 70.4 percent of the girls age 15 and 82.2 percent of the

boys of the same age used a condom (WHO, 2004). There are three main causes of unsafe sex: confidence in partner (37.2 percent), lack of condom availability (24.8 percent), and “sensitivity diminution” (21.5 percent). Only 72.4 percent of schoolchildren think that condoms prevent HIV and STIs (Nariunas, 2001).

Safe sex education has engendered harsh criticism from the Universal Program on Family and Sexuality Education in the Lithuanian Ministry of Science and Education, yet discussion on all forms of contraception has been recommended for adolescent curricula. Consequently, information on condoms depends on the sensibility of the teacher.

The most popular contraception methods for Lithuanian women are condoms and contraceptive pills. Male condoms are used by 23 percent of women ages 15–24 to prevent unwanted pregnancy. Female condoms are not available because of lack of demand.

Attitudes of the Lithuanian Population toward People Living with HIV/AIDS

A population’s tolerance toward its most vulnerable social groups can impact programming, implementation, and political support for its HIV/AIDS, drug use, and other prevention programs. It also indicates the achievements of educational awareness work.

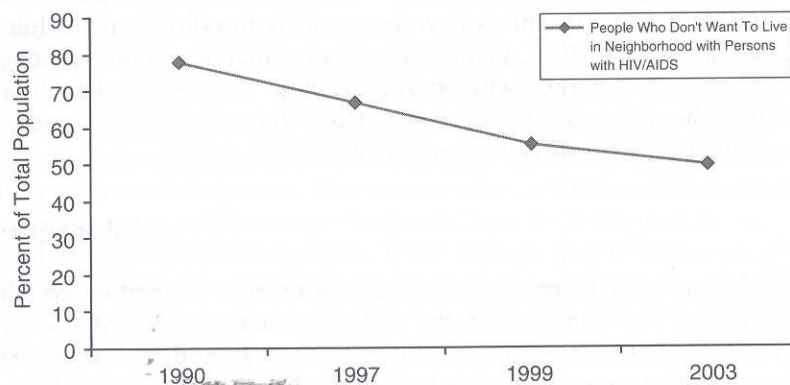


Figure 9.5 Trends in Tolerance toward People Living with HIV/AIDS in Lithuania, 1990–2003

Source: Data from Lithuanian AIDS Center.

A 2003 survey of public opinion about vulnerable groups showed a significant increase in tolerance toward people with HIV (figure 9.5). In 1990, 77.6 percent of those questioned admitted that they did not wish to live in a neighborhood with HIV-positive individuals. This percentage dropped to 49.3 percent in 2003. Young people—ages 15–24—were more tolerant toward people with HIV/AIDS than those ages 50–74. People with a university education and those with higher incomes usually have a more tolerant opinion about individuals with HIV. From 1990 to 2003, homophobia has diminished 2.3 times, and the number of people preferring not to have former convicts as neighbors has decreased 1.2 times. Attitudes toward drug users, however, have not changed significantly: 90 percent of respondents in 2003 stated that they would not like to have drug users as neighbors.

The tolerance of the Lithuanian population toward people with HIV/AIDS, ex-convicts, and MSM has increased, illustrating the success of HIV/AIDS awareness education. The minor change in tolerance toward drug users indicates that a high level of stigma still exists (Lithuanian AIDS Center, 2004).

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