

**MID-TERM EVALUATION OF THE LATVIAN NATIONAL HIV  
PROGRAMME: 2009-2013**

**A Report Produced  
By**

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**March 2011**

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## **GLOSSARY**

AGIHAS	Support group for people living with HIV
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretrovirals
ASAP	AIDS Strategy and Action Plan
EU	European Union
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug User
ITPC	International Treatment Preparedness Coalition
MDR-TB	Multi-Drug Resistant TB
MSM	Men who have Sex with Men
NGO	Non-Governmental Organization
NSP	Needle and Syringe Programme
PLHIV	People living with HIV
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

## **ACKNOWLEDGEMENTS**

The evaluation team would like to thank everyone that made this work possible. Particular thanks are due to the Latvian Ministry of Health and the UNODC and WHO country offices for their practical and logistic support. Thanks are also due to everyone who met with us and expressed their views and opinions.

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## SUMMARY

This document is the report of a mid-term evaluation of the national HIV programme in Latvia for 2009 to 2013. The evaluation was conducted by a team from UNODC and the WHO Regional Office for Europe. It follows an evaluation of access to HIV treatment and care, conducted by a similar team, in 2009.

Latvia continues to experience a significant HIV epidemic. This is spreading mainly among injecting drug users and their sexual partners. Although some targeted HIV prevention measures have been introduced in the community, for example needle and syringe programmes and pharmacotherapy with methadone, these have not yet been implemented at a large enough scale to fully control the spread of the epidemic. These important programmes have not yet been introduced in prisons.

Latvia's response to HIV is taking place against the backdrop of a very severe financial crisis. Funds available to the health sector have been reduced. Funds allocated to the national HIV programme only cover around one third of need. Prison budgets have been severely cut and funds available for health care in prisons have been slashed. NGOs of critical importance to the national HIV response face risk of imminent closure because funds are simply not being made available to them.

There have been significant reforms in the health sector in Latvia since 2009. Hospitals have closed. The number of beds has been reduced. But, despite their importance and low cost, public health functions have not yet been prioritized in these reforms. These functions have been badly-fragmented between new institutions, such as the Centre of Health Economics, and clinical centres, such as the Latvia Infectology Center. The inappropriate concentration of HIV-related functions at the Latvia Infectology Center is hard to justify. This is particularly problematic because of the very bureaucratic way in which this Center handles information. This creates a serious bottleneck which makes effective practice of modern public health quite impossible. This issue should be addressed urgently by reallocating public health functions for all infectious diseases to the Public Health Department of the Centre of Health Economics and pursuing the functional integration of the Latvia Infectology Center into general hospitals.

NGOs play a critical role in effective responses to HIV. They allow for participation of people living with HIV and populations particularly affected by the epidemic. They provide accountability mechanisms for government. They provide essential services, particularly those that governments find difficult to provide. In Latvia, NGOs have been providing such services, e.g. for IDUs and in prisons. The recent inclusion of one NGO into the services of the Latvia Infectology Center is a positive step. But, there are very few NGOs and their capacity is limited. They have no reliable means of funding. As a result, the few that exist survive on project-by-project funding and the enthusiasm and commitment of their staff and volunteers. This situation is not sustainable and is likely to worsen when the UNODC project ends. Unless sustainable funding sources are identified, this sector will fail to develop or grow. There is a significant risk that some NGOs will close.

HIV in Latvia is mainly transmitted among injecting drug users and their sexual partners. There has been some expansion of essential services, such as needle and syringe programmes and pharmacotherapy with methadone. For example, from 2007 to 2010, the number of centres providing methadone pharmacotherapy increased from one to ten. The number of people receiving methadone rose from 85 to 271 in the same period. From 2006 to 2010, the number of centres providing needles and syringes rose from 12 to 18. During the same period, the number of needles and syringes distributed rose from 117,000 to 310,000. But, the coverage of these remains inadequate. It is estimated that less than 2% of opiate injectors are receiving pharmacotherapy. The number of needles and syringes distributed only amounts to 17 per injecting drug user per year. In particular, the absence of these services in Latvian prisons means that drug users face disruption of services on entering the prison system. This increases the risk of HIV transmission in that setting. In addition, HIV positive IDUs are under-represented among those PLHIV on ART. Currently, less than half (46%) of those on ART are IDUs although almost two thirds (63%) of all people living with HIV are IDUs.

The situation in Latvian prisons is catastrophic. Severe budget cuts in prisons have fallen disproportionately on the provision of health care services. Staff have been severely reduced. The workload has increased dramatically for those that remain. Health care is now limited to emergency care; services provided by the Ministry of Health, such as ART and TB treatment; and what prisoners can afford to pay for themselves. Many drug users spend time in prison. Essential services that they receive in the community, such as methadone pharmacotherapy, are disrupted when they enter the prison system. Follow-up on discharge from prison is weak or non-existent. Those on ART in prison may not receive this once they leave. These issues need to be addressed urgently. In the long-term, the prison health system needs to be integrated into the community system provided by the Ministry of Health. In the short-term, methadone should be provided by the Ministry of Health in the same way as TB drugs and ARVs are provided currently. In addition, a study is needed to understand why so many prisoners are reported to be refusing HIV testing.

The number of laboratory HIV tests performed in Latvia has fallen over the last two years. This is of concern. A clearer policy on HIV testing is needed to ensure that those most vulnerable to HIV infection, such as prisoners and injecting drug users have access to testing. Since 2009, some progress has been regarding antiretroviral drugs. They have been included in the reimbursement list, there has been some streamlining of regimens and there have been reductions in costs. The cost reductions have been achieved by comparing prices of ARVs with other countries, negotiating directly on price with drug companies and more rational use of first- and second line regimens. As a result, the cost per person of ART fell from 9,265 lats in 2008 to 3,949 lats in 2010. However, these costs are well above international price levels. With more forceful negotiation, it should be possible to reduce prices further. This will be essential as significantly more people will need ART over the next five years. Decentralization of ART outside Riga is a welcome step although take-up has been quite limited. Latvia needs to update its treatment guidelines so that they are in line with European norms. In particular, the threshold for treating asymptomatic patients must be raised from a CD4 count of <200 to <350. As people with HIV live longer on ART, there will be an increasing demand for treatment of viral hepatitis. Some of this could be prevented by introducing hepatitis B vaccination for particular

sub-populations now. Improving access to hepatitis C treatment will require reducing the need for co-payment for this.

#### **Recommendations from this evaluation**

1. There is need for **further reform of health structures**. This should include:
  - Strengthening public health functions through the Public Health Department of the Centre of Health Economics including integrating disease specific epidemiology and public health functions into their role.
  - Functional integration of the Latvia Infectology Center into general hospitals.
  - Strengthening the capacity of the Clinic of TB and Lung Disease as a WHO Collaborating Centre and freeing it from excessive bureaucratic control in the Latvia Infectology Center.
  - Quick gains in prisons, such as Ministry of Health providing methadone as it currently provides ART and TB drugs
2. There is need for **more participation of NGOs in the response to HIV** including in prisons. The most important means of achieving this would be by providing reliable and sustainable funding.
3. There is need to **refocus the national response to HIV on injecting drug users**. This should involve ensuring equitable access to ART and further expansion of pharmacotherapy of opioid dependence and needle and syringe programmes.
4. This must include **ensuring continuity of services in prisons**. Methadone needs to be made available in prisons. Costs of expanding community services to include prisons would be minimal. A study is needed into why so many prisoners refuse HIV tests. There is need for expanded TB screening in prisons and improved follow-up of those leaving prison. There should be more use of rapid HIV tests in prisons and the education work started in prison, with UNODC support, should continue.
5. There is need for a **clearer policy on HIV testing and counselling**. This should ensure that HIV testing counselling is available to those populations most vulnerable to HIV infection, such as injecting drug users and prisoners.
6. **National ART guidelines must be brought into line with the European norm**, i.e. recommending treatment for asymptomatic people with HIV with CD4 counts <350. The decentralization process should continue. Greater use should be made of NGOs in providing adherence support.
7. There is need to **finalize guidelines on TB preventive treatment for PLHIV**.
8. The severe financial crisis facing Latvia is recognized. The opportunity should be seized for **a specialist in health financing to conduct a thorough review of the health budget** to ensure that funds are being allocated to the most important priorities. This needs to include funding for NGOs, services in prisons and continuation of activities started by the UNODC project.
9. The Ministry of Health should **pursue measures to further reduce the price of ARVs**. This could include more vigorous negotiation with pharmaceutical companies, joint purchasing with other countries and/or direct importation of generic medicines. The Ministry of Health should also review the approach for procuring TB drugs. Savings could be obtained by procuring these drugs through direct price negotiation with pharmaceutical companies, as is now done for ARVs, or by direct procurement through global mechanisms such as the Green Light Committee.
10. There is need to **improve services related to viral hepatitis**. This should include introduction of hepatitis B vaccination and reduction of co-payments charged for hepatitis C treatment.

## INTRODUCTION AND BACKGROUND

Latvia's national response to HIV is based on an agreed national programme, adopted in 2009 (Government of Latvia, 2009). It runs from 2009 to 2013. Prior to adopting the programme, it was reviewed by UNAIDS co-sponsors through the AIDS Strategy and Action Plan (ASAP) mechanism (ASAP, 2008). That review expressed concerns about relatively high costs of antiretroviral therapy (ART), as well as obstacles for access to HIV treatment. An evaluation of access to HIV treatment and care was conducted in Latvia in 2009 (De Joncheere et al., 2009) because of reports of interruptions in ARV supplies. In addition, UNODC also raised concerns about limited access to treatment in prison settings and for injecting drug users (IDU).

The estimated cost of the national programme was forecast to be 9.5 million lats<sup>1</sup> in 2009 and 10.2 million lats in 2010 (Alban and Mieзитis, 2007). The majority of funds for the national programme come from the state budget. However, because of the economic situation, the state budget only allocated 3.27 million lats to the programme annually for both 2009 and 2010<sup>2</sup>. There are concerns that limited availability of funds means that some planned activities are not being conducted. There are specific concerns about the provision of HIV-related services in prisons.

The national programme's goals are to limit the spread of HIV infections and to decrease the number of new HIV cases. The key tasks are to:

1. Avert new HIV cases among selected target groups
2. Implement comprehensive HIV prevention activities
3. Improve access to health care services for people living with HIV (PLHIV)
4. Promote evidence-based planning and management activities for HIV prevention
5. Scale-up HIV prevention activities and improve national coordination

This document is a mid-term evaluation of the national HIV programme. Its objective is to evaluate the programme's implementation and its cost effectiveness in the last two years. The evaluation is also expected to look forward considering that the budget is expected to stay at 2010 levels. The evaluation seeks to give practical input for further development of effective HIV prevention in Latvia in conditions of restricted governmental budgeting. This should include suggestions for resource allocation. Assessment and recommendations are expected in two main areas: structures and systems, and coverage and quality of services.

The evaluation is requested by the Ministry of Health as an integral part of the collaborative agreement between the Government of the Republic of Latvia and the World Health Organization to support the scaling up the response to HIV in Latvia.

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<sup>1</sup> At the time of writing 1 lat was approximately equivalent to €1.4

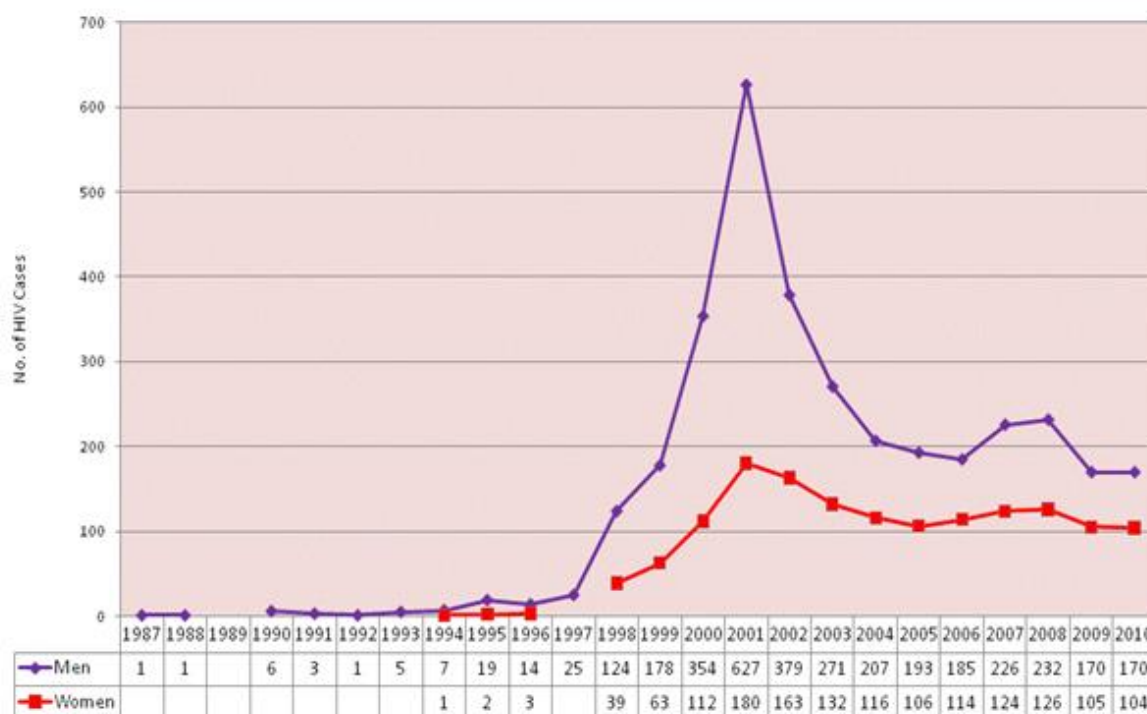
<sup>2</sup> These figures exclude the costs of antiretroviral drugs which are financed separately from the state budget.



## CURRENT STATUS OF THE HIV EPIDEMIC IN LATVIA

From 1987 to 2010, 4,888 people were registered with HIV infection. Of these, 3,398 (70%) were male and 1,490 (30%) were female. The number of newly-registered people with HIV peaked in 2001. Over the last two years, the number of new diagnoses has remained stable, at 170 per year for men and 100 per year for women (see Figure 1). However, it is unclear if this figure represents accurately the number of new infections occurring or is affected by HIV testing policy<sup>3</sup>. There are also concerns that many people with HIV are being diagnosed late. In 2010, there were 274 new HIV diagnoses, of which 221 (81%) had a CD4 count at the time of diagnosis. Of these, 123 had a CD4 count <350 at the time of diagnosis. This means that, in 2010, between 45-56% of those diagnosed with HIV were diagnosed late.

**Figure 1: Distribution of newly-registered HIV infections by sex: 1987 to 2010**



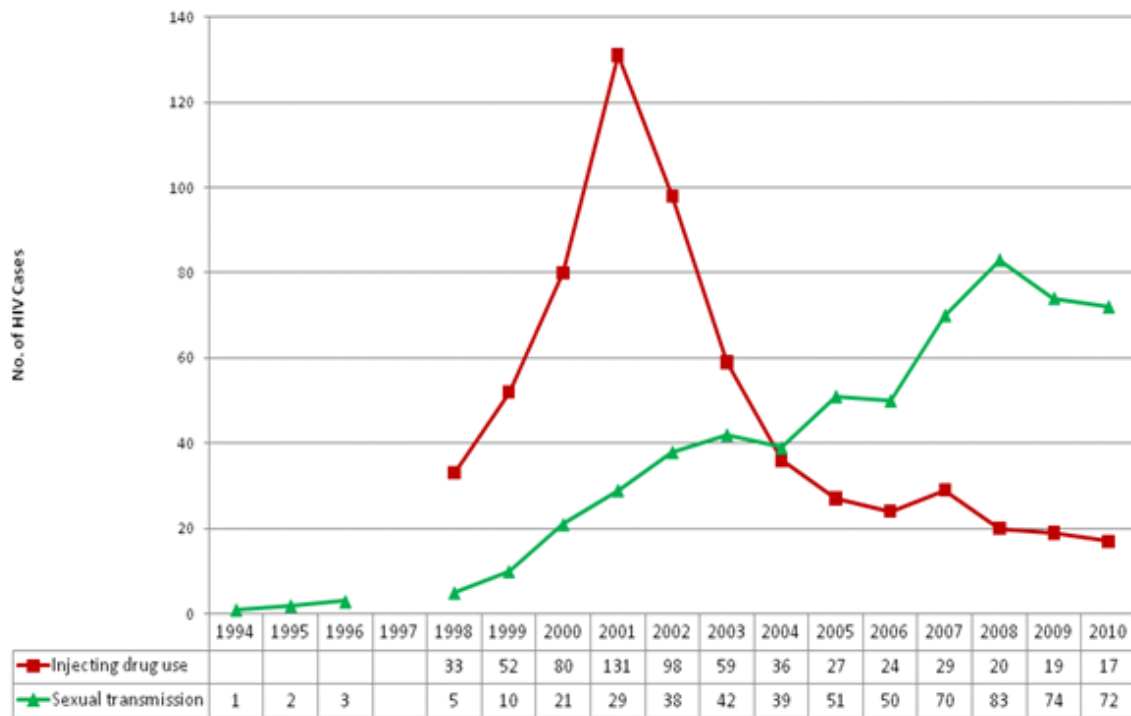
The HIV epidemic in Latvia has been largely-driven by injecting drug use among men. In such an epidemic, it would be expected that heterosexual transmission of HIV would occur among the sexual partners of injecting drug users. Over time, it would be expected that the number of HIV positive women would rise and the number of men and women infected would be roughly equal. Men infected heterosexually are largely the sex partners of female injecting drug users.

This is the situation in Latvia (see Figures 2 and 3). The number of women infected heterosexually has risen. Since 2004, more women have been infected heterosexually than through injecting drug use. However, this does not mean the epidemic is generalizing. Rather, it is the natural course of an HIV epidemic among

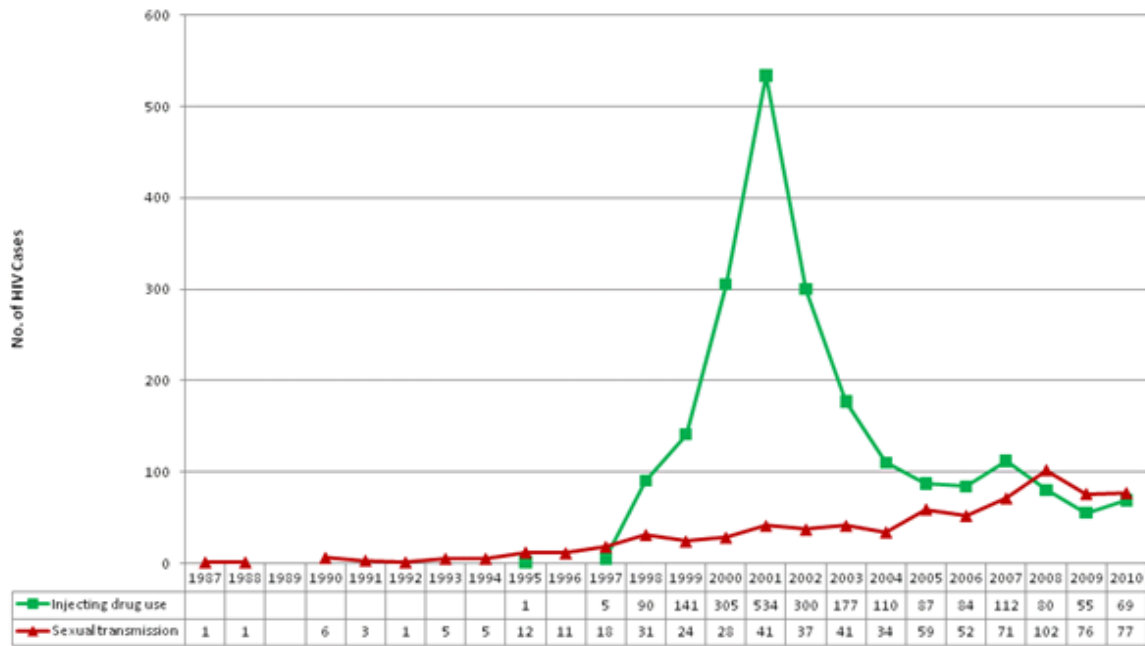
<sup>3</sup> From 2000 to 2006, between 80-90,000 people were tested annually for HIV in Latvia. The number has declined since then and was less than 60,000 in both 2009 and 2010 (Upmace, 2011).

IDUs. There is no evidence of generalization of the epidemic, such as men becoming infected who have not injected drugs, had sex with a partner who has injected drugs or had sex with another man. It is important to understand this. HIV transmission can be reduced most cost-effectively in Latvia by focusing prevention efforts among IDUs. These efforts should ensure that transmission through both injecting drug use and sex between injecting drug users and their partners is prevented. Regular surveys to monitor the prevalence of HIV and hepatitis B and C among IDUs should be undertaken to better document the effectiveness of interventions in Latvia.

**Figure 2: Newly-registered HIV infections among women by reported route of transmission: 1994-2010**



**Figure 3: Newly-registered HIV infections among men by reported route of transmission: 1987-2010**



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Figures 2 and 3 also appear to provide evidence that the response to HIV in Latvia has been effective in slowing HIV transmission through injecting drug use. New infections through injecting drug use have apparently reduced and stabilized. However, these results need to be interpreted with caution because rates of HIV testing among IDUs, particularly in prisons, are relatively low. Less than one third (31%) of IDUs report having received an HIV test in the last year (UNODC, 2011). Only 1% of all HIV tests performed in Latvia in 2009 were among IDUs (Skripste, 2010).

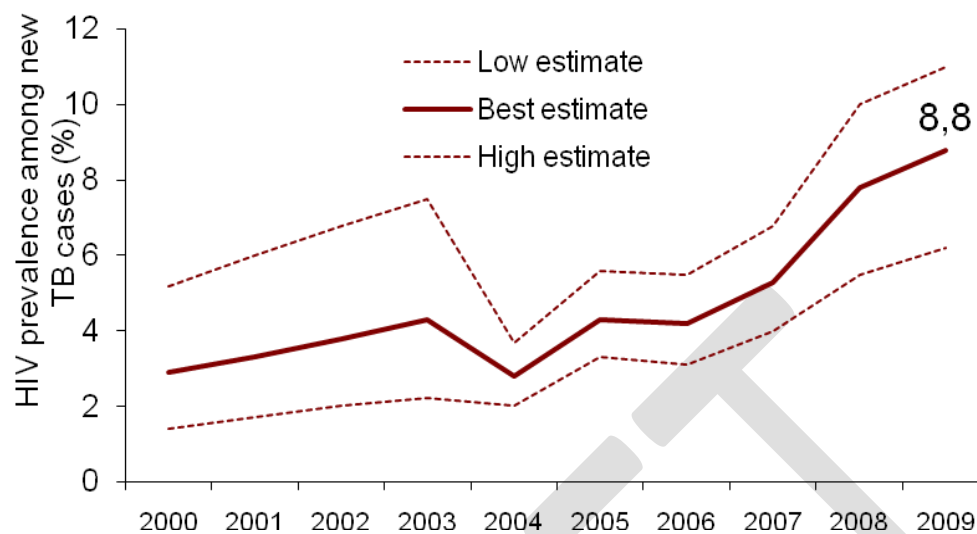
Whatever the explanation, new infections among IDUs are continuing at a relatively high level. Evidence from other countries, e.g. Western Europe, shows that HIV transmission through injecting drug use can be completely controlled by effective prevention measures, such as harm reduction interventions. These measures not only protect those who inject drugs, but also the entire population. Such measures need to be prioritized and delivered at an increased scale if further progress is to be made in reducing the rates of HIV transmission through injecting drug use in Latvia to levels seen in other parts of the European Union.

There is also evidence that life years lost per person as a result of HIV are higher among IDUs than among non-IDUs (Karnite et al. 2010b). Higher rates of HIV infection among IDUs are positively associated with a history of imprisonment (Karnite et al., 2010c).

There are concerns that the true extent of HIV transmission among sex workers, men who have sex with men and sex partners of IDUs in Latvia is unknown. Further research on these topics is needed. In a recent Internet survey, 708 respondents from Latvia reported an HIV prevalence of 4%. A recent study (Karnīte and Dudareva, undated) identified men who have sex with men as a potential 'bridge' population for HIV transmission.

In addition, there are other infections that are associated with HIV infection and injecting drug use. A recent study (Karnīte et al., 2010a) documented that 74% of IDUs in Latvia were infected with hepatitis C. TB is the most common AIDS-indicative disease among PLHIV in Latvia. The number of cases of TB/HIV co-infection rose from 14 in 2000 to 73 in 2009. The proportion of new TB cases with HIV co-infection also rose during that period (see Figure 4). Rates of multi-drug resistant TB among people living with HIV are high. For example, in 2007, rates of MDR-TB were 15% among PLHIV but only 8% among those who were HIV negative. There is evidence that rates of death from TB are higher among PLHIV than among those who are not HIV-infected. Rates of defaulting from TB treatment are also reported to be higher among PLHIV.

**Figure 4: Proportion of new TB cases with HIV co-infection: 2000-2009**



Almost 5,000 people have been identified as having HIV infection in Latvia since 1987 (see Figure 1). Of these, 632 are known to have died and 508 are currently receiving antiretroviral therapy. This means that around 4,000 are HIV-infected but are not yet on treatment. These people are all likely to need treatment over the next five years.

Deaths among people known to be living with HIV are reported to be mostly unrelated to their HIV infection. PLHIV are five times more likely to die from other causes than from HIV-related issues. One of the most frequent causes of death is drug overdose (Government of Latvia, 2009).

## METHOD

The terms of reference for this evaluation are provided in Annex 1 (p45). The evaluation focused on considering the structures and systems in place related to the national response to HIV and the coverage and quality of services available for people living with HIV. There was also a particular focus on structures and services related to prisoners and injecting drug users.

The evaluation was conducted during an in-country mission from 15<sup>th</sup>-18<sup>th</sup> February 2011<sup>4</sup>. The team consisted of eight members provided by UNODC and the WHO Regional Office for Europe. Team members reviewed a range of background documents (see Annex 2, p50) and interviewed a range of stakeholders. Stakeholders included government officials from the Ministry of Health and the Ministry of Justice, staff from the Latvia Infectology Center, and representatives of NGOs. Visits were also made to a number of institutions and activities in Riga, including a prison and a low threshold centre. Full details of the mission schedule are provided in Annex 3 (p54).

As with all studies of this nature, there were a number of limitations. Time available to the team was very limited. As a result, it was not possible to visit any activities or organizations outside of Riga.

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<sup>4</sup> All team members visited Latvia at the same time with the exception of Kees de Joncheere who visited the following week.

## PROGRESS AGAINST RECOMMENDATIONS OF LAST EVALUATION

This section briefly reviews progress against the recommendations of the last evaluation (De Joncheere et al., 2009). This draws on a number of reports on progress in implementing the national HIV programme (see Box 1; Rugāja, 2011; Foglele and Rugāja 2010; Šmate and Grīsele, 2011).

### **Box 1: Reported progress in implementing the national HIV programme in Latvia** (From Šmate and Grīsele, 2011)

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

There has been substantial reform of institutions within the Ministry of Health. A number of agencies were closed including the Public Health Agency. New agencies were formed, including the Health Payment Centre and the Centre of Health Economics. The Latvia Infectology Centre took on a number of activities previously carried out by the Public Health Agency including monitoring and epidemiological surveillance of infectious diseases and methodological support to health care institutions and education providers related to infectious diseases. The State Agency of TB and Lung Diseases was also brought under the control of the Latvia Infectology Center.

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

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

**Recommendation 1: Speed up the institutional reform of state agencies** including revisiting the topic of prison health reform and the early adoption of the new national HIV programme. Part of this process included defining more clearly the roles and responsibilities of different bodies.

**Progress since last evaluation**  
Mixed progress. National HIV programme was adopted but underfunded. No progress on prison health reform. Reform of state agencies has resulted in public health functions related to HIV being badly-fragmented.

No progress has been made on prison health reform. Indeed, the cuts in the prison administration budget have resulted in very severe cuts in the funds available for

health in prisons. The situation, which was previously described as problematic (Stöver et al., 2007) is now described as a potential ‘catastrophe’ (see p29).

The national HIV programme was adopted in 2009 (Government of Latvia, 2009). However, the agreed budget of 3.3m lats was only around one third of that required (Šmate, 2011).

There has been radical reform of the health sector and state agencies. According to official figures (Šmate, 2011):

- Number of employees were reduced from 1,038 at start of 2009 to 570 at end 2009
- 39 emergency health care institutions merged into one
- 131 hospitals in 2003 were reduced to 42
- 17,001 hospital beds in 2009 were reduced to 15,358 at the start of 2010

The Centre of Health Economics was formed from:

- State Medical Prices and Reimbursement Agency
- Health Statistic and Medical Technologies State Agency
- State Health Insurance Agency
- Public Health Agency (Taube, 2011)

Although there is a Public Health Department within the Centre of Health Economics, it is not responsible for all areas of public health in Latvia. For example, HIV-related public health matters are handled by the Latvia Infectology Center. These reforms have resulted in public health functions relating to HIV being badly-fragmented. Placing public health functions within a clinical agency, the Latvia Infectology Centre, was a backward step.

<p><b>Recommendation 2: Scale up access to ART</b> by decentralizing treatment outside of Riga through involving infectious diseases specialists of regional medical centres, involving NGOs in the provision of adherence support and coordinating more closely with essential services for IDUs, such as the provision of methadone maintenance therapy.</p>	<p><b>Progress since last evaluation</b>            Limited progress. ART and methadone pharmacotherapy decentralized but take-up limited. Delivery systems remain separate. NGO provided with operating space at LIC but NGOs lack reliable funding for provision of adherence support. Guidelines allowing ART for asymptomatic people with CD4 count &lt;200 are outdated and a serious barrier to access to ART.</p>
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Decentralization of treatment has occurred. People on ART can now get treatment from local infectious diseases specialists and from any pharmacy with a contract with the Health Payments Centre. However, concerns over confidentiality of data have meant that very few people on ART have taken up this offer.

The provision of a room by the Latvia Infectology Center to an NGO to provide support services for PLHIV is a very positive step. However, the involvement of



NGOs in supporting adherence to ART is severely hindered by the lack of a consistent and reliable source of funding.

There has been some expansion of methadone maintenance treatment outside of Riga and some progress in providing this jointly with TB treatment. However, methadone maintenance treatment and ART continue to be provided by quite separate systems. The biggest barrier to access to ART remains the guidelines that treatment should only start for asymptomatic people once their CD4 count is <200.

**Recommendation 3: Promote more rational use of ARVs** by reviewing the ARVs on the national drug list and merging outpatient and inpatient lists.

**Progress since last evaluation**  
Good progress. All ARVs now included on list of reimbursable medicines.

Since January 2010, all antiretroviral medicines have been included on the reimbursable list and qualify for 100% reimbursement. There are prescribing restrictions on some ARVs (Rugāja, 2011).

**Recommendation 4: Adopt a more public health focused approach to ART.** In particular, this would involve specifying:

- The ARVs to use in first line, second line and 'salvage' regimens
- Criteria to start ART
- Criteria to switch regimens
- Criteria for substitution of one ARV with another one.

**Progress since last evaluation**  
Some progress. There is greater clarity on first line, second line and 'salvage' regimens. Most clients are on first line therapy. But, criteria for starting ART for asymptomatic people are outdated.

In 2009, Latvia developed recommendations for more rational pharmacotherapy of ART, based on WHO and national guidelines. This took into account issues of clinical and cost effectiveness. More detailed ART recommendations are being developed. Almost three quarters (73%) of ART clients are on first line regimens (Rugāja, 2011). However, the guidelines specify that treatment should only be started for asymptomatic clients with CD4 <200. This is out of step with latest WHO guidelines.

**Recommendation 5: Obtain lower ARV prices** by better procurement practices including increasing scale of purchases by reducing number of different regimens offered, using price comparison data in negotiations and direct purchasing from manufacturers abroad using existing legal mechanisms. Other options, such as using generics where patents have expired and where public health concerns merit it, should also be considered.

**Progress since last evaluation**  
Some progress. Health Economics Centre has succeeded in obtaining lower prices for many ARVs by comparing prices with other EU countries and negotiating directly with manufacturers. The use of generics has been considered but no action has yet been taken on this.

Considerable progress has been made in this area using a 2006 regulation which specifies that the price paid for a pharmaceutical should not be higher than the third lowest price in the European Union and should not be higher than Lithuania and Estonia. (Rugāja, 2011). Using this:

- The cost of regimens declined from 5,620 lats in 2009 to 4,793 lats in 2010. But, this varies by regimen. In 2010, the cost per capita was approximately 4,000 lats for first line regimens, 7,000 lats for second line regimens and 16,000 lats for 'salvage' regimens.
- The cost per person treated was 9,265 lats in 2008, 5,205 lats in 2009, 3,949 lats in 2010 and will be an estimated 4,032 lats in 2011.

Although almost two thirds (65%) of those on first line ART are on the cheapest regimens, this is only the case for just over one third (36%) of those on second line regimens. However, overall expenditure on ART is expected to grow from 2.01 million lats in 2010 to 2.50 million lats in 2011. This reflects the rising number of people on ART from 313 in 2008, 415 in 2009, 508 in 2010 and an estimated 620 in 2011. As more people need antiretroviral therapy and health budgets fall, further reductions in the cost of ARVs will be needed.

**Recommendation 6: Take steps towards more equitable access to ART,** particularly among IDUs. The most significant step that could be taken would be scaling up methadone maintenance treatment in the community and prisons. Measures are also needed to address stigma and discrimination experienced by IDUs in Latvian health services.

**Progress since last evaluation**  
Limited progress. There has been some limited scale-up of methadone maintenance treatment in the community but not in prisons or police detention. Access to ART is limited in prisons.

Since 2007, nine new drug treatment centres have opened outside of Riga. As a result, the numbers of people receiving methadone maintenance treatment rose from 78 in 2006 to 271 in 2010. However, this represents less than 2% of all injecting opiate users in Latvia. Methadone remains unavailable within the Latvian prison system which means that essential treatment is interrupted or simply not available for the many drug users in Latvian prisons.

**Recommendation 7: Adopt a more public health focused approach to patient monitoring.** This will involve more aggregation of key data which would be made easier by the introduction of an electronic patient database. HIV resistance testing needs to be part of a more well-developed system on drug resistance, based on threshold surveys on transmission of drug resistance and observational cohort analysis of prevalence and incidence of resistance. Implementation of drug resistance tests at individual level is recommended after 2<sup>nd</sup> line ART failure. This will improve practice

**Progress since last evaluation**  
Good progress. There has been a reduction in the frequency of laboratory testing of PLHIV on ART and a reduction in inappropriate drug resistance testing.

and offer cost savings.

Since April 2009, the laboratory monitoring of clients on ART has been reduced. For example, immunological tests are now conducted once or twice per year as compared to every three to four months. Viral loads are now measured annually as compared to twice per year (Januskevica, 2011). Drug resistance testing is only conducted in cases of suspected treatment failure. Between 35-40 people received these tests annually in 2009 and 2010.

**Recommendation 8: Promote greater integration of services.** In particular, this should focus on TB, HIV and drugs services. A big step forward would be co-location of ARV and methadone maintenance treatment. Greater integration of government services with those provided by NGOs, e.g. on ART adherence, would be welcome.

**Progress since last evaluation**

Some progress. The TB centre is now providing methadone to five clients. However, there has been no progress in co-locating methadone and ART provision.

As part of the expansion of methadone maintenance treatment, methadone is now available to patients receiving TB therapy at the Clinic of Tuberculosis and Lung Diseases. This is potentially a good model for further integration of methadone maintenance therapy with other services, e.g. ART provision. The allocation of a room to AGIHAS within the Latvia Infectology Center is a very positive step and should allow this NGO to play a positive role in supporting clients to adhere to ART.

## FINDINGS

### Structures and systems analyses and organizational development

#### Management and coordination systems

##### *National Coordinating Commission*

Latvia has a National Coordinating Commission to limit the spread of HIV, TB and sexually-transmitted infections (Šmate, 2011). This commission meets quarterly and is led by the Ministry of Health. Membership includes HIV prevention centres, the Ministry of Justice, State Prison Administration, the University of Latvia, National Armed Forces, Riga Stradin's University, the Health Payment Centre, Riga Centre of Psychiatry and Addiction Disorders, hospitals, general practitioners, NGOs and international organizations, such as UNODC and WHO.

Although respondents appreciate the existence of this commission, some expressed concern about its role and function. For example, NGOs were concerned that it had no decision-making powers and was, in reality, just a platform for exchange of information and opinions. Some respondents would like it to have a clearer role in overseeing the implementation and delivery of the national HIV programme. Concerns were also expressed about its focus on operational issues rather than on strategic issues, such as the catastrophic absence of essential HIV services in prisons.

##### *Fragmentation of public health functions*

There has been significant health sector reform in Latvia in recent years. Much of this has had positive effects in terms of reducing costs and excess institutional capacity. However, public health functions have not been given sufficient priority in this reform and have become badly fragmented. The responsibility for the public health functions relating to some important infectious diseases, e.g. TB and HIV, are handled separately from other diseases, handled by the Public Health Department of the Centre of Health Economics. The absence of a body, such as a 'Health Protection Agency', for all critical public health functions in Latvia is a major structural weakness.

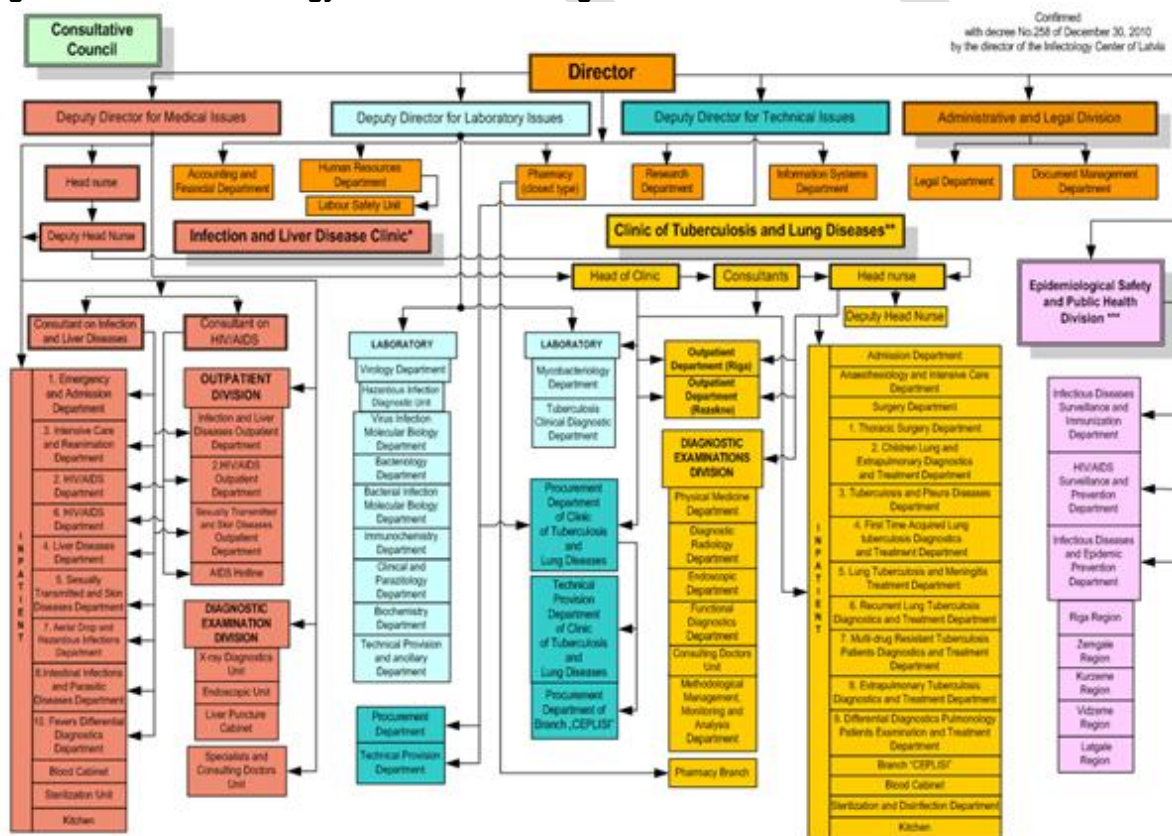
It is recognized that creation of new structures is unlikely to be viable in the current financial climate. However, more public health functions, e.g. relating to HIV and TB, could be transferred to the Public Health Department of the Centre of Health Economics. In particular, the separate existing electronic data systems for infectious diseases, HIV and TB need to be integrated. Combining the HIV programme of the Ministry of Health and the drugs programme of the Ministry of Interior under a strong and effective public health body would make sense. Effective delivery of critical public health functions will be essential if the targets outlined in the 'Latvia 2030' document (Government of Latvia, 2010a) are to be achieved. Diseases, such as, TB, HIV and hepatitis are particularly important in this context because they lead to young lives being lost with a disproportionate effect on life expectancy.

DRAFT

## *Inappropriate concentration of HIV functions at the Latvia Infectology Center*

The Latvia Infectology Center has historically been a provider of curative services related to infectious diseases. It has, until recently, had a role in Latvia's national response to HIV that was limited to issues relating to ART. Its expansion to include public health aspects of infectious diseases (see Figure 5) is very difficult to explain or justify when experience and best practice from other countries are promoting more integration of specific disease programmes into overall health systems. Current requirements for requesting information create a serious bottleneck to effective information exchange. A bureaucratic and controlling approach to public health data, that should be freely and transparently available, is highly inappropriate. Serious consideration should be given to integrating the public health aspects of infectious diseases into the work of the Public Health Department of the Centre of Health Economics and functional integration of the clinical aspects of the work of the Latvia Infectology Center into general hospitals.

**Figure 5: Latvia Infectology Center: Current organizational structure**



Although integration of infectious diseases and TB services is welcome in principle, the subjugation of the Clinic of Tuberculosis and Lung Diseases under the Latvia Infectology Center has been problematic. In particular, this arrangement has hindered the work of the Clinic of TB and Lung Diseases as a WHO Collaborating Centre for TB, because of the very bureaucratic decision-making processes currently operating in the Latvia Infectology Center. This issue needs to be addressed urgently.

### *The health system in prisons faces catastrophe*

Responsibility for health in prisons lies with the Ministry of Justice. The system is completely separate from the system operated by the Ministry of Health in the rest of Latvia. The prison health system is financed from the overall budget. Since 2009, this budget has been dramatically reduced and disproportionate cuts have been made on the health budget. For example, in 2009, overall prison staff were reduced by 20% but health care staff were reduced by 45%. Reports were received that critical HIV services, such as HIV testing, are not being provided in prisons because of inadequate financial resources. The continued lack of methadone maintenance treatment, condoms and sterile injecting equipment in prisons constitutes a significant HIV transmission risk.

This situation is of critical concern because so many people vulnerable to and infected with HIV spend time in prison. The dramatic deterioration in prison health services over the last two years means that the risk of HIV transmission in prisons has risen. People with HIV in Latvian prisons risk not getting important medical services and/or having those services disrupted when they are in prison. This situation needs to be urgently addressed.

One positive element is the provision of certain drugs, e.g. for TB, HIV and mental disorders, by the Ministry of Health to prisoners. This ensures that at least some critical services are provided. Extending this provision to include methadone would be a very positive, low-cost step and would ensure that people receiving methadone from the new decentralized services could continue to access those services while in prison.

In the longer term, a more comprehensive solution is needed. The establishment of a working party between Ministry of Justice and Ministry of Health is a good first step but concrete actions need to be taken to integrate the prison health system under the overall national health system operated by the Ministry of Health.

### Financial flow and NGO support systems

#### *The current financial crisis poses serious threats to the national HIV response*

Latvia faces a severe financial crisis. Funding has been reduced to the health sector, in general. Funds allocated to the national AIDS programme were only around one third of those required. It appears that no significant improvement can be expected in this situation until 2014 at the earliest. In 2010, the International Treatment Preparedness Coalition (ITPC) published a report which expressed concern about the world 'backtracking' on HIV treatment. Six countries were presented as examples including Latvia (see ITPC, 2010; Box 2).

**Box 2: International Treatment Preparedness Coalition (ITPC) accuses Latvia of backtracking on HIV treatment** (see ITPC, 2010).

In 2010, ITPC produced a report which accused the world of backtracking on HIV treatment. It featured six country case examples – from India, Kenya, Latvia, Malawi, Swaziland and Venezuela. In Latvia, ITPC noted that *'as part of its budget-tightening steps in the face of a severe economic downturn, the government is cutting the HIV and health services budget and imposing restrictions on the number of PLHIV provided with ART free of charge. Generic medicines are not procured, and as a result, the cost of treatment to the government is shockingly high compared to many other middle-income countries. Many primary care providers are reluctant to treat PLHIV because they have insufficient or limited knowledge about HIV, or because of the stigma associated with illicit drug use. This makes efforts to decentralize services difficult. Currently there is only one main comprehensive ART centre in Latvia. Lack of integration of HIV care and drug treatment services is another key reason why injecting drug users—an especially vulnerable and affected population in Latvia—lack access to HIV treatment.'*

Given the financial constraints facing health service provision in Latvia, it is important to scrutinize the current health budget to ensure that key services are funded adequately. These include:

- Expanding the number of people receiving ART. It is expected that at least 5,000 people will require ART over the next five years.
- Funding the activities and services of NGOs. Many other countries facing similar financial crises are seeking to divest government of services because private providers, including NGOs and community groups, are often able to provide better quality services at lower cost.
- Ensuring continued funding for activities started under the UNODC project.
- Addressing the crisis of funding facing health services in prisons.
- Hepatitis B vaccination for IDUs and MSM.

Table 1 summarizes the reported expenditure<sup>5</sup> of the national AIDS programme for 2009 and 2010. It is of concern that not all of the funds (£3.3 million lats) allocated to the programme per year were used. Almost three quarters (74%) of the programme expenditure in 2009 was spent on health care services for PLHIV. Almost all of this related to purchase of ARVs. In 2010, the proportion of the programme budget spent on health care for PLHIV was 82%.

<sup>5</sup> A number of different sets of figures were provided and there are some discrepancies between these. The figures used here are taken from the Excel sheet entitled Programme for Limiting the Spread of Human Immunodeficiency Virus (HIV) (2009–2013) implementation activities and output indicators (2009, 2010.)\_updated\_03032011 13:52



**Table 1: Reported expenditure national AIDS programme: 2009 and 2010** (000s lats)

	2009	2010
Prevention of new HIV positive cases in the target groups	463	232
Implementation of large-scale HIV prevention measures	304	275
Better availability of health care services for HIV positive persons and AIDS patients	2208	2297
Promotion of evidence-based planning and management of HIV prevention measures	26	10
Increased scale and better co-ordination of measures for reducing HIV prevalence	0	0
<b>TOTAL</b>	<b>3000</b>	<b>2812</b>

From 2009 to 2010, programme funds spent directly on HIV prevention fell by a third (34%) from 767,000 lats to 507,000 lats. Funds spent on prevention among target groups were halved from 463,000 to 232,000 lats. These changes are illustrated in table 2. The total amount spent by Latvia on HIV prevention is much less than US\$1 per person per year. It fell from \$0.70 in 2009 to only \$0.40 in 2010. The proportion of HIV prevention spending focused on those populations most-affected by HIV also fell from 58% in 2009 to only 45% in 2010. It appears that where financial savings have been made, they have fallen disproportionately on the services for those most-affected by HIV.

**Table 2: Reported expenditure: HIV prevention: 2007-2010<sup>6</sup>**

	2007	2009	2010
Reported spending on HIV prevention (US\$m)	0.996	1.58 <sup>7</sup>	0.89 <sup>8</sup>
Percentage of HIV prevention spending focused on IDUs, sex workers and MSM	34%	58%	45%
HIV prevention spending per capita <sup>9</sup> (US\$)	0.44	0.70	0.40

Sources of funding outside the national HIV programme need to be identified and utilized. Greater clarity is needed in terms of what is expected from municipalities in terms of healthy lifestyles and health promotion. Previously, the WHO Baltic Project on HIV, TB and health systems brought together the Ministry of Health, municipalities and others, and this could be a model that could be used to clarify the role of municipalities in HIV prevention.

#### *Progress has been made in reducing the costs of ART*

Considerable progress has been made in reducing the costs of ART by comparing prices with other European countries and negotiating prices directly with the

<sup>6</sup> Data for 2007 is from the 2008 UNGASS report. Data for 2009 and 2010 from the report of expenditure of the national HIV programme (see footnote 5).

<sup>7</sup> 792,000 lats @ exchange rate of 1.99998. This figure includes funds spent on promotion of evidence-based planning and management of HIV prevention measures.

<sup>8</sup> 516,000 lats @ exchange rate of 1.72409. This figure includes funds spent on promotion of evidence-based planning and management of HIV prevention measures.

<sup>9</sup> Assuming a population of 2.25 million.

manufacturers (see p18)<sup>10</sup>. In addition, more rational use of drugs means that more people are now on first-line drugs. As a result, the cost per person treated with ART fell from 9,265 lats in 2008 to 3,949 in 2010.

Given that the total government expenditure on medicines was around 70 million lats in 2009, the cost of ARVs already accounts for more than 3% of government spending on medicines. However, the number of people expected to receive ART will rise considerably over the next five years (see p39). Price reductions will be needed in order to allow more patients to receive treatment. Options for achieving this include:

- Further improvements in rational prescribing of ARVs, e.g. reducing the need for regimen changes, increased use of recommended second-line regimens.
- Better selection of second-line regimens to avoid cross-resistance with first line drugs which will avoid the need for expensive HIV drug resistance testing.
- Purchasing drugs jointly with other countries. Discussions have begun with other Baltic countries on the possibility of joint purchasing.
- More forceful negotiation with the pharmaceutical industry and importers to bring prices down.
- Purchasing generic antiretroviral drugs. ARV prices in Latvia remain higher than international prices due to lack of competition and non-availability of generics. Although this problem has been discussed for many years, little progress has been made despite it being addressed in the Bremen declaration. The current price levels of ARVs together with substantial reductions in the budget of the Ministry of Health constitute significant risks to both the continuity of ARV supply to current patients and the ability to increase the numbers of patients receiving ART. If further discussions with the industry and the European Union do not yield results, the government may eventually need to consider direct importation of generics and use those on a named-patient basis.

#### *NGOs are a critical element in an effective national HIV response*

NGOs are a critical element of an effective national response to HIV. They allow populations that are particularly vulnerable to HIV infection and PLHIV to participate in the response in a meaningful way. They also are an important accountability mechanism in relation to government services, and they often provide essential

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<sup>10</sup> The procurement of anti-TB drugs is managed differently from the procurement of ARVs. The Clinic of TB and Lung Diseases forecasts the annual need for anti-TB drugs, which are then procured with Ministry of Health funds from the European market. Non-registered anti-TB drugs can be imported in Latvia if they meet European Union standards for good manufacturing practice. The Ministry of Health is currently considering procuring anti-TB drugs directly from the IDA Foundation through the Global TB Drug Facility (GDF) and the Green Light Committee (GLC). The Clinic of TB and Lung Diseases has been reporting annually to the Green Light Committee since 2001. This mechanism is used by Estonia because it is considered to ensure the supply of high-quality drugs at lower prices than the open market.

services that governments find it difficult to provide, particularly to marginalized and neglected populations.

NGOs are playing an important role in the national response to HIV in Latvia. For example, NGOs have been providing essential HIV services in prisons. These services have included testing for HIV, TB and hepatitis C, counselling and conducting relevant research. They have also provided training of staff of HIV prevention centres, prison staff and prisoners. NGOs also provide vital services for injecting drug users. For example, with support from Riga Municipality, DIA+LOGS has expanded services with a new mobile unit, syringe exchange and provision of voluntary counselling and testing services.

The important role of NGOs in the national HIV response has been recognized by the Latvian Government. Cooperation between government and NGOs was strengthened through agreeing a memorandum of cooperation between NGOs and the Cabinet of Ministers. NGOs have seven members on the National Coordinating Committee to limit the spread of HIV, TB and sexually-transmitted infections.

#### *But NGOs lack sustainable funding sources*

However, NGOs lack access to reliable and predictable funding. In general, NGOs operate on the basis of short-term, project funding. Raising funds in this way is becoming more difficult as fewer donors are now providing funds to Latvia. Some NGOs and most low threshold centres receive funding from municipalities<sup>11</sup>. Some NGOs have received funding from pharmaceutical companies. Accessing project funds requires strong project-writing skills which are not found in all organizations. Accessing funding from the European Commission is particularly difficult because of the requirement of co-financing. With the very difficult financial environment in Latvia, this situation has worsened markedly over the last two to three years. NGOs have had to reduce their number of employees and their levels of salary. There are concerns that the situation will get even worse when the current UNODC project ends. There are particular concerns among NGOs that they receive no funding from central government, e.g. from the Ministry of Health. The national HIV programme's implementation plan envisaged the then Public Health Agency developing proposals on how NGOs could be more involved in HIV prevention services and providing social assistance to PLHIV. It is unclear if this was done or which agency is now responsible for this following the closure of the Public Health Agency.

#### *Lack of funding is damaging NGO capacity*

The deteriorating financial situation for NGOs means they have struggled to attract and retain suitably-qualified staff. As a result, their technical and human resource capacity has decreased as a result of the financial crisis.

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<sup>11</sup> This funding is provided by municipalities on a voluntary basis. In Latvia, municipalities have statutory responsibility for two areas of health – access to health care and healthy lifestyles. Healthy lifestyles is not formally-defined but municipalities take this to mean issues related to food, sport, ageing and children. They have not yet included HIV prevention and promotion of sexual health as part of promotion of healthy lifestyles.

## Monitoring, evaluation and quality assurance systems

The national AIDS programme has an implementation plan with specified indicators/predictable results (Government of Latvia, 2009). The Ministry of Health has attempted to track progress of the programme against these indicators (Ministry of Health, 2011). However:

- There are currently too many (50+) indicators to be tracked and analysed effectively.
- Some key indicators are either missing, such as the proportion of those on ART who are IDU or require further calculations, such as the number of needles and syringes distributed per IDU.
- There are some monitoring gaps which reflect gaps in programmes, e.g. indicators relating to methadone pharmacotherapy in prisons.
- There are a very large number of poor quality, low level, process indicators such as the number of materials distributed, the number of people trained, the number of lectures delivered and the number of times a website is updated.
- Some indicators are difficult to interpret, for example, the number of people receiving post-exposure prophylaxis. A fall could mean that less people were exposed or that the medicines needed were not available or provided.
- None of the indicators appear to be fully- or clearly-defined. In some cases, the indicators are particularly unclear or ambiguous.
- Some targets are set as percentages without clear definition of numerators and/or denominators.
- Some targets are very low. For example, the number of syringes and needles needed for 20,000 IDUs is of the order of 2-4 million, i.e. ten times more than the targets set. The same is true of the target for the number of people to receive methadone pharmacotherapy.
- Several of the targets do not increase at all over the life of the programme, e.g. the target for the number of people receiving ART which is set inappropriately low.
- Some targets are set at a level lower than the baseline, e.g. the number of prisoners receiving ART.
- Some of the indicators lack baselines.
- Some of the indicators lack targets. They are simply indicated with an 'x'.

The report that has been produced is a very welcome development. However, it appears that this was the first report produced, i.e. after two years of the programme's operations. Such reports need to be produced more frequently and should be used to refine and manage the programme. This will only be possible if the plan has a few key indicators with meaningful and stretching targets. There are a few cases where programme performance has been lower than the targets set, e.g. numbers of condoms distributed to IDUs and number of HIV tests in prisons. However, it is not clear how this information has been used.

There is a pressing need to review and revise the indicators and targets being used to track the national programme.

The capacity for monitoring, evaluation and quality assurance needs to be rapidly developed. Relevant training and technical support is needed. NGOs have to significantly increase their capacity to monitor the implementation of services that they provide.

The current gap can be attributed to the lack of public health capacity and fragmentation of public health functions. A new Department of Surveillance and Evaluation with responsibility across all areas of public health would be desirable. If formed, clarity would be needed as to how data will flow to coordinating bodies.

There is currently no publicly-available, easily-readable summary of the HIV situation in Latvia and the main elements of the national response.

Independent quality assurance schemes for services are either incomplete or have not yet been established. The limited focus on quality assurance in the delivery of a variety of services is of concern. An effective quality assurance system requires at least the following elements:

- An agreed set of quality standards, which could be included within contracts and applied nationally.
- A system of inspection or review of performance against such standards. Mechanisms for this might include surveys, supervision visits etc.
- Consultations with clients, e.g. through surveys. This can be helpful both in establishing quality standards and in assessing the degree to which they have been met.

The most important developments in the monitoring and evaluation system needed for scaling-up Latvia's response to HIV would be:

- Establishing robust mechanisms for determining the rate of new HIV infections and how these are occurring.
- Reviewing and revising the implementation plan for the national AIDS programme so that it is structured around a small number of key indicators with relevant and ambitious targets.

## Healthcare systems connected with services for PLHIV, including in prisons

### *Latvia is undergoing major reform of its health services*

There has been radical reform of the health sector in Latvia, focused particularly on reducing the number of hospital beds. For example, in 2009, the number of hospital beds was reduced from 17,001 to 15,358. Currently, there is a major focus on hospitals serving relatively small populations (Edwards, 2011).

### *These reforms have affected HIV services*

These reforms have affected HIV services in a number of ways. For example, the provision of ART has been decentralized. People living with HIV needing ART can now receive this from their local infectious diseases doctor and can collect their medicines from a local pharmacy. Although this is a welcome development, utilization of this facility has been quite limited. It appears that there are concerns about confidentiality in local settings. In addition, prisons have not yet started to use the decentralized ART services.

There has also been expansion and decentralization of drug treatment services over the last two years. In 2010, 359 people were receiving methadone or buprenorphine in ten centres across Latvia. There has been agreement that drug treatment services can be reimbursed by the Health Payments Centre. However, there are a number of challenges facing the provision of these services:

- Their provision is over-regulated, e.g. restricting who can prescribe methadone and limiting certain activities, e.g. providing take-home methadone.
- Methadone is still unavailable in prisons.
- Some of the new centres have very few clients – these may not be economically viable unless the client base can be expanded.

### *Health care in prisons faces a catastrophic crisis*

The prison budget has been dramatically reduced in Latvia and cuts have fallen disproportionately on the provision of health care. For example, although overall prison staff fell by 20% in 2009, the number of prison health staff was reduced by 45% (see p23).

## Organizational development and capacity building of coordinating institutions and service providers.

There have been some activities to develop the capacity of service providers as part of the implementation of the national HIV programme. These include:

- Training of HIV prevention centre staff and NGO representatives.

- Training of doctors, nurses, psychologists and social workers to work with injecting drug users.
- Training of prison health care practitioners and staff on prevention of HIV and other blood-borne and sexually-transmitted infections.
- Educational activities on precautionary measures to be taken when coming into contact with blood for health care staff and representatives of other professions such as police officers, fire-fighters, rescue services' staff, prison staff, national armed forces staff.

Most of these activities have been delivered using project funding, particularly from UNODC. After the UNODC project finishes, there will be a need for these types of activities focused on professional development to be maintained in order to further strengthen the capacity of staff providing decentralized ART and methadone pharmacotherapy centres. Increasing the capacity of service providers should result in increased take-up of services.

A number of factors have negatively affected the organisational development and capacity of key institutions involved in the national response to HIV. For example:

- Some functions, e.g. related to public health, have been severely fragmented by recent institutional and organizational reforms
- Some institutions have taken on responsibilities for which they are not well-suited, e.g. clinical institutions, such as the Latvia Infectology Center, taking on public health functions
- Reductions in available financing have affected the capacity of important institutions, such as NGOs

### Integration of services

#### *Services for management of TB/HIV co-infection*

TB patients are routinely-offered HIV testing and PLHIV are screened for TB. All newly-diagnosed PLHIV are initially admitted to the Latvia Infectology Center. TB screening is conducted according to an agreed algorithm. This involves chest X-ray and sputum smear microscopy if the person is symptomatic or through a TB questionnaire if the person has no symptoms. Sputum smear microscopy is done at the laboratory of the Clinic of TB and Lung Diseases. No special TB infection control measures are taken during this period of investigation. GenXpert technology is available for the rapid detection of TB and MDR-TB.

PLHIV with sputum smear-negative TB receive their TB treatment as in-patients in the HIV department of the Latvia Infectology Center. PLHIV with sputum smear-positive TB are referred for TB treatment to the Clinic of TB and Lung Diseases. Clinical management is decided and monitored by a 'consilium' consisting of TB and HIV specialists. National guidelines are unduly restrictive concerning starting ART while still on TB treatment. In 2009, 73 people were treated with TB/HIV co-infection.

However, only 60% of these received ART while still on TB treatment in the Clinic of TB and Lung Diseases. TB/HIV patients are treated under strict infection control measures. Those with a history of injecting drug use are offered methadone pharmacotherapy.

Overall, Latvia has a strong record in responding effectively to TB. The country adopted the DOTS strategy in 1995 and was one of the first countries in the region to implement up-to-date programmatic management of MDR TB. The number of TB cases has been falling since 1998. The number of MDR TB cases has also fallen but more slowly. TB transmission is now occurring mostly among particularly vulnerable groups. These groups include injecting drug users.

After discharge from hospital, people with TB/HIV co-infection continue their TB directly-observed treatment under the supervision of general practitioners, in close consultation with TB specialists based in 26 district-level TB cabinets across Latvia. Until recently, ART was only available in Riga. It has now been decentralized to eight districts but take-up has been limited (see p16).

Isoniazid preventive treatment is not provided to PLHIV because this practice has not yet been included in the national guidelines. A special Task Force has been already established to decide if isoniazid should be used as a TB preventive measure given the high rates of MDR-TB. Cotrimoxazole preventive therapy is routinely provided to all newly-diagnosed TB/HIV patients.

#### *Availability of hepatitis B and C treatment is limited*

One of the main barriers to receiving hepatitis treatment has been the requirement for a 50% co-payment, although this co-payment requirement is waived for the very poorest. This co-payment requirement was reduced to 25% from 1<sup>st</sup> March 2011 which is a welcome development.

#### *There have been positive developments in integrating drug and TB treatment services*

It is reported that patients on TB treatment in need of methadone maintenance therapy can receive this at the Clinic of TB and Lung Diseases in Riga. Currently, five patients are receiving TB treatment and methadone together. Delivering these treatments together works well because both require daily observed medication.

#### *HIV services in the community and in prisons are poorly-integrated*

HIV services available in the community are poorly-integrated with those available in prisons. As a result, there is often discontinuity of services when people spend time in the prison system. This has significant implications for effective HIV prevention and provision of care and treatment for PLHIV. For example, there is reported to be a lack of coordination between the Latvia Infectology Centre and prisons relating to the provision of ART. The team were told that at least 16 prisoners in 'desperate need' of ART were not receiving it. The team also received reports that high numbers of prisons decline HIV tests, CD4 counts and ART. The reasons for such refusals are very unclear. The prison's administration should review how staff are



communicating with sick prisoners on these issues as poor communications are likely to be at least partially responsible for these findings.

There are no direct linkages made with HIV services in the community when prisoners are released. They are simply told where to go to receive services but there are no systems to support them actively in making this transition or to monitor whether or not they have reached the community services.

*NGO services are not well-integrated into the national HIV response*

Although the importance of NGOs in national responses to HIV is well-recognized both internationally and in Latvia, NGOs in Latvia are not well-integrated into the national HIV response, particularly in terms of receiving funding under the national HIV programme.

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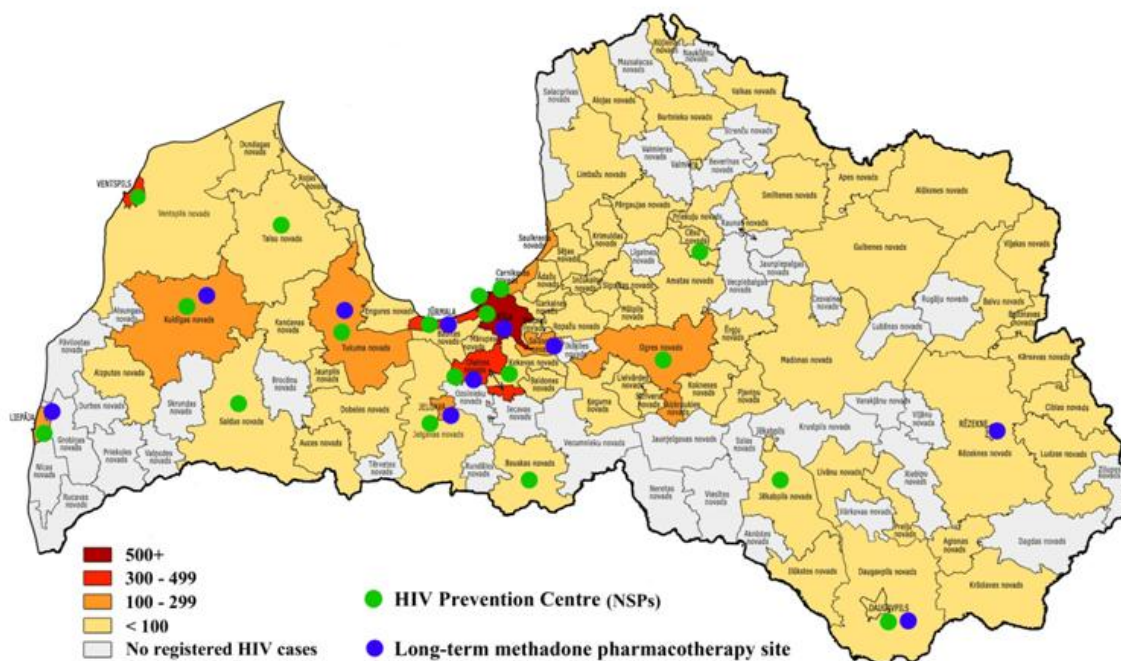
## Access to services, coverage and quality of services

### Prevention and health care services targeted at IDUs and prisoners

#### *Drug treatment services for IDUs have expanded*

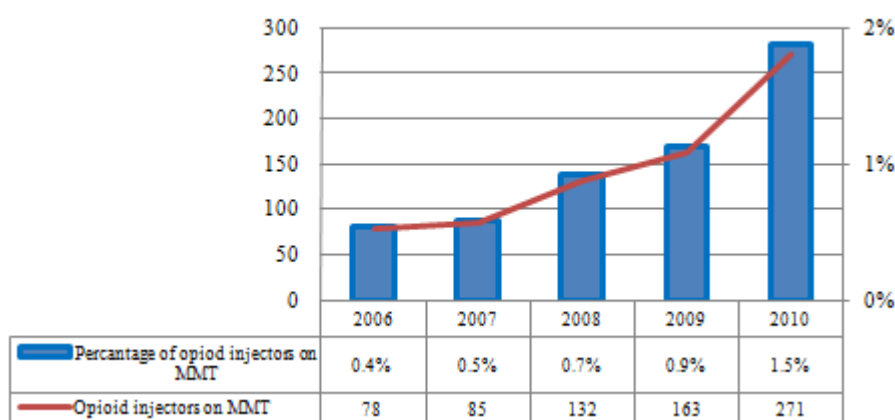
Since the last evaluation in 2009, the availability of methadone maintenance services have expanded beyond the Centre for Psychiatry and Addiction Disorders in Riga. Currently, there are ten such centres across Latvia providing methadone maintenance therapy (see Figure 6). Five people currently receive methadone at the Clinic of TB and Lung Diseases.

**Figure 6: Distribution of methadone maintenance therapy sites and needle and syringe programmes in Latvia**



The number of people on methadone treatment rose from 85 in 2007 to 271 in 2010 (see Figure 7). In addition, 49 people were receiving buprenorphine at the end of 2010. Drug treatment centres offer clients annual tests for both HIV and hepatitis C. Of those on substitution therapy, 70 are known to be HIV positive.

**Figure 7: Number and percentage of opioid injectors on methadone in Latvia: 2006 to 2010**



New centres have been set up in places where there was considered to be a need and support from local government and the local community. In some places, e.g. Liepaja, Jurmala and Olaine, municipalities have provided premises. However, there are a few examples of municipalities that declined to establish centres, e.g. Ventspils. Positive steps in allowing the expansion of drug treatment services include acceptance that such services are refundable from the Health Payments Centre and broadening of regulations to allow non-narcologists to prescribe methadone.

Overall, the quality of the services provided is reported to be good with most centres providing sufficient dosage of methadone, sufficient length of treatment and psychosocial support.

*But there are still considerable barriers to access*

Currently, the percentage of opioid injectors on pharmacotherapy in Latvia is very low (1.7%). Medical professionals and others still have negative attitudes towards IDUs, in general, and methadone, in particular. This makes it difficult to identify people and premises for the provision of methadone. Regulations regarding methadone are still too rigid and are restricting access to this essential treatment. These include requiring people starting methadone to have three days in-patient treatment in Riga, too rigid exclusion criteria and severe restrictions on take-home dosage. In addition, the number of doctors allowed to prescribe methadone could be expanded to include General Practitioners. The system of reimbursement for methadone treatment by the Health Payments Centre creates little financial incentive for new centres to begin operating and gives little time and space to build up a sufficient number of clients.

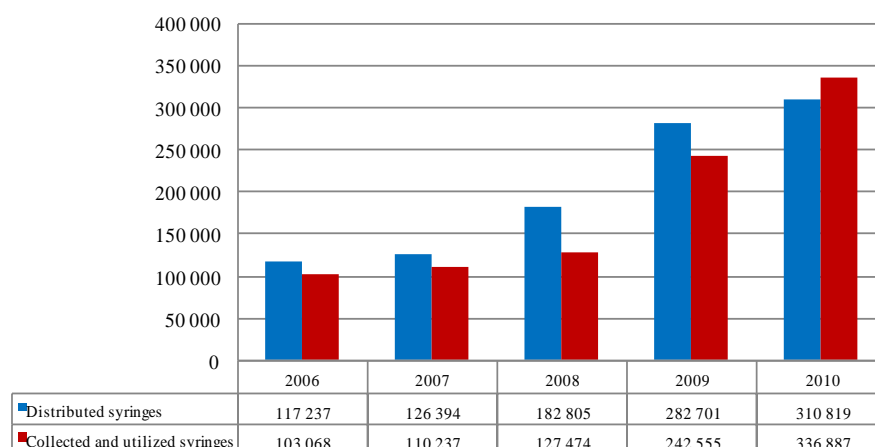
Pharmacotherapy of opioid dependence is still unavailable within Latvia's prison system and for those in police detention. This is a major problem as it results in many clients interrupting their treatment. Since 2008, policy and legal barriers preventing this have been removed. All that is required is for practical issues of financing and provision to be resolved.

WHO is planning support to Latvia and other European countries to increase access to methadone under an EU-funded project focused on increasing access to opioid medication in Europe.

*Coverage of needle and syringe programmes remains limited*

The number of needles and syringes distributed by programmes in Latvia rose from just over 117,000 in 2006 to over 310,000 in 2010 (see Figure 8). From 2007, the number of needle and syringe programmes rose from 12 to 18 (see Figure 6). Services also increased due to introduction of outreach services and peer-driven interventions. However, in 2010, this only equated to 17 syringes per IDU. This is much lower than levels of 100-200 syringes per IDU per year recommended by WHO, UNODC and UNAIDS. Half of the needle and syringe programmes reach less than 100 IDUs per year. Needles and syringes are also available for sale from pharmacies but data on these sales is not available. Despite evidence of injecting drug use in custodial settings no needle and syringe programmes have yet been implemented in these settings.

**Figure 8: Number of syringes distributed and returned by programmes in Latvia: 2006-2010**



There are concerns that the expansion in needle and syringe programmes that has been seen since 2006 may be reversed when the UNODC project closes. For example, this project has been providing incentives to volunteer peer outreach workers for collecting used syringes and needles and referring IDUs to low threshold centres. Since these incentives stopped, the number of clients using services has declined.

Although needle and syringe programmes have received capacity building support from both UNODC and the Latvia Infectology Center, there are problems with these services. Some are not that focused on providing services to IDUs, concentrating more on general HIV prevention in schools and among other population groups. In addition, some of the counsellors lack relevant knowledge and skills. There are also inadequate national guidelines for needle and syringe programmes on issues ranging from staff safety to protocols for exchange of syringes. Less than one quarter (23%) of needle and syringe programmes monitor the extent to which users are satisfied with services. Key elements of injecting equipment, e.g. filters, waters and safe disposal containers are not provided by programmes. The evaluation team

visited one site in Riga and were told that the needles procured and available were not the type preferred by IDUs.

Four programmes (22%) are operated by NGOs. Two are operated by the Latvia Infectology Center. Two thirds (67%) operate within municipal structures. Most funding, e.g. for premises and salaries, comes from municipalities. Latvia Infectology Center provided syringes, condoms and rapid HIV tests using funding from the national AIDS programme. The programme operated by DIA+LOGS is considered to embody many aspects of good practice including outreach work and its system of staff remuneration. Programmes with very limited numbers of clients need to urgently review their practice to take steps to attract larger numbers.

### *The prison health system in Latvia faces catastrophe*

For a small country, Latvia has a very large prison population. At the end of 2010, there were 6,771 prisoners amounting to an incarceration rate of 301.2 per 100,000 inhabitants. This is much higher than the EU average of around 120 per 100,000. Very few sick prisoners are released on compassionate grounds, mostly related to cancer.

At the end of December 2010, there were an estimated 1,789 drug users in Latvian prisons. In addition, there were 477 known people living with HIV in prisons, which is an HIV prevalence rate of 7%. In the women's prison the HIV prevalence is even higher. In 2010, there were 395 female prisoners, of whom 66 were HIV-positive. This is a prevalence of 17%. In 2010, 47 new cases of HIV infection were diagnosed in prisons. However, the policy and practice of conducting HIV tests in prisons are unclear. In addition, the number of refusals for HIV tests increased substantially from 415 in 2009 to 763 in 2010. The reasons for this increase are unknown. Prisoners have to confirm in writing when they refuse an HIV test. At the end of December 2010, there were 46 people in prisons receiving ART. A further eight were reported to have refused ART.

It is very positive that the Prison Administration introduced HIV-related educational activities for prisoners in 2009 and 2010. This corresponds to planned activities within the national AIDS programme. This included involving 1,674 prisoners in group consultations, providing individual consultations to 115 prisoners and providing training to 394 prison staff. Activities included education on safer sex and reducing risks for injecting drug users. These activities have been supported from UNODC and have resulted in prison staff talking about drug use in a non-judgemental way for the first time. However, it is unclear how these services will continue once the UNODC project ends.

Essential services including drug substitution therapy and needle and syringe programmes have not yet been introduced into any of Latvia's prisons. The lack of these services means that HIV cannot be effectively controlled in Latvian prisons. Injecting drug use remains the main route of HIV transmission in Latvia, both in the community in general and in prisons. Every year, the amount of drugs found in prisons increases. More mobile phones are being seized. Clearly, there is a market for and consumption of drugs inside prisons. Condoms are not provided by the

health services in prisons. They are available for sale in prison shops. But, very few appear to be sold through this route.

Since 2009, the budget for medical services in prisons has been drastically reduced. Health services are given very low priority within the Prison Administration. An example of how this has affected one prison is provided in Box 3. Attempts are being made by the Ministries of Health and Justice to address the situation. For example, a meeting to discuss cooperation of medical and rehabilitative services was held in February 2011. Ministry of Health does finance some services in prisons, e.g. the costs of HIV testing, ART and TB treatment. The Ministry of Health began funding HIV testing in 2009 following a period of four to five months when no HIV testing was conducted in prisons because of lack of funds. Some key costs, including transportation, have to be paid from the Prison Administration budget. One way of reducing these transport costs would be for prisons to use decentralized ART services rather than relying on services from the Latvia Infectology Center only. Increasingly, prisoners need to pay for medical care themselves. Clearly, this possibility is only available to those prisoners with money available.

**Box 3: An example of the situation in Latvian prisons: Ilguciems women's prison**

Ilguciems is the only prison for women in Latvia. Although intended to hold 385 prisoners, it currently accommodates 400. There were 494 new admissions in 2010. Sentences range from two months to 19 years, with an average of 5 years. Of the current prisoners, three quarters have some experience of using drugs and two thirds are described as drug users. Data concerning ongoing drug use in the prison is not available.

The prison has 126 staff. Drug treatment services are limited to symptomatic therapy and psychological support.

There were 66 HIV positive prisoners at the time of the visit, of whom 17 were reported to have developed AIDS. Only seven patients were reported to be receiving ART. During 2010, five HIV positive women gave birth in the prison. There were no cases of mother to child transmission. During 2010, there were eight cases of TB. Of these, six had HIV co-infection. HIV testing is reported to be available on a voluntary basis. Confidentiality is reported to be respected. NGOs are reported to be active in the prison providing a range of services.

Services available to women released from the prison are very limited and have been reduced as a result of budget cuts. As with all prisons, health services have been drastically reduced since 2009 as a result of budget cuts. There are fewer staff. Staff turnover has been high. The budget for medicines and other goods has been reduced by 69%. Essentially, the only medical services now in the prison are for emergencies.

Some critical health services are simply unavailable in prisons currently. TB screening is now only performed for patients with very severe symptoms rather than on admission and every six to 12 months. Only half of Latvia's prisons have X-ray facilities. No agreement has been reached between the ministries of health and justice about the use of mobile X-ray facilities for TB screening in prisons. Although active TB has declined in prisons, there are specific concerns about MDR-TB. At the end of December 2010, there were 38 people with TB being treated in the prison hospital. Of these, nine had MDR-TB and seven were co-infected with HIV. A small

study, conducted by an NGO, screened 214 prisoners for HIV, TB and hepatitis. This detected two undetected cases of TB<sup>12</sup>.

Latvian prisons lack any diagnostic screening for viral hepatitis. As a result, hepatitis C remains undiagnosed and treatment is not offered. Hepatitis B vaccination is not available in prison for either staff or prisoners. Although officially prohibited, tattooing is widespread in prisons and poses a significant risk of transmitting hepatitis C. Measures including provision of information about risks of tattooing, provision of bleach and information on how to use it need to be introduced.

Respondents reported that there are almost 200 applications per year to the Ministry of Health from prisoners who believe that they have been ill-treated or had their rights violated. Very few are upheld.

### Health care of people living with HIV

#### *Reductions in HIV testing mean risks of under-reporting*

Latvia relies on reports of new HIV diagnoses as its main way of tracking the national HIV epidemic. However, stabilizing rates of newly-reported HIV infections may represent a reduction in new infections but it could also reflect a reduction in HIV tests conducted. There is limited analysis of data on which population groups receive HIV tests. However, there is evidence that testing has declined particularly among some groups such as injecting drug users and prisoners. This is of particular concern. The high rates reported of prisoners refusing HIV tests raises concerns about the quality of pre-test counselling in prisons and this needs to be investigated. Many members of marginalized populations rely on NGOs for HIV testing. However, NGOs are only able to provide HIV testing intermittently when they have funds available for that purpose. There is a need to ensure that health providers initiate HIV testing and counselling for all those most at risk of HIV on any contact with the health service, e.g. at needle and syringe programmes and in prisons.

#### *Many people living with HIV are lost to medical follow-up*

Not all those diagnosed with HIV infection are registered for medical follow-up. Of 4,888 people known to have HIV, 632 are known to have died. Of the remaining 4,256 only 3,311 are registered at the Latvia Infectology Center. Part of the problem may be the highly-centralized nature of HIV care in Latvia. People who are not able or willing to register at the Infectology Center have no alternative place to register and receive follow-up. In addition, the Infectology Center does not analyze or produce figures of the number of registered PLHIV seen annually.

#### *The number of people needing ART is going to increase*

At the beginning of 2011, 508 people were receiving ART in Latvia (Januskevica, 2011). There are many reasons why the number of people needing ART in Latvia will increase over the next five years. This reflects the number of people known to be

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<sup>12</sup> This corresponds to a prevalence of TB in the sample of 935 per 100,000 populations which is very high when compared to the national TB prevalence in Latvia. The TB prevalence in Latvia is estimated by WHO to be 48 (13-83) cases per 100,000 population.

infected who will become ill and require treatment over time. Also, currently treatment guidelines in Latvia are not in line with international best practice. Adjusting these, i.e. to allow treatment of asymptomatic patients with CD4 counts < 350, will result in more people needing treatment. Currently, less than half (46%) of those on ART are IDUs although almost two thirds (63%) of all people living with HIV are IDUs (Januskevica, 2011). Providing better support services to IDUs, particularly improved availability of methadone pharmacotherapy, will result in more IDUs accessing ART. Not all those with TB/HIV co-infection are receiving ART. Although this was 78% in 2006, it was only 29% in 2008 (Viksna et al., 2011).

#### *Clinical management of people on ART could be stronger*

In 2010, 249 new patients started ART but 138 discontinued their treatment. In addition, a further 84 required change of their ART regimen. These levels of default and regime change are unacceptably high. They indicate poor clinical care and the need to prepare patients better for initiation of ART, for more adherence support and for more intensive case management and patient monitoring. Greater involvement of civil society in preparing people for ART and supporting them once on the treatment could be critical for greater success in these areas.

#### *Services related to viral hepatitis are very limited*

Co-infection with viral hepatitis is not addressed adequately currently. Not all people living with HIV are offered testing and treatment for viral hepatitis. Hepatitis C treatment is only available to those people who can afford to make considerable co-payments. Hepatitis B vaccination is not provided to PLHIV, IDUs, MSM, sex workers or prisoners.

#### *Drug resistance testing has been reduced appropriately*

Drug resistance testing has been drastically reduced as recommended in the previous evaluation. About 35 patients in 2009 and 40 in 2010 were tested for suspected treatment failures. A national working group, as recommended by WHO, is believed not to be necessary because of the size of the country. A report on the situation in 2010 will be published soon. Until this report is available it will be unclear how well the system for HIV drug resistance prevention, monitoring and surveillance is working. This report needs to capture whether important early warning signs are monitored, such as:

- Prescribing practices, the percentage of those receiving standard first line or second line regimens
- Patients lost to follow-up twelve months after starting ART
- Patients still on first line therapy twelve months after starting ART
- Percentage of patients picking up all their prescribed ARVs on time
- Percentage of patients keeping their appointments
- Pill count/adherence
- Continuity of drug supply and avoidance of stock-outs

There are plans to conduct a survey recommended by WHO to monitor drug resistance prevalence and incidence in populations eligible for ART. Such a survey



aims to monitor how successfully resistance is prevented in Latvia. It focuses on how programme indicators are used to evaluate if ART programmes are functioning to minimize the emergence of HIV drug resistance. It also seeks to evaluate the patterns of drug-resistant mutations that emerge with first line regimens in sentinel centres based on specimens from populations eligible for and starting ART for the first time.

### Psychosocial support to PLHIV and case management.

#### *Mental health needs of PLHIV are often overlooked*

A report on HIV and mental health (MOH, undated, b) concluded that mental health issues among people living with HIV in Latvia are often overlooked. No data is available on the number of PLHIV in Latvia with mental health problems. A key problem regarding the mental health of PLHIV is the lack of integrated services for drug users who are HIV-infected. The division between general mental health services, provided by psychiatrists, and drug addiction services, provided by narcologists, is unhelpful. Recent moves to involve more psychiatrists in providing services for drug users are extremely positive. Mental health services are extremely limited in custodial settings.

#### *Better psychosocial support could result in better treatment adherence*

Although ART provision has been decentralized to a number of sites outside Riga, the number of PLHIV using these services remains low. Reasons for this are not clear but may include lack of confidentiality and fear of negative attitudes towards PLHIV and IDUs. Providing stronger psychosocial support at these decentralized ART sites, e.g. through the involvement of NGOs, could address some of these concerns.

The provision of a room within the Latvian Infectology Center for AGIHAS to provide HIV counseling and treatment adherence support is a positive step. However, this service has limited capacity and only currently operates one day per week. There is a need for this service to be available more hours per week to better-serve the needs of clients. In addition, as with much of the work of the Infectology Center, the procedure for involving NGOs with clients is unduly bureaucratic. A person with HIV is required to enter into a signed agreement with the Infectology Center for them to be referred to NGO social workers. There is also a need for this kind of psychosocial support to be provided in settings outside the Latvia Infectology Center, e.g. in custodial settings.

## CONCLUSIONS

There has been significant progress since the evaluation of access to HIV treatment and care in 2009. The stated priorities for the health sector of health promotion and disease prevention are highly appropriate. There has been substantial institutional reform motivated by the desire to rationalize costs and improve cost effectiveness. Areas of progress specifically-related to HIV include:

- Contributions by government ministries and NGOs to the national HIV response with support through a UNODC project
- Provision of a room to an NGO in Latvia Infectology Center for provision of services to PLHIV
- Expansion of methadone pharmacotherapy including integration with TB treatment
- Some expansion of needle and syringe programmes
- Education programmes in prisons
- Consistency of treatment for TB-HIV patients

Progress has been made in a number of areas in relation to ART. Treatment has been decentralized. ARV prices have been reduced by making comparisons with other countries and negotiating price directly with manufacturers. There is now more rational prescribing ART with most patients on low cost, first line regimens.

Nevertheless, HIV is continuing to spread in Latvia, particularly among injecting drug users and their sexual partners. This continued spread constitutes a significant public health problem for Latvia. If uncontrolled, HIV, TB and viral hepatitis could threaten life expectancy gains envisaged under Latvia 2030 because of significant numbers of young lives lost. Recent health reforms have resulted in fragmentation of public health functions and inappropriate concentration of activities in the Latvia Infectology Center. Severe budget cuts within the prison system mean that the prison health system faces catastrophe. Despite the modest reduction in ARV unit price, the overall cost of ART in Latvia is likely to rise as more people need treatment. Critical activities, started through a UNODC project, need to be maintained and expanded.

## RECOMMENDATIONS

1. There is need for **further reform of health structures**. This should include:
  - Strengthening public health functions through the Public Health Department of the Centre of Health Economics including integrating disease specific epidemiology and public health functions into their role.
  - Functional integration of the Latvia Infectology Center into general hospitals.
  - Strengthening the capacity of the Clinic of TB and Lung Disease as a WHO Collaborating Centre and freeing it from excessive bureaucratic control in the Latvia Infectology Center.
  - Quick gains in prisons, such as Ministry of Health providing methadone as it currently provides ART and TB drugs
2. There is need for **more participation of NGOs in the response to HIV** including in prisons. The most important means of achieving this would be by providing reliable and sustainable funding.
3. There is need to **refocus the national response to HIV on injecting drug users**. This should involve ensuring equitable access to ART and further expansion of pharmacotherapy of opioid dependence and needle and syringe programmes.
4. This must include **ensuring continuity of services in prisons**. Methadone needs to be made available in prisons. Costs of expanding community services to include prisons would be minimal. A study is needed into why so many prisoners refuse HIV tests. There is need for expanded TB screening in prisons and improved follow-up of those leaving prison. There should be more use of rapid HIV tests in prisons and the education work started in prison, with UNODC support, should continue.
5. There is need for a **clearer policy on HIV testing and counselling**. This should ensure that HIV testing counselling is available to those populations most vulnerable to HIV infection, such as injecting drug users and prisoners.
6. **National ART guidelines must be brought into line with the European norm**, i.e. recommending treatment for asymptomatic people with HIV with CD4 counts <350. The decentralization process should continue. Greater use should be made of NGOs in providing adherence support.
7. There is need to **finalize guidelines on TB preventive treatment for PLHIV**.
8. The severe financial crisis facing Latvia is recognized. The opportunity should be seized for **a specialist in health financing to conduct a thorough review of the health budget** to ensure that funds are being allocated to the most important priorities. This needs to include funding for NGOs, services in prisons and continuation of activities started by the UNODC project.

9. The Ministry of Health should **pursue measures to further reduce the price of ARVs**. This could include more vigorous negotiation with pharmaceutical companies, joint purchasing with other countries and/or direct importation of generic medicines. The Ministry of Health should also review the approach for procuring TB drugs. Savings could be obtained by procuring these drugs through direct price negotiation with pharmaceutical companies, as is now done for ARVs, or by direct procurement through global mechanisms such as the Green Light Committee.
10. There is need to **improve services related to viral hepatitis**. This should include introduction of hepatitis B vaccination and reduction of co-payments charged for hepatitis C treatment.

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## **ANNEX 1: TERMS OF REFERENCE**

### **Background:**

Latvia operates in a framework of the national program/strategy for fighting HIV infection – “Programme for Limiting the spread of HIV infection 2009-2013” (accepted by Cabinet of Ministers on 30 Jun 2009, direction Nr.437). The main financial resources for implementing the Programme and the national program before (2003-2008) have been the state budget.

The 2008-2013 draft Programme document was reviewed by UNAIDS co-sponsors through the ASAP mechanism (ASAP, 2009). That review revealed relatively high costs of ART in Latvia, as well as obstacles for access to HIV treatment. In addition, UNODC had raised concerns about limited access to treatment in prison settings and for injecting drug users (IDU).

A previous evaluation “Evaluation of the Access to HIV/AIDS Treatment and Care in Latvia” (Kees de Joncheere et al., May, 2009) has taken place in March 2009 by WHO/EURO and UNODC. At this time problems of supply interruption of HIV treatment in Latvia had been observed. It had been agreed that a similar, but broader, mission will take place in 2010/11 to evaluate the mid-term progress of the implementation of the national HIV/AIDS strategy (Programme 2009-2013) in Latvia.

According to the previous national HIV infection control program (2008-2012, prepared by UNODC with foreign and local consultants) the proposed funding was 9.5 million LVL for 2009 and 10.2 million LVL for 2010 („Estimation of costs of HIV Strategy 2008-2012, Latvia” Anita Alban and Aigars Miežitis, World Bank, 2007).

The Programme implementation due to the economic situation in the state budget funds amounted to 3,266,140 LVL in 2009 (One third of the external experts’ recommendations), and remained in 2010 at 2009 levels, so it did not include measures/activities requiring additional financial resources. Also the HIV/AIDS care system of prisoners raises concerns.

The 2009-2013 Programme goals are to limit the spread of HIV infections and to decrease the number of new HIV cases.

The key tasks are:

1. Avert new HIV cases among selected target groups;
2. Implement comprehensive HIV prevention activities;
3. Improve access to health care services for PLWH and AIDS patients;
4. Promote evidence-based planning and management activities for HIV prevention;
5. Scale-up HIV prevention activities and improve national coordination.

### **Objectives and aim:**

The objective is to evaluate the implementation of the 2008-2013 Programme and its cost effectiveness in the last 2 years and give a perspective until 2013 and beyond, considering that the budget for implementation remains at a level of 2010, excluding

the budget for ART (ART will be provided from the state budget as budget of the state agency "Infectology Centre of Latvia" to all patients in need.

List of background data, reports available at the time of evaluation:

- The final report of the UNODC project "HIV/AIDS prevention and care among injecting drug users and in prison settings in Estonia, Latvia and Lithuania"
- Programme for limiting spread of HIV infection 2009-2013" (action plan included) (EN), (electronically)
- Monitoring report of implementation of the Programme for limiting spread of HIV infection (2009-2013) in 2009-2010 (EN), (electronically)
- Financing the Programme for limiting spread of HIV infection (2009-2013) in 2009-2010 (EN), (electronically)
- Respective documentation of the State agency "Infectology Center of Latvia" (LV) (hard copy) etc.

The aim of the evaluation is to give practical input for further development of effective HIV prevention (incl. resource allocation) in Latvia in conditions of restricted governmental budgeting. So, assessment (incl. cost effectiveness) and recommendations are expected in two main areas: structures and systems, and coverage and quality of services, as well as make proposals for the internal evaluation topic in 2012.

The evaluation is requested by the Ministry of Health as integral part of the collaborative agreement between the Government of the Republic of Latvia and the World Health Organization to support the scaling up the response to HIV/AIDS in Latvia.

**Expertise needed:**

- Structures and systems analyses (including financial systems)
  - reaching and influencing target groups
  - needed coverage and systems in HIV prevention and harm reduction
  - health care systems (including infectious diseases related to HIV/AIDS)
- Coverage and quality of services (HIV prevention centres for IDUs)
- Management of Programme (2009-2013) implementation - organizational development
- NGO structures and capacity
- Institutional support for NGOs

**Areas and key questions:**

**1) Structures and systems analyses and organizational development.** The assessment of:

- 1.1. Management and coordination systems, including structures and systems for harm reduction;
- 1.2. Financial flow and NGO support systems (as providing financial support to service providers);
- 1.3. Monitoring, evaluation and quality assurance systems;
- 1.4. Healthcare systems connected with services for PLWH (including in prisons);

## 1.5. Organizational development and capacity building of coordinating institutions and service providers.

Questions to be answered when investigating each of the areas (1.1-1.5):

1. What is the capacity of the systems and organizations in place?
2. How has the capacity in the area developed in recent years?
3. Do present structures support the needs in fighting the epidemic in Latvia?
4. What are the strong and weak points of the developed systems?
5. Are there areas that need revision/restructuring, gaps to be filled or unnecessary practices that need to be removed?
6. What is needed to further scale up the national response?

## 1.6. Integration of services

Questions to be answered when investigating area 1.6:

1. To what extent HIV services are integrated to other services needed (TB, HCV, STIs, antenatal care, etc) and related to each-other?
2. What are the main gaps and positive developments in integrating different services?

The levels to look at under the section one:

- State and municipalities level
- Level of patients, NGOs and other service providers

## **2) Access to services, coverage and quality of services. The assessment of:**

- 2.1. Prevention and health care services targeted at IDUs and prisoners;
- 2.2. Health care of PLWH – health monitoring, ARV, relation to TB, HCV and STIs, getting PLWH to the health care system;
- 2.3. Psychosocial support to PLWH and case management.

Questions to be answered when investigating each of the areas (2.1-2.4):

1. Is coverage of interventions sufficient for stopping the epidemic, increasing the quality of life of PLWH and achieving the targets set?
2. What are the main problems in achieving the sufficient coverage?
3. Are the services accessible to the target groups?
4. What are the hindering factors related to accessing the services?
5. Is the quality of interventions sufficient for stopping the epidemic and increasing the quality of life of PLWH?
6. What are the gaps in present quality assurance systems?
7. What is needed for improving the quality of services?

## **Methods:**

The evaluation mission will be organized with a focus on structures and systems in place and the coverage and quality of services for PLWH, on structures and services related to interventions targeted at IDUs and prisoners.

#### Methods of evaluation:

- Desk review of documents, reports and other materials related to HIV infection issues in Latvia. Materials will be provided by MOH before the in-country mission.
- Interviews with key informants in chosen organizations with visits to service provision sites in Riga- Key informants will be relevant government officials in different ministries (MoH, MoJ) and state agency "Infectology Center of Latvia", representatives of NGOs (e.g. HIV/AIDS patient's organizations). Institutions/organizations and key informants will be chosen in cooperation of evaluation experts and the state agency "Infectology Center of Latvia".

#### Partnerships:

- World Health Organization Regional Office for Europe: HIV/AIDS, STI and Viral Hepatitis, Pharmaceuticals, Health Systems, Tuberculosis
- Independent consultant(s): lead writer Roger Drew, prison expert Heino Stöver
- UNODC Signe Rotberga
- Civil society: AIDS Action Europe expert Anna Zakowicz
- ECDC surveillance expert?
- Programme (2009-2013) - First contact: Inga Šmate, Director of department of Health policy planning, Head of Coordination commission for Limiting the spread of HIV infection, tuberculosis and sexually transmitted infection of Ministry of Health (MoH) ([inga.smate@vm.gov.lv](mailto:inga.smate@vm.gov.lv), phone +371 67876073)
- Ministry of Justice (MoJ) – Organizing meetings under the domain of the ministry. First contact: Kristīne Ķipēna, Head of Unit of Punishment Execution Policy of Sectoral Policy Department of Ministry of Justice, ([Kristine.kipena@tm.gov.lv](mailto:Kristine.kipena@tm.gov.lv)), phone + 371 67046124).

Experts involved: TBA.

Roger Drew will be the main report writer who will consolidate the reports of other experts to the overall report.

#### Timeframe:

All background materials sent until 18.Jan 2011.

Evaluation mission in country 15-18 Feb 2011.

#### Output:

At the end of the mission in Latvia, a meeting will be organized for giving first feedback on evaluation findings. Meeting will find place in the Ministry of Health. Output of evaluation missions is a written report. Report should be structured according to all areas specified in the TOR. Under the section of one area answers should be given to the questions listed in TOR and recommendations given. The report has to contain a list of organizations and people interview and documents reviewed.



- Each of the evaluators involved write a 2-3 page long report on each area s/he has to cover after the mission in Latvia. When writing the report answers will be given to all questions listed in Terms of Reference and maximum 3 recommendations given for improving the situation.
- All evaluators will send their parts by 1 March 2011 to the Roger Drew who will integrate different parts to the overall report and send the first draft report to MOH by 09 March 2011.
- The deadline for the final consolidated report is 25 March 2011 (in English).

The individual reports by the mission members will be collated, edited and summarized by Roger Drew according to WHO EURO Style Guide and Writing for EURO (as sent previously).

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## ANNEX 2: DOCUMENTS REVIEWED

Alban, A. and Miežitis, A. (2007) *Estimation of Costs of HIV Strategy 2008-2012: Latvia*

Alistar, S.S., Owens, D.K. and Brandeau, M.L. (2011) *Effectiveness and Cost Effectiveness of Expanding Harm Reduction and Antiretroviral Therapy in a Mixed HIV Epidemic: A Modeling Analysis for Ukraine*. PLoS Med 8(3): e1000423. doi:10.1371/journal.pmed.1000423

ASAP (2008) *ASAP Review Comments on Latvia National HIV/AIDS Program 2008-2012*

De Joncheere, K., Eramova, I., Kehler, J., Laukamm-Josten, U., Rotberga, S., Zakowicz, A. and Drew, R. (2009) *Evaluation of the Access to HIV/AIDS Treatment and Care in Latvia*

Edwards, N. (2011) *Latvia Mission Report: 15-18 February 2011: Hospital Reform*

Fogele, A. and Rugāja, Z. (2010) *Tasks Accomplished by the Centre of Health Economics in regard to the WHO report of May, 2009 "Evaluation of the Access to HIV/AIDS Treatment and Care in Latvia"*

Government of Latvia (2005) *Cooperation Memorandum between Non-governmental Organizations and the Cabinet of Ministers*

Government of Latvia (2009) *Programme for Limiting the Spread of Human Immunodeficiency Virus (HIV) for 2009–2013 Informative Part* there is also a document entitled planned programme policy and outcomes, a table showing output indicators and an Excel financial report

Government of Latvia (2010a) *Sustainable Development Strategy of Latvia 2030*

Government of Latvia (2010b) *UNGASS Country Progress Report, Latvia*

IHP+ (2009) *Joint Assessment of National Health Strategies and Plans: Joint Assessment Tool: The Attributes of a Sound National Strategy* plus information note on the use of the tool

International Treatment Preparedness Coalition (2010) *Missing the Target: Rationing Funds, Risking Lives: World Backtracks on HIV Treatment: On-the-ground Research in India, Kenya, Latvia, Malawi, Swaziland and Venezuela*

Januskevica, I. (2011) *Antiretroviral Therapy of HIV Infection in Latvia*

Karnīte, A. and Dudareva, S. (undated) *Men who have Sex with Men (MSM) – a "Bridge" Group for HIV transmission in Latvia*

Karnīte, A., Uuskula, A., Raag, M., Rūitel, K., Talu, A., Abel-Ollo, K., Caplinskas, S., Caplinskiene, I., Upmace, I. and Ferdats, A. (2010a) *Prevalence of Hepatitis C Infection and Related Factors among Injecting Drug Users in Estonia, Latvia and Lithuania*

Karnīte, A., Briģis, G., Skrule, J., Lazdina, A. and Upmace, I. (2010b) *Potential Years of Life Lost due to Human Immunodeficiency Virus (HIV) Infection in Latvia from 1991 to 2008*. European Journal of Public Health, 2010. Volume 20, Supplement 1, p. 204

Karnīte, A., Briģis, G., Ferdats, A., Brokere, I., Bulmistre, I. and Upmace I. (2010c) *Factors Associated with Prevalent HIV among Injecting Drug Users in Latvia*

Latvia Infectology Centre (undated) *Estimated Budget of the Centre of Infectious Diseases for HIV/AIDS in 2008 and 2009 (Lats)*

Latvia Infectology Centre (2010) *Structure of SA "Infectology Center of Latvia"* PowerPoint slide

Ministry of Health (undated, a) *ART Regimens Currently being used in Latvia*

Ministry of Health (undated, b) *National Report from a Study on Mental Health and HIV/AIDS. Country Report Latvia.*

Ministry of Health (undated, c) *Epidemiological Situation*

Ministry of Health (2010) *Annex to Programme for Limiting the Spread of HIV for 2009-2013 (Informative Part): Implementation Plan*

Ministry of Health (2011a) *Continuation of the Information Provided by the Ministry of Health*

Ministry of Health (2011b) *Programme for Limiting the Spread of Human Immunodeficiency Virus (HIV) (2009–2013): Implementation Activities and Output Indicators (2009, 2010.)*

Papardes Zieds (2010) *Highly Active Prevention: Scale up HIV/AIDS/STI Prevention, Diagnostic and Therapy across Sectors and Borders in CEE and SEE. Annex 1 Executive Summary of the Project*

Perevoščikovs, J. (2011) *Epidemiological Surveillance of Infectious Diseases in Latvia*

Rugāja, Z. (2011) *Evaluation of the Access to HIV/AIDS Treatment* PowerPoint presentation to mid-term evaluation

Skipste, I. (2010) *Accessibility of HIV Testing and Counselling in Latvia* PowerPoint

Šmate, I. (2011) *Supervision of the Implementation of the Programme* PowerPoint presentation to mid-term evaluation

Šmate, I. and Grisle, G. (2011) *Draft Informative Report on the Implementation of Programme for Limiting the Spread of Human Immunodeficiency Virus (HIV) for 2009-2013 in 2009 and 2010*

Stöver, H., Lehmann, M., Olsena, S., Upmace, I., Skripste, I., Trautmann, F. and Weilandt, C. (2007) *Capacity Building for Institutions Involved in Surveillance and Prevention of Communicable Diseases in Latvian's Penitentiary System*. The final report of an EU Twinning Light Project. The report is also available in Latvian.

Taube, M. (2011) *Tasks of the Centre of Health Economics* PowerPoint presentation to mid-term evaluation

UNODC (undated) *UNODC Funds used in Latvia in 2010* Excel

UNODC (2011) *HIV and Injecting Drug Use in Latvia: Data on Epidemiological Situation and Prevention Services for IDUs*

Upmace, I. (2011) *HIV/AIDS Surveillance System in Latvia* PowerPoint presentation

Viksna, L., Leimane, V. and Riekstina, V. (undated) *Addressing Drug-Resistant TB in People Living with HIV: Where are We?* PowerPoint presentation

Viksna, L., Cirule, A., Leimane, V. and Riekstina, V. (2011) *Collaborative TB/HIV Activities* PowerPoint presentation to mid-term evaluation

WHO (2004) *Policy on Collaborative TB/HIV Activities*

DRAFT

## ANNEX 3: SCHEDULE OF PEOPLE INTERVIEWED



### **Mid-term evaluation of the Latvian national programme “Programme for limiting the spread of HIV infection 2009-2013”**

February 15-18, 2011, LATVIA

Composition of team:

**Dr Ulrich Laukamm-Josten**, Head of the Mission, Division of Health Program, Communicable Diseases, WHO/EUROPE

**Dr Irina Eramova**, Senior Medical Officer, Care and Country Support, WHO/EUROPE

**Dr Pierpaolo de Colombani**, Medical Officer, TB Programme, Division of Communicable Dis., Health Security, Environment, WHO/EUROPE

**Roger Drew**, WHO temporary adviser

**Heino Stöver**, UNODC temporary adviser

**Signe Rotberga**, Regional Project Coordinator, UNODC Project Office for the Baltic States

**Anna Zakowicz**, Board of Directors, European AIDS Treatment Group (EATG)

The Mission is coordinated by **WHO Country Office** in Latvia

Focal point of Ministry of Health: **Dr Inga Smate**, Director, Public Health Department

## PROGRAMME

Day 1	Tuesday, 15 February
09.00-10.00	Organisational issues, clarification of tasks of team members Venue: Albert Hotel (Address: 33 Dzirnavu Str.)
10.30-12.30	<b>Ministry of Health</b> (Address: 72 Brivibas Str.), Conference Hall, 3 <sup>rd</sup> floor Introduction to the Mission's work. <u>Participants:</u> Mr Rinalds Mucins, State Secretary, MoH Dr Inga Smate, Director, Public Health Department Inese Kaupere, Deputy Director, Department of Health Care, Health Economic Center Dr Dace Viluma, Unit Head, Epidemiological Security, Department of Public Health, MoH Dr Gunta Grisle, senior expert, Epidemiological Security, Public Health Department, MoH Dr Anna Klusa, senior expert, Health Care Department, MoH Agnese Rabovica, Director, Department of International Relations and EU matters Liga Serna, Deputy Director, Department of International Relations and EU matters, ministerial focal point for WHO matters WHO/UNODC expert's team Dr Aiga Rurane, Head, WHO CO Latvia

Issues to be discussed:

- Aims of evaluation, MOH expectations
- Progress with regards to implementation of recommendations of WHO/EURO Mission, 2009
- Future plans, main challenges for 2011-2012
- Funding of the National HIV programme, structure, division of functions
- Impact of crisis

12.30-14.00

**Lunch**

14.00-16.00

**NGO perspective**

Venue: Albert Hotel, seminar room "Light" (Address: 33 Dzirnavu Str.)

Participants:

- Aleksandrs Molokovskis, Association HIV.LV
- Ivars Kokars, NGO "AGIHAS"
- Ruta Kaupe, NGO "DIA+LOGS"
- Vivita Gulane, Latvian Red Cross
- Silvija Pupola, Youth Against AIDS

Issues to be discussed:

- Policy, monitoring and coordination mechanisms
- Access to ARV treatment (community and prisons)
- Coverage and quality of harm reduction services
- NGO funding mechanisms

16.00-17.00

**Meeting with Silvija Simfa**, Adviser on Social and Health issues to President of Association of Municipalities

(Venue: Albert Hotel, seminar room "Light")

17.00-.....

Debriefing for team members



**Day 2**      **Wednesday, 16 February**

09.00-11.00      **Ministry of Justice, Prison Administration**

(Address: Raina bulv. 15,  
Room 418)

WHO/UNODC team:

Signe Rotberga, including for **logistic support**

Heino Stöver

Roger Drew

National experts:

Kristine Kipena, Head, Unit of Punishment Execution Policy of  
Sectoral Policy department, Ministry of Justice

Regina Fedosejeva, Head, Medical Service, Prison  
Administration

Dace Viluma, Ministry of Health, Department of Public Health

Issues to be discussed:

- HIV prevalence in prisons

10.00- 16.00 **Latvian Infectology Centre (LIC)** (Address: 3 Linezera Str.)

WHO/UNODC team:

Ulrich Laukamm-Josten

Pierpaolo de Colombani

Irina Eramova

Anna Zakowicz

**Logistic support** provided by Evija Dompalma, UNODC Latvia

Transport provided by LIC

National experts:

Dr Velga Kūse, Deputy Director on Medical Issues, LIC;

Dr Ilze Bērziņa, Chief Physician, HIV/AIDS Outpatients and Inpatients  
Departments, LIC;

Dr Jurijs Perevoščikovs, Head, Department of Epidemiological Security and Public  
Health, LIC;

Dr Inga Januškeviča, Head, HIV/AIDS Outpatients Department, LIC

Dr Tatjana Kolupajeva, LIC

Dr Gita Sture, LIC

Dr Inga Upmace, Head, Unit of Epidemiological Surveillance and Prophylaxis, LIC

Anda Lazdina, public health expert, Unit of HIV/AIDS Epidemiological  
Surveillance and Prophylaxis, LIC

Anna Klusa, Ministry of Health , Health Care Department

- Access to ARV treatment
- Counselling, testing
- HIV prevention. Needle exchange
- Throughcare
- Capacity building of service providers and specialists
- Support services for PLWHA
- Access to Methadone treatment

Issues to be discussed:

- HIV treatment protocols. Monitoring, evaluation, assurance systems.
- HIV drug resistance
- Treatment coverage, forecasting of ARV needs
- ARV procurement for hospital needs, prices,
- HIV testing
- Integration of HIV/AIDS services in other services (TB, primary care, prisons)
- Relations to TB, HCV, STI

11.30-13.30

**Riga Centre for Psychiatry and Addictive Disorders**

(Address: 2 Tvaika Street)

WHO/UNODC team:

Signe Rotberga

Heino Stöver

Roger Drew

Anna Zakowicz

13.00-14.00 **Lunch**

14.00-16.00 **Continued meetings in Latvian Infectology Centre (LIC)**

17.30-..... Debriefing for the team member

(Venue: Hotel Alberts)

National experts:

Dr Astrīda Stirna, Head, Department of Addictive Disorders

Dr Sarmīte Skaida, Chief Physician, In-Patient's Clinic for Addictive Disorders

Issues to be discussed:

- Coverage of methadone maintenance therapy
- Integration with HIV treatment

13.30-14.30 Lunch

15.00-16.30 **NGO Family Planning and Sexual Health Association "Papardes Zieds"** (Address: 34 Grecinieku street)

WHO/UNODC team:

[Signe Rotberga](#)

[Heino Stöver](#)

[Roger Drew](#)

[Anna Zakowicz](#)

National experts:

Iveta Kelle, Director

Baiba Purvīce, Project Coordinator

Anda Karnite, PhD student, Riga Stradins University

Issues to be discussed:

HIV education in prisons, STI prevention/ education

17.30-... Debriefing for team members

**Day 3 Thursday, 17 February**

09.00-11.00 **Health Economics Centre** (Address: 12/22 Dunties Str.)

WHO/UNODC team:

Pierpaolo de Colombani

Irina Eramova

Roger Drew

**Logistic support** provided by Egija Lapina, WHO CO Latvia

National experts:

Dr Maris Taube, Director, Public Health Department, Health Economic Center ,

Zinta Rugaja, Senior Expert, Medicine Evaluation Unit, Health Economic Centre

Inga Tuca, Senior Expert, Medicine Evaluation Unit, Health Economic Centre

Eriks Mikitis, Head, Contract's Unit, Health Payment Centre

Signe Bokta, Head, Unit of Reimbursable drugs, Health Payment Centre

Issues to be discussed:

**Latvian Infectology Center** (Address: 7 Klijānu Str.)

WHO/UNODC team:

Signe Rotberga

Ulrich Laukamm-Josten

Heino Stöver

Anna Zakowicz

National experts:

Dr Jurijs Perevoščikovs, Head, Department of Epidemiological Security and Public Health, LIC;

Dr Inga Upmace, Head, Unit of Epidemiological Surveillance and Prophylaxis, LIC

Dr Iveta Skripste, public health expert, Unit of HIV/AIDS Epidemiological Surveillance and Prophylaxis, LIC

Anda Lazdina, Unit of HIV/AIDS Epidemiological Surveillance and Prophylaxis, LIC

Dr Inga Šmate, Director, Public Health Department, MoH

Gunta Grisle, Ministry of Health, Public health Department

Issues to be discussed:

- Epidemiological situation
- National Coordination commission
- Monitoring, evaluation, surveillance
- Organisational development and capacity building of coordinating institutions and service providers

- treatment guidelines
  - ARVs procurement
  - Pricing: possibilities to reduce the costs
- 11.30-13.00 **TB and Pulmonary Diseases Clinic, Latvian Infectology Center**

(Address: Upeslejas, Stopinu pagasts)

WHO/UNODC team:

Pierpaolo de Colombani

Irina Eramova

Roger Drew

**Logistic support** provided by Egija Lapina, WHO CO Latvia

National experts:

Dr Andra Cirule, Chief Physician, TB and Pulmonary Diseases Clinic, LIC

Dr Iveta Ozere, physician, pulmonary diseases, TB and Pulmonary Diseases Clinic, LIC

Dr Vaira Leimane, Director, WHO CC on MDR/TB in Latvia

Inga Januskevica, Latvian Infectology Centre, HIV/AIDS Outpatient Department, Head

Velga Ķūse, Latvian Infectology Centre, Assistant Director

Issues to be discussed:

Integration of HIV/TB services: to what extent are HIV

*Continued: Latvian Infectology Centre (Address: 7 Klijānu Str.)*

WHO/UNODC team:

Signe Rotberga

Ulrich Laukamm-Josten

Heino Stöver

Roger Drew

Anna Zakowicz

National experts:

Inga Upmace, Iveta Skripste, Inga Smate, Jurijs Perevoščikovs, Gunta Grisle

- Coverage of needle and syringe programmes
- Gaps in current response

services integrated to other services;

TB, drug dependence treatment. Main gaps and positive developments in integrating different services;

TB/HIV case management. Collaboration with NGO sector.

13.00-14.00

Lunch, **meeting in Hotel Albert**

Lunch, **meeting in Hotel Albert**

**Site visits**

14.30-16.30

**Female prison 'Ilguciems'**

**AIDS consultation cabinet (NS Programme)**

National experts:

Nadezda Trosjuka, Director of the prison

Dr Leonora Bebere, head of medical unit  
Expert

National experts:

Inga Bulmistre, HIV/AIDS Consultation Office, Head

Iveta Skripste, HIV/AIDS Surveillance and Prevention Department, Public Health

WHO/UNODC team:

Irina Eramova

Heino Stöver

Signe Rotberga  
UNODC

WHO/UNODC team:

Pierpaolo de Colombani

Ulrich Laukamm-Josten,

Anna Zakowicz

Roger Drew

**Logistic support** provided by Egija Lapina, WHO CO Latvia and Evija Dompalma,

17.00-.... Drafting of main conclusions and recommendations  
(Albert Hotel)

**Day 4 Friday, 18 February**

9.00-10.30 **Ministry of Health**  
Meeting chaired by Rinalds Mucins, State Secretary Ministry of Health

Participants:

Juris Bundulis, Deputy State Secretary, MoH

WHO/UNODC expert's team

Dr Aiga Rurane, Head, WHO CO Latvia

National experts met in previous days, i.e. representatives of MOH, national experts from all related institutions, representatives of NGOs

**Presentation of initial findings and recommendations, discussion**

Afternoon Departure