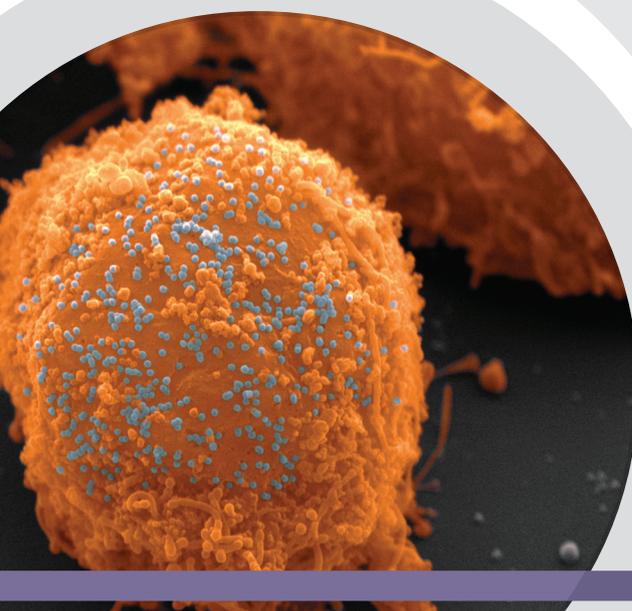




European Monitoring Centre
for Drugs and Drug Addiction



MISSION REPORT

HIV and hepatitis B and C in Latvia

2–4 September 2014

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ECDC MISSION REPORT

HIV and hepatitis B and C in Latvia

ECDC–EMCDDA joint technical mission, 2–4 September 2014



European Monitoring Centre
for Drugs and Drug Addiction

This report of the European Centre for Disease Prevention and Control (ECDC) and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) was produced jointly by both agencies.

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Acknowledgements

ECDC and the EMCDDA would like to thank the Latvian authorities, in particular Jana Feldmane of the Ministry of Health and Dr Nicole Werner-Keišs of the Latvian Center for Disease Prevention and Control, for organising field trips, ensuring access to programmes and services, and facilitating the work of the mission.

Suggested citation: European Centre for Disease Prevention and Control. HIV and hepatitis B and C in Latvia: ECDC–EMCDDA joint technical mission, 2–4 September 2014. Stockholm: ECDC; 2015.

Stockholm, April 2015

ISBN 978-92-9193-634-2

doi 10.2900/822819

Catalogue number TQ-04-15-184-EN-N

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Abbreviations

AIDS	Acquired immunodeficiency syndrome
Anti-HCV	Antibodies against hepatitis C virus
ARV	Antiretroviral therapy
CD4	Subtype of T lymphocytes (T helper cells)
CDPC	Latvian Centre for Disease Prevention and Control (SPKC)
ECDC	European Centre for Disease Prevention and Control
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EEA	European Economic Area
HBsAg	Hepatitis B surface antigen
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
HPP	HIV infection prevention point
HROU	High-risk opioid use/user
MSM	Men who have sex with men
NGO	Non-governmental organisation
NSP	Needle and syringe programmes
UNODC	United Nations Office on Drugs and Crime
OST	Opioid substitution treatment
PLHIV	People living with HIV
PWID	People who inject drugs (formerly referred to as IDUs, injecting drug users)
SPKC	Slimību profilakses un kontroles centrs (CDPC)
STI	Sexually transmitted infection
WHO	World Health Organization

Executive summary

At the request of the Ministry of Health in Riga, a team of experts from the European Centre for Disease Prevention and Control (ECDC) and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) paid a technical visit to Latvia on 2–4 September 2014. The aim of the joint mission was to analyse the epidemiological situation, review current prevention and control efforts, identify gaps and propose key actions for strengthening the response to HIV and hepatitis B and C. The mission focussed on three topics: harm reduction among drug users, testing, and vertical transmission.

The mission confirmed the very high rate of infections with hepatitis B and C, HIV, and especially AIDS, mainly concentrated among certain populations at higher risk. The limited data on trends is also a cause for concern.

In comparison with other European countries, the rates of mother-to-child transmissions, infections in the prison population, persons who inject drugs, and high-risk opioid use were also very high. Based on the findings of this mission, the following key actions for strengthening the response to HIV and hepatitis B/C are recommended:

1. Enhance cooperation between stakeholders in the field of drug misuse and related fields and the field of infectious diseases – at local and national levels and in policy and practice areas – to achieve better synergies.

Justification: Latvia is among the countries with the highest rates of high-risk opioid use and injecting drug use in Europe. The prevalence of HIV and HCV infections among people who inject drugs (PWID) is high and rising. Despite the fact that PWID are the main population of concern for infection prevention efforts, there is a lack of integration between drug prevention policies and infection prevention efforts.

2. Expand the network of HIV Prevention Points (HPPs) geographically and ensure sustainable funding to deliver effective prevention measures at scale.

Justification: The network of HPPs does not yet cover the whole country, funding is limited and lacks stability.

3. More opioid-dependent clients should receive either methadone or buprenorphine maintenance treatment (minimum coverage level: 30% of the target population by 2017). The current national Drug Action Plan 2011–2017 objective should be reviewed in light of this recommendation.

Justification: Long-term maintenance treatment with opioids (OST) has shown to be effective to reduce the transmission of infectious diseases among PWID. The low number of clients on OST reflects the limited availability and accessibility of OST in Latvia.

4. PWID should receive at least 100 syringes and additional injecting equipment per year and free of charge. Ideally, 200 free syringes are provided per year.

Justification: HIV and hepatitis C can be prevented by harm reduction measures such as the provision of clean needles and syringes. The current level of provision of harm reduction services is low and insufficient to have an impact on the spread of infections among PWID in Latvia.

5. Create opportunities for knowledge transfer and training for NGOs and HPP staff involved in the prevention of infections among PWID.

Justification: The involvement of staff at the municipal level in harm reduction services is a relatively recent development; there is a need to strengthen training activities, knowledge exchange, and mutual learning.

6. Opioid substitution treatment should be available at all HPPs run by the government or NGOs and, where appropriate, at GP practices. OST provision in these settings could be managed under a shared-care model with narcology centres.

Justification: Methadone and/or buprenorphine-based substitution treatment should be easily accessible to the target population. Experiences in other Member States have shown that rapid scale-ups are feasible and safe as long as they involve primary care health professionals, such as family doctors.

7. Data protection measures and access policies for the centralised drug treatment registry at CDPC should be urgently reviewed by a multidisciplinary legal and ethics committee. The committee will be responsible for assuring that data protection of the drug treatment registry is in accordance with EU data protection laws. Additionally, the funding of the drug treatment registry should be independent from the Ministry of Justice. Other centralised health-related client registries, e.g. the mental health client registries, should be reviewed accordingly.

Justification: The mission was concerned about information governance of client data. Additionally, national experts reported that drug users mentioned alleged access to medical records by non-medical services as a reason for not accessing drug treatment.

8. Expand the range and coverage of drug-related health services in prisons and improve through-care between prison and community, including the involvement of external service providers.

Justification: The number of former and current drug users in the prison population is high. About one in ten prisoners lives with HIV/AIDS. However, the availability of effective prevention services in prisons is very low.

9. Review the current HIV testing policy and hepatitis screening/testing practices to better reach those at risk and improve the early diagnosis of infections. Confirmatory testing for those who test positive for HIV, HBV and HCV, including those found positive by rapid tests performed in the HPPs, should be encouraged and made free of charge (use direct referrals, eliminate user fees, consider incentives).

Justification: Infectious diseases testing provides opportunities for other preventive interventions, such as counselling and drawing people into care, which may result in reduced risk of future transmission.

10. Expand the provision of antiretroviral treatment (ART) so it is in accordance with the latest WHO guidelines. ART should cover 90% of all people known to be living with HIV (PLHIV). Following-up on these patients should reduce the current fragmentation of services and improve communication between dermatovenerologists, outreach workers, narcologists working on drug treatment (including OST), and staff working in prevention and social support.

Justification: The number of PLHIV currently on treatment in Latvia is still too low. This is likely due to overly restrictive treatment protocols, services which are difficult to access, and challenges in being retained in care. On many occasions, the difficulties to access services – and the related costs – were raised as an obstacle to care.

11. Review the acceptability of the prevention and treatment services to the main target populations. Interventions to reduce the burden of HIV or hepatitis among people from key populations must be respectful, acceptable, appropriate and affordable in order to ensure participation and retention in care. Additional trust-building measures for pregnant women who are known to be injecting drug users is urgently needed in order to encourage them to come into care earlier and thus reduce the risk of mother-to-child transmission.

Justification: The shortage of specific HIV prevention points (such as for MSM or sex workers) makes access time-consuming and difficult. Also, people at risk tend to shun formal services because of a deep-seated distrust of health and government services. Therefore, informing people at risk about services, how they are provided and how much they cost is important to build trust with regard to testing, outpatient treatment of sexually transmitted infections (STIs), and antenatal services for pregnant PLHIV.

12. The careful monitoring epidemics is essential for informed policymaking. Disease surveillance and the gathering of behavioural data are two main areas in need of immediate improvement.

Justification: The proportion of incomplete data is unacceptably high. Better data are needed to guide health policy and inform the prevention and control of infections.

13. Current programme coordination mechanisms should be reviewed and modified so the involvement of key stakeholders and community representatives is strengthened.

Justification: A good national programme on HIV and hepatitis B and C should strive to be as inclusive of those affected as possible to ensure greater relevance and better prioritisation. This would also mobilise other sectors of society.

14. Main prevention efforts need to be focussed on PWID, but other high-risk populations – namely men who have sex with men (MSM) and sex workers – should be allocated more resources because it seems unlikely that municipalities will support services to stigmatised populations.

Justification: The current level of prevention, treatment and care services specifically directed at MSM and sex workers is insufficient to have any impact on their vulnerability to future infection with HIV, hepatitis and other STIs.

1 Introduction

1.1 Background

At the invitation of the Latvian government, the European Centre for Disease Prevention and Control (ECDC) conducted a country mission to Latvia in September 2011 which focused on HIV and hepatitis B and C. The objectives of the mission were to review national strategies and programmes for HIV and STI and to discuss the situation of HIV and hepatitis surveillance, prevention and control. In the mission report, ECDC raised several suggestions to Latvian authorities for improvements in HIV and hepatitis B and C surveillance, testing, prevention and control.

In 2012, Latvia reported the highest notification rates for acute hepatitis B, the highest overall notification rates for hepatitis C, and the second highest notification rates of HIV in the EU/EEA.

In November 2013, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), together with ECDC, held a regional seminar for the three Baltic countries which focused on monitoring, and responding to, drug-related infectious diseases among people who inject drugs. The agencies were alarmed by the high rate of injection-related infections and the relative lack of drug-related services: opioid substitution treatment (OST) remains at one of the lowest levels in Europe. At this occasion a country mission and targeted support were requested by participating experts from the Latvian Centre for Disease Prevention and Control and Reitox National Focal Point.

In January 2014, ECDC Director Marc Sprenger conducted a country visit to Latvia. The discussions with the Ministry of Health and the Latvian Centre for Disease Prevention and Control (CDPC, also referred to in this report as 'Slimību profilakses un kontroles centrs', or SPKC) identified HIV and hepatitis B and C surveillance (and related prevention and control activities) as priority areas for a technical country mission.

ECDC invited the EMCDDA for a joint mission to Latvia, to be organised in September 2014, and to assist national experts in their efforts to prevent and control HIV and hepatitis B and C among different risks groups.

1.2 Scope and purpose

The objective of the joint technical mission was to review the status of HIV and hepatitis surveillance, prevention and control together with national experts, in order to:

- better understand the epidemiological situation and determinants for HIV and hepatitis B and C;
- review current prevention and control efforts aimed at these diseases, in the community and in prisons, looking in particular for gaps or where efforts may become more effective;
- propose key actions for strengthening of local services based on this assessment;
- identify any priority areas where ECDC might provide further support.

Specifically, the mission was expected to focus on the following areas:

- Harm reduction for drug users, including reasons for the reported limited uptake of available services by users, especially access and availability of opioid substitution treatment and coverage of the outreach services;
- Testing for HIV and hepatitis B and C, including testing policies and uptake;
- Vertical transmission of HIV and HBV, including policies and gaps in implementation.

As a secondary objective, the mission was also asked to review and provide comments on the Latvian Action Plan for the elimination of HIV infection, sexually transmitted infections and hepatitis B and C for 2014–2016.

1.3 Mission team

The six ECDC–EMCDDA experts were joined by one external expert. In Latvia, the team was supported by representatives of the Ministry of Health, the SPKC, various NGOs, and EMCDDA's Reitox National Drugs Focal Point. Annex 2 lists the names of all mission participants and experts consulted during the mission.

1.4 Method

The three-day mission took the team to Riga, Olaine and Bauska. Key reports and documents were received before the visits and used to prepare key questions.

The visit started with a one-day seminar with key stakeholders from several Latvian organisations, government agencies and NGOs, held at the Ministry of Health in Riga. Participants discussed the latest trends in epidemiology

and drug-related infections, and participants were updated on recent changes in legislation and programme coverage.

Over the next two days, the team visited several organisations engaged in HIV and hepatitis testing, infectious disease services, harm reduction services, and prevention and control activities.

At the end of the visit, the team met again with key stakeholders to share the main findings of the mission and to discuss recommendations. The mission programme is included in Annex 1. The documents provided to the mission team are listed in Annex 3.

2 Epidemiological situation

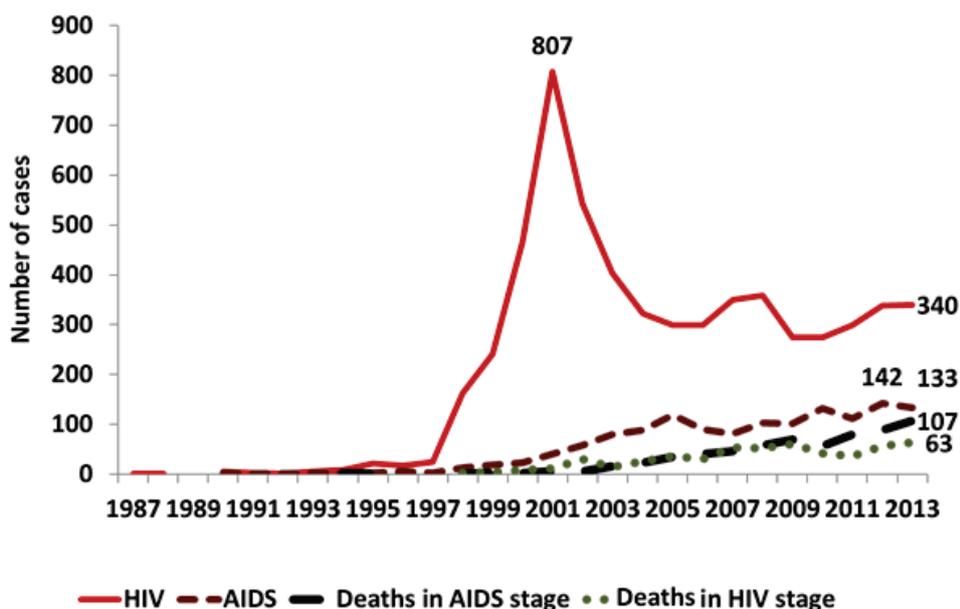
2.1 HIV and AIDS

HIV and AIDS surveillance in Latvia is coordinated by the Latvian SPKC. While community-based HIV testing is performed at various clinics, through the network of HIV Prevention Points (HPP), at GP practices and other venues, all confirmatory testing is performed centrally at the National HIV Reference Laboratory in Riga. Monthly reports on the number of tests are received via the HPPs and the national reference laboratory.

There were about 90 000 HIV tests performed in 2013, most of these tests (53 000, 58.9%) were among blood donors. Fewer HIV tests were performed in 2013 than in previous years, and this decrease is partly attributed to fewer blood donors.

In 2013, there were 340 cases of HIV reported and 133 cases of AIDS. Most notified HIV cases were residents of Riga. The overall rate of HIV cases diagnosed in 2013 per 100 000 population is 16.8, which is the second highest in the EU and well-above the EU/EEA average of 5.7 per 100 000 population. The highest incidence is among 25–39-year-old men, with higher incidence among men than women in all age groups except for 15–24-year-olds, where the incidence in women is higher.

Figure A: Newly registered HIV and AIDS cases, 1987–2013



Source: Latvian Centre for Disease Prevention and Control

Latvia has historically had a high HIV incidence among people who inject drugs (PWID), with a large outbreak of HIV in this population reported in 2001. Since 2001, the overall number of notified HIV cases has decreased, but in 2009 the number of reported cases has started to increase again. The epidemic curve shown in Figure A strongly suggests steady-state transmission, where new cases have occurred at a fairly constant rate since the initial outbreak in 1997–2003. In 2013, the largest transmission category (36.8%) were persons classified as heterosexual transmission, while 29.7% were classified as 'unknown'; 22.7% were linked to injecting drug use, 2.9% to vertical transmission, and 7.9% occurred in MSM. Latvian authorities partially attribute the recent increase in the 'unknown' transmission category to reduced resources for surveillance in recent years, which may have negatively impacted on the completeness of epidemiological data.

In recent years, a rising number of HIV cases have been attributed to mother-to-child transmission. In 2013, 32 births to HIV-positive women were reported, 10 of which were infected through mother-to-child HIV transmission.

AIDS cases have increased, and the rate of AIDS cases per population is the highest in the EU/EEA (6.6 per 100 000 in Latvia, compared to 0.9 per 100 000 in the EU/EEA as a whole). HIV-TB co-infections have also increased in recent years. An increasing trend of HIV-related deaths has been observed in Latvia. In 2013, there were 107 deaths reported among AIDS cases and 63 deaths reported among persons living with HIV.

Main conclusions/findings:

- After a steady decline which started in 2001, the number of reported HIV infections has been on the increase over the last few years, even though the testing rates have dropped over the same period.
- Contrary to the situation in other EU/EEA countries, AIDS is on the increase in Latvia. The fact that AIDS incidence is nine times higher than the EU/EEA average suggests a deficiency in antiretroviral treatment coverage/uptake.
- Surveillance data suggest unrestrained steady-state transmission in some parts of the population (PWID) and suggests that HIV infection has become endemic in certain population groups in Latvia.
- There are continued cases of HIV infection attributable to mother-to-child transmission.
- The increase in cases classified as 'unknown' is worrisome because it makes the effective targeting of prevention and control efforts more difficult.

2.2 Hepatitis B and C

The surveillance of hepatitis B and C in Latvia is also coordinated by the Latvian SPKC. The surveillance system is underpinned by a legislative framework for the reporting of communicable diseases, including hepatitis B and C. Reports are sent from clinicians and laboratories to regional surveillance sites and from there to the epidemiologists at SPKC. For surveillance purposes, SPKC uses the EU 2012 case definitions for hepatitis B and C.

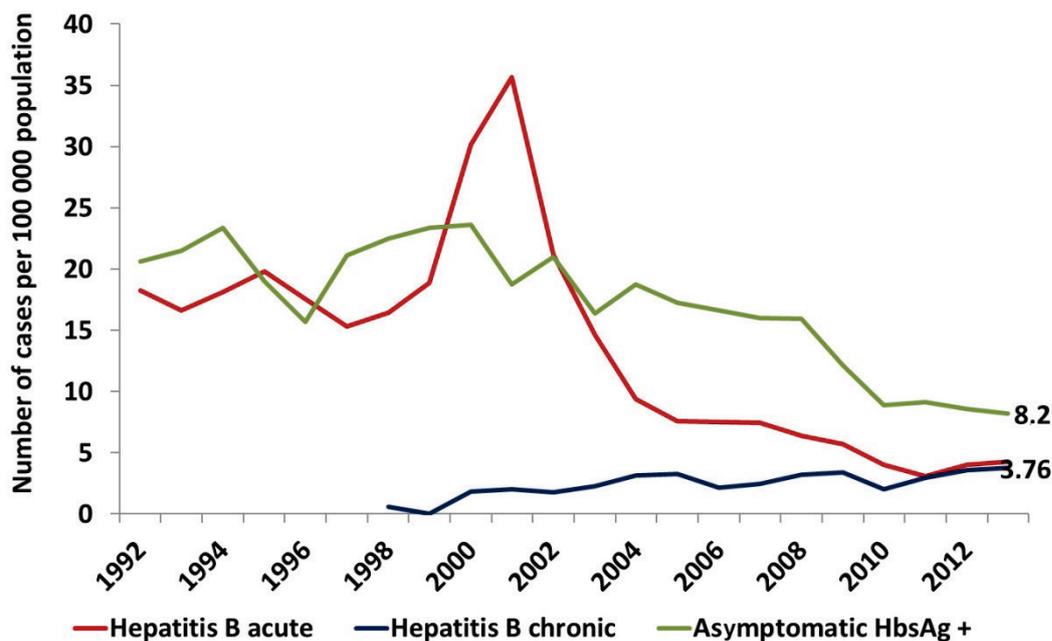
Case-based data are recorded electronically and on paper, and data are analysed monthly and annually. All cases notified to the SPKC are followed up by epidemiologists to obtain detailed epidemiological information and to undertake contact tracing, yet in 30% of acute hepatitis B cases, 80% of chronic hepatitis B cases, and 50% of chronic hepatitis C cases the mode of transmission cannot be determined. If nosocomial transmission is the suspected cause of infection, a detailed investigation is undertaken.

HPPs and outreach services often use hepatitis express test kits in the community. All confirmatory testing is performed at the national reference laboratory.

A total of 329 confirmed cases of hepatitis B were reported to ECDC in 2012 (82 acute, 73 chronic and 174 classified as unknown). There has been a decline in the overall number of cases reported since 2006, but changes in the reporting of acute and chronic cases since 2006 make it difficult to review trends in the different disease stages. Rates of acute infections in Latvia were the highest among EU/EEA countries in 2012. Rates of acute and chronic cases of hepatitis B in Latvia were highest among cases from Riga. Cases among males are more common, with a male-to-female ratio of 1.4:1. Most cases occur among those between 20 and 34 years of age. In 2012, 1.2% of cases were younger than 15 years.

Following the introduction of the universal infant vaccination programme against hepatitis B in 2000, which was followed by a catch-up campaign in 14-year-olds, there has been a dramatic decline in the number of hepatitis B cases in children under six. However, in 2012 and 2013 there was a reversal of that trend, with six cases identified.

Figure B: Newly registered hepatitis B cases, 1992–2013

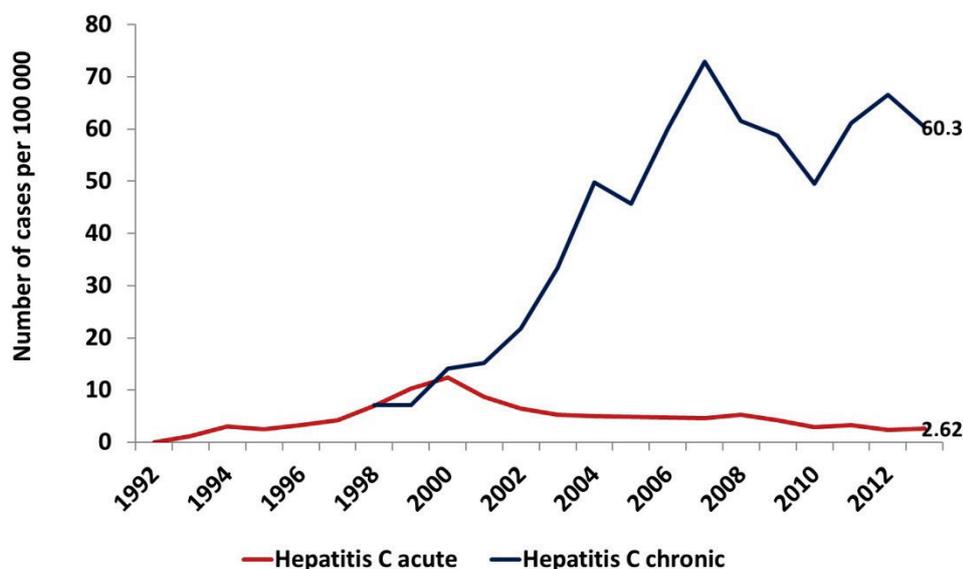


Source: Latvian Centre for Disease Prevention and Control

The most commonly reported routes of transmission for acute cases reported to ECDC in 2012 were injecting drug use (33.3%), followed by (unspecified) sexual transmission (22.7%) and nosocomial transmission (13.3%). Data on transmission for chronic cases was incomplete. Because of incomplete data it is difficult to identify transmission trends. Six cases (1.8% total) were classified as imported in 2012 (four acute, one chronic, one unknown).

A total of 1348 hepatitis C cases were reported to ECDC from Latvia in 2012 (48 acute and 1300 chronic). The overall number of hepatitis C cases reported from Latvia has remained fairly stable since 2006. Latvia had the highest overall rate of reported hepatitis C in Europe in 2012 (62.2 cases per 100 000). Rates of cases of acute and chronic hepatitis C in Latvia were highest among cases from Riga than other parts of the country. Cases are more common among males with a male-to-female ratio of 1.2:1. Most cases are between 25 and 44 years of age. In 2012, 1.0% of cases were younger than 15 years.

Figure C: Newly registered hepatitis C cases, 1992–2013



Source: Latvian Centre for Disease Prevention and Control

Data on transmission were incomplete, but information on acute cases indicates that the most common routes of transmission were injecting drug use (29.2%), nosocomial transmission (22.9%) and (unspecified) sexual transmission (25.0%). Because of incomplete data it is difficult to identify transmission trends. Only 1.6% of the cases reported in 2012 were classified as imported (four acute, 16 chronic).

A recent population-based prevalence survey was undertaken in Latvia. The prevalence of anti-HCV and HCV-RNA was found to be 2.4% and 1.7%, respectively. There has been no recent prevalence survey of HBsAg among the general population in Latvia.

Main conclusions/findings:

- Rates of acute hepatitis B infections in Latvia were the highest among EU/EEA countries in 2012 but the overall trend over time has shown signs of a decline.
- Latvia has the highest overall rate of reported hepatitis C in Europe in 2012 (62.2 cases per 100 000).
- Nosocomial transmissions still account for a significant proportion of acute cases of both hepatitis B and C.
- Recent cases of hepatitis B in young children suggest failures in the antenatal screening programme.
- Routine epidemiological data should be more complete regarding the mode of transmission.

2.3 Bio-behavioural surveillance in Latvia

Latvia does not have a routine behavioural surveillance system. The majority of projects that involve behavioural surveillance studies occur at irregular intervals and are funded by the European Commission or other external sources.

14 studies on HIV prevalence among PWID have been carried out since 1997, showing rising levels of infection. Results of comparable bio-behavioural studies conducted in 2007 and 2012 indicate increases from 23% to 32% in HIV prevalence and from 74% to 82% in HCV prevalence. In the TUBIDU respondent-driven sampling study in 2012, extremely high rates of HIV infection were found among female drug injectors (45%); two-thirds (66%) of drug users aged 24 years or younger were infected with HCV. The above-mentioned cohort study reported prevalence rates of 84% for HCV and 26% for HIV among those tested with a rapid test in 2012 and 2013. Among young injectors (< 24 years), HIV and HCV prevalence were 14% and 65%, respectively, suggesting significant needle sharing and an unmet need for prevention among this population. Available data indicates that needle sharing has increased from 30% in 2007 to 37% in 2012.

In 2011, the EC-funded BORDERNET work project carried out a bio-behavioural surveillance study among 117 outdoor sex workers and reported the following disease prevalences: HIV 22%, HBV 47%, HCV 58%, syphilis 23%, chlamydia 38% and anogenital herpes 63%. Of those tested, most knew that they were infected with HIV, but few knew about the other infections. 83% of the sex workers surveyed were also injecting drugs (current or ever injectors).

The European MSM Internet Survey (EMIS), carried out in 2010, included 708 Latvian MSM. These had a self-reported HIV prevalence of 7.8%, although half of the respondents of the survey had never tested for HIV and fewer than 30% of the men had tested in the last year. Unprotected sex with a partner of discordant or unknown status was high at more than > 35%.

There is very little surveillance of sexual partners of PWID, but one respondent-driven sampling study in the vicinity of Riga in 2007 reached 61 regular sexual partners of PWID who were not drug injectors. Of these, 11.5% had HIV; 30% were infected with HBV and 30% with HCV.

Main conclusions/findings:

- The prevalence of HIV and HCV infection among PWID is high and rising.
- The available data suggest that Latvia has a high prevalence of HIV among sex workers (many of whom inject drugs). HIV prevalence among MSM appears to be moderately high when compared to other EU/EEA countries.
- Latvia has a high prevalence of HCV, both in the general population and key risk groups, e.g. PWID, sex workers and prisoners.
- Latvia largely lacks a system for routine bio-behavioural surveillance among key populations, e.g. sexual partners of PWID, MSM and sex workers.
- The high and increasing prevalence of blood-borne infections among PWID suggests that there is a serious lack of effective prevention services. The evidence suggests that even though services exist, they are either not reaching those in need or are insufficient.
- Without more investment in targeted comprehensive preventive services for marginalised and vulnerable groups, i.e. PWID and especially female PWID, Latvia will see a strong increase in preventable AIDS-related deaths and infantile HIV infections.
- Blood-borne infections associated with injecting drug use represent a health crisis which has spun out of control.

3 Problem drug use in Latvia

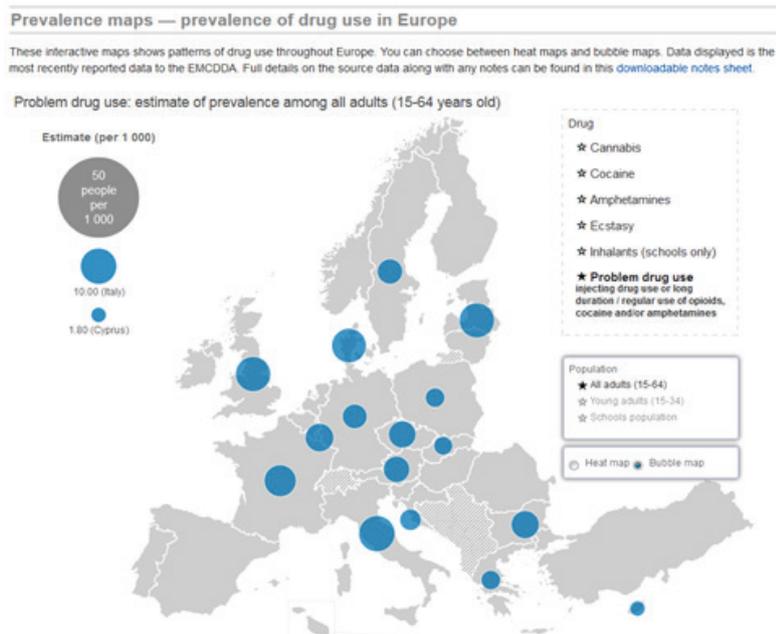
According to latest available estimates referring to the years 2012/2013, there are between 7 983 and 12 699 people who inject drugs in Latvia (central estimate: 10 034). The number of high-risk opioid users is estimated to be 9 298 (6 146–14 476) while the number of high-risk amphetamine/methamphetamine users is estimated to be 5407 (3 900–7 595) (Kaupe and Trapencieris, 2014). Latvia is one of the countries with the highest problem drug use prevalence¹ in the EU (Figure D). While polydrug use patterns are increasing, the majority of people in need of drug treatment in Latvia are injecting heroin or an amphetamine/methamphetamine.

3.1. Profile of problem drug users in Latvia

Since 2006, 1439 problem drug users have been recruited at low-threshold facilities in Riga and other cities into an open cohort study (Kaupe and Trapencieris, 2014). This study aims to assess drug use patterns, risk behaviour, and demographic/socio-medical factors (living situation, employment, sources of income, service needs, level of access to drug-related health services).

More than a third (35%) of the overall cohort are regular users of heroin, and there is an older population of users of a home-made opioid preparation ('hanka'). Survey data show that the use of amphetamines or methamphetamines (street name: 'vitamins') has gained in popularity, with 42% of the cohort reporting regular use. The increase in amphetamine and methamphetamine use over the past years is corroborated by police data on drug seizures.

Figure D: Prevalence of problem drug use in Europe



Source: EMCDDA, available from: <http://www.emcdda.europa.eu/countries/prevalence-maps>

A total of 529 drug users were interviewed in the latest recruitment wave (2013), 70 of whom participated for the first time in the study. Their mean age was 33 years, and around one third are female. Less than one quarter (24%) of study participants are ethnic Latvians, while the majority (68%) are ethnic Russians, and 8% are nationals of neighbouring countries (Lithuania, Belarus) or Roma. This profile corresponds with data on drug users in other information sources, e.g. drug treatment databases. The educational level of respondents was significantly lower than that of the general population. One third of study participants reported living together with other drug users, and one in three drug users were in full-time employment. Injection is the most frequent mode of use in this group, and polydrug use patterns are common, including amphetamines, opiates and benzodiazepines.

¹ For background data on Latvia see also: <http://www.emcdda.europa.eu/countries/data-sheets/latvia>

Main conclusions/findings:

- The prevalence of opioid use and injecting drug use in Latvia is among the highest in Europe.
- A majority of high-risk drug users are non-Latvian born males.
- The educational level amongst problem drug users is low.
- Drug use patterns among high risk drug users include the use of opioids, amphetamines/methamphetamines and benzodiazepines.
- Prevalence of HIV and HCV infection among PWID is high and rising, suggesting that the current response in Latvia is insufficient.

4 Findings of the joint mission

4.1 Harm reduction

Effective prevention services for PWID can have a positive effect on HIV and HCV rates. This includes specialist services which address infectious disease testing and treatment, drug treatment, and other services such as needle and syringe programmes. Given the high rates of HIV and hepatitis among PWID in Latvia, the availability and quality of the respective interventions are crucial, which can only be achieved with adequate and stable funding.

Limited availability of opioid substitution treatment. Opioid substitution treatment (OST) (and harm reduction in general) in Latvia has a coverage which is too low to have an impact on the transmission of infectious diseases among people who inject drugs. The low number of clients enrolled in OST reflects the limited availability and accessibility of these programmes. Current OST programmes have a number of procedural obstacles that may deter a large percentage of the intended target group from accessing treatment. However, as current OST programmes operate at maximum capacity, there is a clear need to expand coverage, preferably by involving NGOs, HPPs, and GPs.

Lack of stability in funding. At present, the municipalities fund substantial portions of NGO activities, particularly harm reduction and outreach work. The involvement of the municipalities is not uniform, with some taking a keen interest (such as Riga municipality) while others take little or no interest, which leads to PWID having to travel to neighbouring municipalities in order to access services.

The central government only funds the centralised procurement of supplies (such as rapid tests for HIV, hepatitis B, hepatitis C, syphilis; syringes; injecting paraphernalia); the government could improve funding stability by partially covering staff costs.

Criminal justice system's access to drug treatment and mental health registries as a deterrent to accessing treatment. Some local experts pointed out that police access to drug treatment and mental health registries was an unnecessary deterrent to users accessing substance abuse treatment programmes. It was also reported that these registries were funded by the Ministry of the Interior, which according to the experts, serves as a justification for breaching data confidentiality.

Shortcomings in coordination and information flow

The mission was informed that there was a lack of objective information about opioid substitution treatment and some irrational fears. Several clinicians were worried about the increasing problem of polydrug use (especially the growing use of amphetamines). To improve this situation, local drug use patterns should be analysed and evidence-based information on drug treatment should be disseminated. All communication measures should be tailored to clearly defined target groups (e.g. clinicians, drug users, general public).

The coordination of the different activities (NGO activities, prevention work) can be improved. A number of stakeholders stated that the HIV Commission should function more effectively and that the central monitoring of the prevention and control activities – as well as the collaboration between the narcology service and the HIV prevention services – was insufficient.

Budget cuts were cited as one of the reasons for the various shortcomings over the last few years, and these cuts hit health promotion and other prevention services particularly hard.

Opioid substitution treatment

Treatment for drug users is offered at various outpatient and inpatient facilities throughout Latvia, and opioid substitution treatment and OST is an essential part of the Latvian drug treatment system. In 2012, outpatient treatment was offered in 42 treatment centres, while inpatient treatment was provided in specialised psychiatric hospitals as well as regional and local general hospitals.

Outpatient services provide mainly psychosocial intervention, cognitive behavioural therapy, motivational interventions and long-term maintenance programmes, while inpatient facilities offer emergency care for overdose cases, detoxification and short-term psychotherapy programmes. Two specialised psychiatric centres provide long-term medical rehabilitation in therapeutic communities.

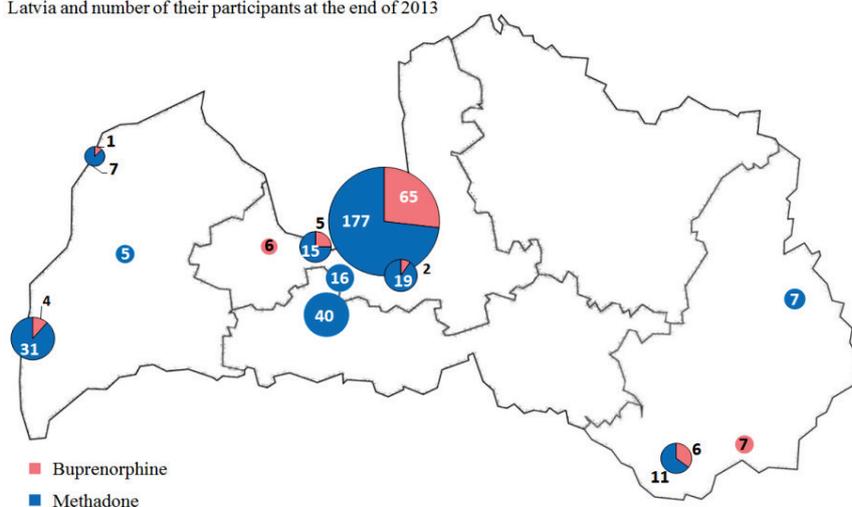
In 2012, a total of 2187 clients entered drug treatment in Latvia, 46% of whom identified opiates (heroin 33%, other opiates 13%) as their primary drug; other primary drugs were amphetamines (20%) and cannabis (14%). A total of 602 drug-related hospitalisations were reported, representing about 5% of all hospitalisations recorded in the Latvian health system in 2012. Average duration was four to five days, which indicates that most hospital patients only underwent detoxification. About 420 drug-dependence treatments (detoxification, Minnesota Programme, motivation programme) were recorded at 11 narcology treatment centres.

The Riga Centre of Psychiatry and Addiction Disorders has been providing methadone maintenance treatment (MMT) since 1996, and, starting in 2005, buprenorphine maintenance treatment has been offered. In 2012, OST was provided at 10 locations, mostly in Riga and surroundings (see figure E below). Ten opioid substitution treatment (OST) offices operated by multidisciplinary rehabilitation teams provide MMT, while buprenorphine programmes are now available from eight providers. Methadone is provided free of charge by the state, while buprenorphine is available at the patient's own cost.

Until 2012, the provision of OST was limited to narcology clinics, but a new regulation under the medical treatment law (Regulation No. 70) extends OST provision to other healthcare institutions, while the treatment itself remains under the regular supervision of narcologists through the medical council. Thus, initiation and implementation of OST has to be supervised by a medical council consisting of three doctors, two of which must be narcologists. These legal amendments also allowed methadone and buprenorphine maintenance treatments to be continued among patients in places of detention.

Figure E: Location of OST programmes in Latvia

Location of methadone and buprenorphine programs in Latvia and number of their participants at the end of 2013



Source: 2013 National Report (2012 data) to the EMCDDA by the Reitox National Focal Point. Latvia: new developments, trends and in-depth information on selected issues.

Data submitted to EMCDDA by the Latvian REITOX National Focal Point (data from the registry of opioid substitution treatment (OST) clients kept by the Riga Centre of Psychiatry and Addiction Disorders) indicate that the number of high-risk opioid users (HROU) receiving OST over the last 10 years has increased from 54 in 2004 to 424 in 2013, representing a ninefold increase over this time period. This significant increase is the result of a change in political and professional attitudes towards the use of OST for HROUs, which led to additional specialist centres providing OST, an amendment of laws allowing greater flexibility in prescribing treatments, and the introduction of buprenorphine OST.

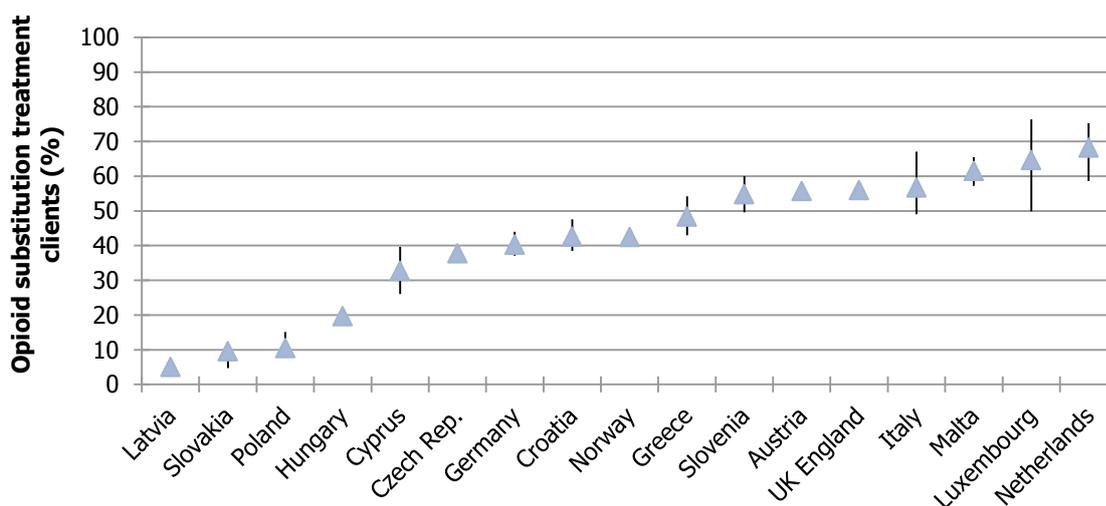
Despite this positive development, the proportion of HROUs who benefit from this treatment is still very low. In 2013, the treatment coverage ranged between 3% and 88% (median: 5%) of the target population, which is also the lowest coverage currently documented in the European Union. Additionally, data of the overall treatment coverage for HROUs (OST and drug-free treatments) show that about 31.3% of the estimated number of HROUs in Latvia received at least one kind of treatment in 2013 (figure does include counselling provided by the NGO DIA+LOGS).

The 2011–2017 Drug Action Plan for Latvia calls for a total of 600 HROUs on OST by 2017. According to Latvian sources, this target was based on a pragmatic assessment of available funding and capacity of specialist treatment centres at the time of drafting of the Action Plan. This assessment took place in the midst of the financial crisis in Latvia (2009–2010). Three more OST treatment centres would have to be opened to achieve this target (total: 11 centres by 2017), but even then coverage would only be between 4% and 10% (mid-estimate: 6%) of the target population – well below the coverage needed to have a tangible impact.

Main findings

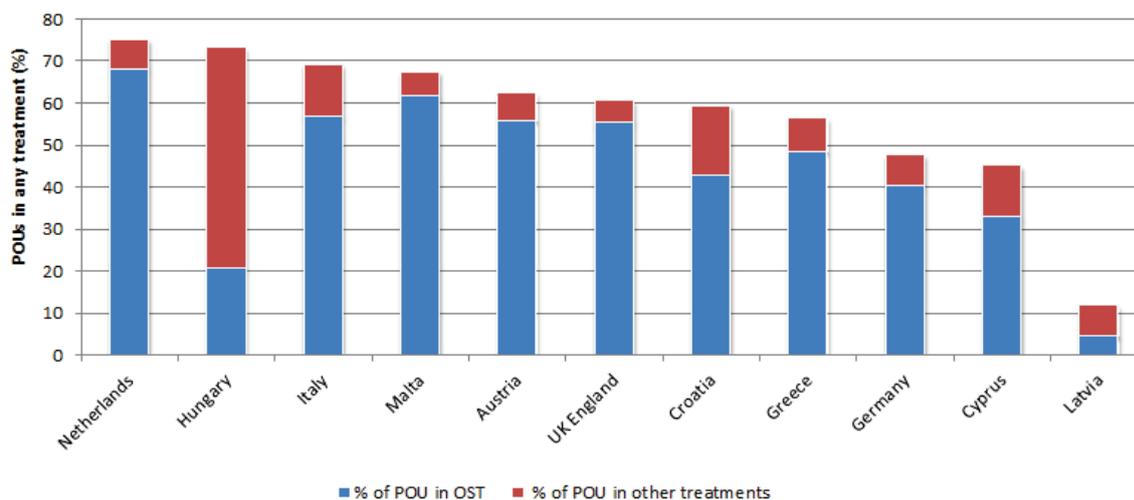
- Cabinet Regulation No. 70², which extends OST provision to other healthcare institutions, is seen as a very positive development. Despite the new law, OST provision is still hardly taken up by institutions other than those operated by narcologists.
- With an OST treatment coverage of 5% of the target population, Latvia has the lowest coverage of any EU country. Additionally, the overall treatment coverage (OST and drug-free treatment) for HROUs indicates that a very large proportion of this population is out of treatment (> 80%).
- The current Latvian Drug Action plan calls for 600 HROUs on OST by 2017, which would only achieve a coverage of 6% of the target population.

Figure F: Opioid substitution treatment clients as a percentage of the estimated number of high-risk opioid users (HROUs) in the EU



Note. 2013 data for Latvia, 2012 data (or most recent year available) for other EU countries

Figure G: Overall estimated number of high-risk opioid users in treatment (in opioid substitution treatment and other treatment plans) as a percentage of the estimated number of high-risk opioid users



Source: EMDDDA.

2013 data for Latvia, 2012 data (or most recent year available) for other EU countries

² Cabinet Regulation No. 70 'Procedure for the treatment of patients addicted to alcohol, drugs, psychotropic, or toxic substances, gambling or computer games' of 24 January 2012.

OST in clinic based facilities

During the visit at the Riga Centre of Psychiatry and Addiction Disorders, discussions with senior staff members raised several points:

- With 180 patients in Riga and an additional 30 patients at another centre, the Centre is the largest OST provider in Latvia. It also provides OST to 13 prison inmates who were on OST before being incarcerated. The Centre is currently operating at maximum capacity.
- OST patients receive multidisciplinary support as part of standard treatment. The medical team is composed of narcologists, nurses, psychologists and social workers. Infectiologists are not part of the team.
- Methadone treatment is free of charge for all clients. Clients need to cover their own transportation costs to reach the clinic. Buprenorphine, however, is not free of charge for the patient, and only Subutex and Suboxone (combined formulation of buprenorphine HCl and naloxone HCl) are available. Generic formulations of buprenorphine-based substitution medications for the treatment of opioid dependence are not available in Latvia.
- The cost of the methadone treatment is covered by the government, at an 80mg average dose per patient. Costs can be averaged out between two or more patients, e.g. 100mg for one patient and 60mg for another one are acceptable.
- Initiation of OST requires a mandatory medical health check (blood test, X ray, etc.) and a clinical decision taken by a panel of at least two narcologists. OST will only start after the medical results are available to the Centre. The patient is responsible for the medical checks, which are conducted outside the Centre. The proportion of individuals who fail to complete the medical exams and yet return to the centre to start OST was unknown.
- In theory, detection of substance use through urine screening while on OST will refer the patient to a medical council composed of narcologists who will determine the cause of action, possibly leading to a discharge of the patient. In reality, it appears that discharge is generally only administrative as the patient may re-enter the treatment programme the following day.
- Referral pathways between the OST centre and infectologists were reported to be one way: the narcologists generally refer OST patients to infectologists, but not the other way around. It was unclear whether infectologists reject OST for HROUs on principal, or whether they do so because of their attitude towards HROUs, but the fact is that infectologists do not refer HROUs to OST centres.
- Narcologists acknowledge the need to expand OST, especially through alternative routes, e.g. through NGOs or general practitioners. They also stressed their willingness to cooperate with different stakeholders such as NGOs or GPs to support the provision of OST at other sites. The shared care model was mentioned, where narcologists can support prescribing GPs. It was also mentioned that adding OST to the quality-of-care standards for GPs could serve as an incentive for GPs to offer OST. The HPP in Olaine, which is staffed by a trained nurse, with once-a-week visits from a narcologist who can prescribe OST, could serve as a model for other HPPs, both governmental and NGO-run.

Further discussions with NGOs (e.g. DIA+LOGS, WOMEN-SW) and the HPP of SPKC further underlined the urgent need to increase the availability of, and access to, OST. Drug treatment centres are very willing to cooperate with specialists, although additional resources and political support are needed for this cooperation. Finally, there are strong indications that PWID are highly interested in accessing OST if it is less restrictive and more accessible.

Main conclusions/findings:

- There was agreement by addiction specialists that OST needed to be expanded, possibly by involving NGOs and HPPs. However, political and financial support was reported as crucial to make this a reality across Latvia.
- A number of structural and procedural barriers to access OST were identified (e.g. travel costs for patients from rural areas; repeated urine screenings to assure drug-free status; high cost of brand-name buprenorphine [> 190 euros/month]; health checks prior to start of treatment, etc.). However, it should be stressed that despite their limited availability and accessibility, current programmes are of good quality.
- Limiting the amount of government-reimbursable OST to an average dose of 80mg methadone per patient was considered counter-productive because this could result in underprescribing.
- A number of health professionals (e.g. infectiologists), parts of the general public, and some policymakers appear to be prejudiced against OST and would like to limit its use.

Needle and syringe programmes

Since the establishment of the first low-threshold health facility for HIV prevention in 1997, the network of HIV prevention points (HPPs) has been expanded to 18 sites in 16 cities across Latvia. Mobile units operate from three sites, and outreach workers are linked to eight of these sites. Target groups include drug users and other groups at risk: former prison inmates; homeless people; sex workers and their clients; ethnic minorities; MSM; and immigrants.

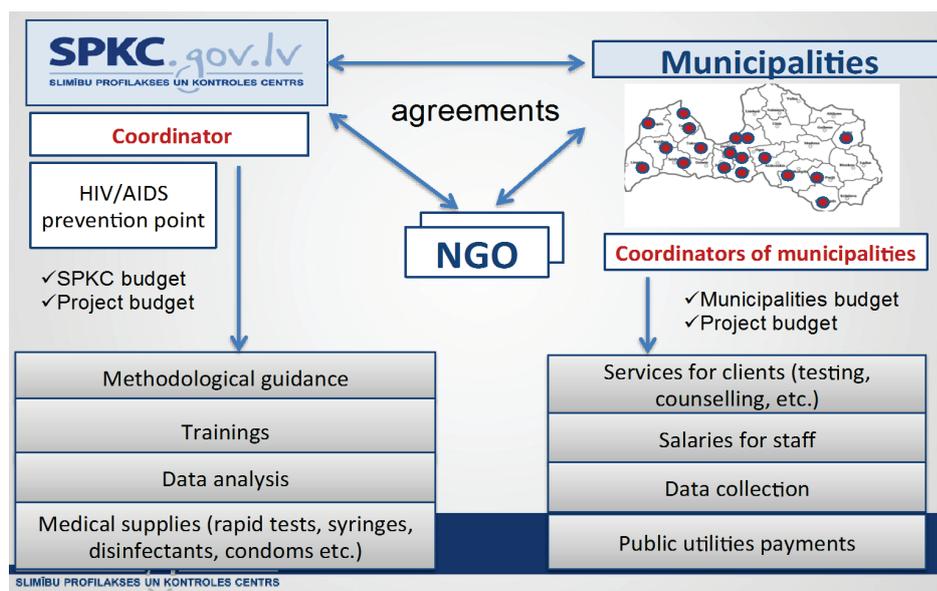
The legal status and financing model of HPPs is complex and not uniform across all facilities (Figure H). In one HPP the mission team visited, an outreach worker was funded through a local politician's fundraising activities. Municipalities often provide the HPP premises, pay utility bills, and pay the salaries of the staff. They are also responsible for data collection, while SPKC is in charge of the procurement of medical supplies, methodological guidance, training, and data analysis. Medical supplies include: rapid tests, syringes, needles, disinfectants (for hands, surfaces, wounds), condoms, lancets, gauze pads, roll bandages, rubber gloves, iodine swabs, plasters and cotton wool³.

The services most commonly offered by HPPs include the provision of sterile injecting equipment, the distribution of condoms, as well as counselling by medical workers, social workers or psychologists. Rapid tests for HIV, HBV, HCV and syphilis are available at 15 sites and OST is provided at two of the 18 HPPs.

In most cases, HPPs are managed by their respective municipality. However, some HPPs, including Latvia's largest, are run by NGOs, negotiate their annual budget directly with SPKC and the municipalities.

State funding for the largest service provider (the NGO DIA+LOGS) was EUR 80 000 Euros in 2013; subsidies for other HPPs (information was only available for seven HPPs) ranged between EUR 14 000 and EUR 28 000 (four HPPs). Three HPPs received less than EUR 14 000. In 2013, EUR 36 208 for medical supplies at HPPs came out of the state budget, including EUR 16 430 for rapid tests.

Figure H: Legal status and financing of HPPs



Source: SPKC, Ilze Straume, presentation on 'Harm reduction services, HIV and hepatitis testing policies and practices', Riga, 2 September 2014

SPKC maintains a database on service provision and case monitoring, which was originally created under a UNODC project, which facilitated the establishment of several HPPs between 2006 and 2010⁴. It includes demographic information on clients (age, gender, nationality, educational level), behavioural data (drug injecting, sex work,

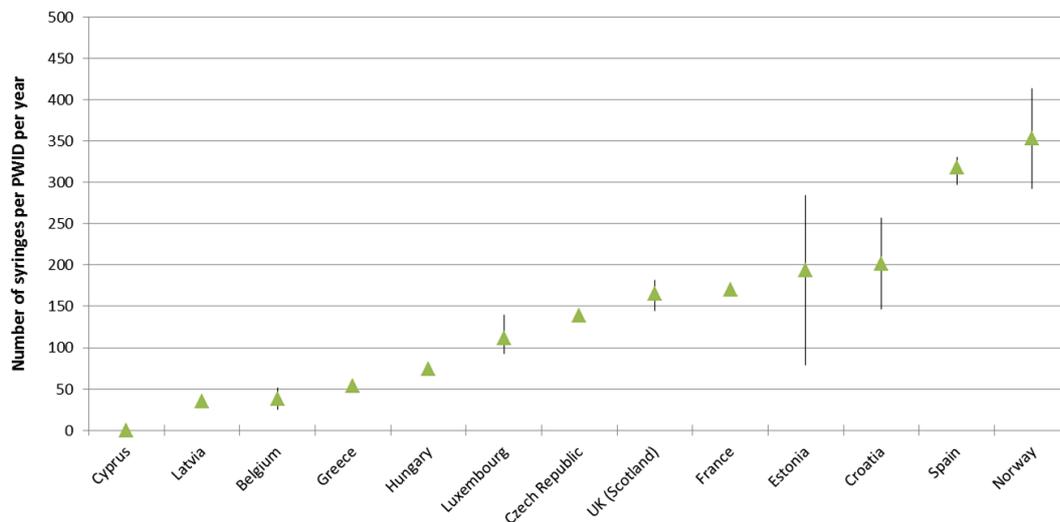
³ Drug-related infections such as hepatitis C have been linked not only to sharing syringes but also to the use of other shared injecting supplies. Provision of all injecting paraphernalia such as clean water, sterile cookers, alcohol swabs and dry wipes is recommended to reduce transmission and can also act as a motivating factor that encourages PWID to use services.

⁴ The UNODC project 'HIV/AIDS prevention and care among injecting drug users and in prison settings in Estonia, Latvia and Lithuania' was carried out from 2006 to 2010 and supported by a five million USD grant from the Netherlands. For more information see: <https://www.unodc.org/balticstates/en/about/index.html>.

prison terms, pregnancies, HIV status); data on drug use patterns and on the use of services (infectious diseases testing, syringes and condoms received, motivation, rehabilitation, and other treatment options).

HPPs offer syringes in sizes from 1ml–20ml. Paraphernalia distribution includes alcohol pads, but not water or drug preparation containers. At the largest facility, most syringes are distributed through outreach work and through secondary exchange. Between 2010 and 2013, the number of syringes given out by HPP staff varied between 310 000 and 340 000. In 2013, this amounted to 27–44 syringes per estimated drug injector (Figure J), which is below recommended levels⁵ (≥ 100 and ideally > 200 /PWID/year). Considering the long history of HPPs in Latvia, this is either a consequence of insufficient funding or due to a mismatch between services and target populations, with a high probability that the lack of funds is responsible for this situation.

Figure J: Syringes distributed through specialised programmes in 13 European countries, 2012 or most recent year*



Source: EMCDDA

* Data for Latvia refer to the year 2013

Main conclusions/findings:

- The network of HPPs includes NGOs and public institutions, is coordinated by SPKC, and funded mainly by the municipalities.
- The network has been geographically expanded but syringe provision points do not cover all of Latvia.
- A service provision database has been established.
- The distribution of free syringes and other injecting paraphernalia is far from meeting the estimated needs.
- At the current operational level, HPPs are unlikely to prevent transmission of infections among PWID.
- The lack of commitment – and the resulting low level of funding on part of the municipalities and the state – makes it impossible for HPPs to achieve a level of service which reduces infections in PWID.
- The existing services are overly dependent on philanthropic or international projects.

Low threshold outreach and other community-based services

HPP in Olaine

The HPP in Olaine, a city of about 12 700 inhabitants 20 km southwest of Riga, is one of several low-threshold facilities for injecting drug users established under the UNODC project⁶. Together with the HPP in Liepaja, it

⁵ See benchmarks defined in regional risk assessments on HIV among PWID as cited in:

Pharris A1, Wiessing L, Sfetcu O, Hedrich D, Botescu A, Fotiou A, et al. Human immunodeficiency virus in injecting drug users in Europe following a reported increase of cases in Greece and Romania, 2011. *Euro Surveill.* 2011 Dec 1;16(48).

Hedrich D, Kalamara E, Sfetcu O, Pharris A, Noor A, Wiessing L, et al. Human immunodeficiency virus among people who inject drugs: is risk increasing in Europe? *Euro Surveill.* 2013 Nov 28;18(48):20648.

⁶ https://www.unodc.org/balticstates/en/grants/latvia/2008/olaine_proj.html and https://www.unodc.org/balticstates/en/grants/latvia/2010/Olaine_proj.html

belongs to the two HPPs in the country that offer methadone maintenance treatment. It is open on weekdays from 9.00–17.00. Opening hours are divided into syringe distribution, consultations and rapid testing in the morning, and methadone dispensing hours in the afternoon (12.00–16.30), followed again by syringe provision (16.30–17.00). The staff consists of a social worker and a part-time nurse who works in the afternoon. Peers are reported to be involved in outreach syringe provision. A local psychologist is available on demand, and every Monday during methadone dispensing hours, a narcologist provides consultations. Referrals to local GPs are made if necessary.

In 2013, the HPP had a total of 54 clients and 20 to 30 clients visit every day. According to SPKC statistics, a total of 455 social and 164 medical consultations have taken place. Twenty slots for OST clients are available at Olaine, and 18 clients are currently enrolled in the programme. In 2013, a total of 3063 syringes were given out, and 2633 syringes were returned.

The Olaine HPP runs an OST programme that was set up by a Riga-based narcologist in order to provide better access to the treatment of clients outside the capital. He negotiated a collaboration project with the municipality's social services and set up a small business to employ a nurse. Medications and weekly medical consultations are funded by the state, while the salary of the social worker, rental costs and utilities come out of the social security budget. All OST treatments begin with a five-day stay at Riga Narcological Center Hospital, under the supervision of at least two doctors who have specialised in narcology.

HPP staff identified the following problems: the negative public sentiment towards drug users makes it difficult for many PWID to seek help; services for clients with small children are lacking; referral mechanisms for clients who tested positive for HIV or HCV in a rapid test and have to go for confirmation testing to Riga should be improved; difficulties to convey the importance of condom use.

Main conclusions/findings

- The Olaine HPP provides an interesting model for the decentralised implementation of OST.
- Referral of clients to confirmatory testing should be facilitated.
- Childcare services for mothers who inject drugs are lacking.

HPP in Bauska

The HIV prevention point in the Bauska municipality (population approximately 27 000) features two small rooms and is staffed by a nurse (who also coordinates the HPP), a social worker (the only one in the municipality who deals with substance abuse issues) and an outreach worker (a former drug user and ex-convict). This HPP is open weekdays, and the outreach worker distributes needles and syringes to drug users on the streets in the afternoons.

The centre has about 300 regular clients, with 23 new clients last year. Most of their clients are drug users but the centre also distributes free condoms to young people. HPP staff estimate that there are approximately 700 to 800 PWID in the municipality who would like to access services but are afraid to do so because they think they would be reported to the authorities, which would result in a series of difficulties, e.g. losing their driver's licence.

Most clients are unemployed and are between 20 and 50 years of age. The HPP estimates that about 50% of their clients are Roma, although most of these were born in Latvia and speak Russian. HPP staff estimate that about a third of youth in Bauska use drugs (mostly smoking rather than injecting) and attribute this to Bauska's proximity to a major highway which connects the nearby Lithuanian border to Riga and Tallinn.

It is possible to buy syringes in pharmacies in Bauska.

In 2013, the HPP distributed approximately 10 000 syringes, collected 6 000 used syringes, and performed approximately 20 to 30 tests a month for each of the following diseases: HIV, HBV, HCV and syphilis. About 30 clients of the centre are infected with HIV.

The HPP receives supplies from the central government, but the facilities and staff salaries have to be funded by the municipality. The outreach worker's salary is supported by a grant set up by a member of parliament. Although the central government does not require the recording of names of syringe recipients, the municipality insists that syringes cannot be distributed anonymously and records are kept (name, date of birth) in order to ensure that only residents benefit from the programme. Despite these restrictions, which deter many potential clients, the HPP often serves PWID from outside the Bauska community and still tries to protect the privacy of its clients.

Staff reported that drug users will be arrested if they carry syringes *and* heroin, regardless of the amount of heroin found. Police tolerate the delivery of needles and syringes to PWID on the streets. The coordinator has contacted the local police and feels that their approach is a bit more lenient now.

Bauska does not have a narcologist and methadone is not available. The staff agree that OST should be offered in Bauska, but there are insufficient organisational and financial resources.

Collaboration between the HPP and the Bauska polyclinic and the local tuberculosis clinic is good. There is, however, no hospital in the area that can care for persons living with HIV or hepatitis. In some instances, the municipality provides free transportation to Riga for these patients.

Main conclusions/findings

- The Bauska HPP provides a good example of how to successfully implement low-threshold services.
- Clients have to travel to Riga to have access to OST.
- Funding is fragile and probably not sustainable.

HPP in Riga

This HPP is located in central Riga, staffed by only one nurse, and open on weekday afternoons. In 2013, 330 clients received support. Since its opening in early 2012, a total of 2 396 consultations were given for 1193 clients.

Like the other HPPs, this site offers disease prevention and counselling; rapid tests for HIV, HBV, HCV and syphilis; and needle/syringe provision and exchange. The main risk groups served are PWID (52% of visits in 2013), ex-convicts, sex workers, MSM, pregnant women with unknown HIV status, and adolescents at risk.

The site has seen an increase in the number of visits in 2014, with 394 visits during the first eight months of 2014, compared with 256 during the same period in 2013. There was a similar increase in the number of tests carried out (884 in 2014, 625 in 2013), which was attributed to increased awareness of the HPP's existence and an overall higher demand. The demand for syringes in the first six months of 2014 was the same as the combined total for 2013). There are no limits on the number of syringes per client, and stock was sufficient to cover the demand.

In 2013, eight persons tested positive for HIV (three MSM, four PWID and one child). A total of 226 HBV tests were conducted (one positive); 247 HCV tests identified 50 positive persons. The Riga HPP has developed a manual on HIV testing, health promotion and counselling and serves as a training centre for health tests. Rapid tests can only be given by operators who received standardised training.

After a positive rapid test, free confirmatory testing is carried out at the national reference laboratory, following a referral from a general practitioner. The HPP has no information on compliance with these testing requirements and the number of confirmed positive tests.

The municipality of Riga is still very committed to continued funding of NGOs and supports their work on harm reduction. Riga also supports the treatment of tuberculosis: the municipality covers transport costs, ensures that patients receive their medicines, and attend their clinic consultations in person.

Riga municipality has also set aside some funds for small prevention projects (up to EUR 1500).

Officials from the municipality of Riga said supplies are usually not the problem but distributing sterile injecting equipment to the right people was difficult. Some NGOs support a daily hotline for counselling and educational information, but there is a clear need for additional funding to help increase their social media and web presence.

Main conclusions/findings

- The Riga HPP is good example of a low-threshold service provider which is under pressure because of a rapidly increasing demand for its services while its budget is not growing nearly as fast.
- The HPP does not receive feedback on the numbers and results of confirmatory tests taken after referral to GPs/the national reference laboratory.

Sex worker drop-in facility, Riga

This facility is a collaborative project between an NGO and the Lutheran church, with the aim to prevent infections among sex workers. *Papardes zieds*, a local NGO, resides in a church-owned building ('Freedom 61'), located in a part of Riga known for street prostitution. The centre is used as a drop-in facility for sex workers, where staff provide general support services and offer rapid testing. Most of the women selling sex also use drugs, predominately amphetamines. It is estimated that the project is in contact with approximately 250 street-based sex workers. Staff members at the centre acknowledge difficulties in reaching hotel-based sex workers. Because of its affiliation with the Lutheran church, it does not provide condoms to the sex workers. SPKC dermatovenerologist provide consultations, rapid testing and referrals. While inpatient treatment of STIs is free, outpatient treatment is not, and one of the main roles of the STI doctor is to motivate the sex workers to check into a hospital. The church offers housing, employment and reintegration to those who want to quit sex work.

A previous project (WEDworks, an EU project coordinated by SPI in Berlin, Germany) collaborated with *Papardes zieds*. Between March and July 2014, the project mapped places where sex workers would meet and attend for harm reduction services or healthcare. The project trained doctors, social workers, social services staff and others to initiate case management services for female sex workers. The project also provided rapid testing for HIV, hepatitis B and C, and syphilis. During this pilot project, 109 women were reached, with a total of 158 first-time visits to social workers, outreach workers, venerologists and other medical doctors. No HIV-cases were found among the women tested in this project.

Main conclusions/findings

- Sex workers are a group that is extremely vulnerable to HIV and other infections. There is a large overlap between street-based sex work and drug use in Latvia.
- Outpatient treatment of STIs is not free, which acts as a barrier.
- Services for sex workers are not comprehensive, and service gaps need to be closed.

DIA+LOGS outreach team and drop-in facility, Riga

The DIA+LOGS centre in Riga is open on weekdays and provides syringe exchange, condoms, wound treatment and other medical services, and psychological counselling. A mobile outreach unit with two to three outreach workers operates between 16.30 and 21.00. The NGO is also involved in research (cohort study) and in training at the national level.

A 2012 study on 13 Latvian HPPs (Kaupe and Trapencieris, 2014) shows that DIA+LOGS reached 30% of all clients, while the SPKC-run HPP in Riga reached 28% of total number of clients in the study. DIA+LOGS provided about 50% of all 340 000 syringes distributed by HPPs in Latvia, which indicates large-scale peer distribution. Peer distribution is effective but offers little opportunity for health education, safer injecting training, and personal contacts.

The main concern among staff was the increase in the number of high-risk drug users in Riga. Response efforts were hampered by decreasing funding and the limited scope of response measures. Riga municipality has been cutting subsidies since 2009, and state funding mechanisms were perceived as too complex. International funding stopped years ago. The current funding model – yearly applications to different entities – was seen as jeopardising the sustainability of the NGO's work. Demands on data collection were perceived as high (especially for outreach work) while the level of data use seemed low.

Staff also underlined that overdose risk and mortality among their clients was high and that overdose prevention programmes (including naloxone distribution) were needed. The most urgent need was to scale up access to drug treatment and to explore new models of collaboration between NGOs and narcologists that allow the implementation of OST programmes at HPPs.

The DIA+LOGS staff argued for a renewed focus on educating drug users on safer injecting practices to reduce new infections, especially among young users. Staff needs to be more knowledgeable about drug paraphernalia: Latvian drug users easily switch between different drugs, which implies that the central procurement process at SPKC needs to have better information and be more flexible so that HPPs can distribute the right paraphernalia. Service staff and drug users should also be better trained to identify risks involved in drug preparation and injecting.

The outreach team needs a new car because the old one is no longer up to the task.

Further prevention materials tailored to Russian drug users need to be developed.

Main conclusions/findings:

- The level of service provision is not sufficient to have an impact on infection rates.
- Harm reduction is only available in a few areas and should be gradually extended.
- The stigmatisation of drug use in Latvia results in high levels of hidden drug use.
- Drug users and society are largely unaware of drug treatment.
- There is a lack of target-group-specific treatment facilities for female and young drug users.
- The required annual renewal of NGO project funding puts sustainability at risk.

MSM outreach services – the MSM Checkpoint

The MSM Checkpoint opened in March 2014. It is the first and only MSM-specific prevention project in Latvia. The aim of the project is to promote the social inclusion of MSM by promoting access to appropriate healthcare services. Time-limited financing is provided by an EEA grant (EEA grants programme 'NGO fund') and a grant from the Soros Foundation. The MSM Checkpoint currently receives no financial support from the Latvian government.

The Checkpoint provides condoms and offers HIV and syphilis rapid testing for gay men and their partners on two evenings per week (2.5 hours each time). So far, 46 persons have been tested for HIV and syphilis, and none have tested positive.

The project also tries to find medical doctors (infectologists and GPs) who are gay-friendly. So far, 11 gay-friendly doctors have been identified and trained. The Checkpoint is planning to refer clients to these doctors for follow-up services. Every Friday, the Checkpoint carries out outreach activities at the main gay club in Riga, where information and condoms are distributed.

Main conclusions/findings

- HIV among MSM is likely underreported in Latvia or the data on mode of transmission is left 'unknown' because of fear of stigmatisation. Risk behaviour among Latvian MSM was identified as high in the 2010 EMIS survey and access to testing was low.
- Testing for HIV among MSM appears to be insufficient.
- Efforts to reduce the stigmatisation of MSM in Latvia also support the prevention and control of infectious diseases.

4.2 Testing

HIV testing at HPPs is insufficient given the size of the more-at-risk populations. Groups with a relatively low risk (e.g. sailors,) seem to be overrepresented, and efforts should be made to prioritise testing for more high-risk populations.

Many Latvian citizens do not know where to go for testing: private health services charge for testing, while other service points offer free test. This uncertainty of whether the test is covered by the patients' insurance could be responsible for the low uptake of HIV and hepatitis C testing.

The current care pathway may deter those who are most at risk: without a referral from a GP, the total cost of the test (pre-test visit, the test itself, and the post-test visit) typically amounts to EUR 48. Latvia should consider possible exceptions to this rigid referral system with regard to infections of high public health impact such as HIV or hepatitis B and C. Fast, cheap and unbureaucratic access to testing is essential when trying to reach high-risk populations.

The low uptake of testing among MSM, and the low availability of user-friendly and low-threshold services for MSM is one area that is a cause for concern.

The Latvian SPKC coordinates all HIV and hepatitis prevention work through its Health Promotion Unit, including the promotion of testing facilities. Only two staff members at the Health Promotion Unit work full-time on HIV. The actual testing is carried out by 15 of the 18 HPPs in Latvia, which offer rapid tests for HIV, HBV, HCV, and syphilis.

Main conclusions/findings

- Offering tests for HIV, HBV and HCV provides an opportunity for other preventive interventions such as counselling and referring people who tested positive to medical care.
- The HPP network is an asset for reaching those most at risk but it needs to expand its capacity for free tests (expanded community-based and outreach testing) and preventative actions.
- The central procurement of sterile injecting equipment and rapid tests is well-organised and cost-effective.
- HPPs conduct an impressive amount of work despite limited budgets.

4.3 Vertical transmission

Antenatal care is provided by a multi-disciplinary team including a gynaecologist, a midwife and a GP. Communication between the different services involved in antenatal and post-natal care is considered to be good. About 1% of pregnant women remain without any antenatal care. Despite this good uptake of services, the overall maternal mortality rate is among the highest in Europe, which led to the introduction of a confidential enquiry into maternal deaths. In 2013, one maternal death was attributed to HIV and related to the lack or rejection of appropriate antenatal care.

HIV – mother-to-child transmission

According to WHO, the prevention of vertical transmission should include HIV testing and counselling, ART, safe delivery, safer infant feeding, postpartum interventions in the context of ongoing ART, early infant diagnosis, and final diagnosis for HIV-exposed infants through linkage of mother and child to care and treatment.

Latvian guidelines on antenatal screening for HIV were produced in 2009, with a planned update in 2014. Antenatal screening for HIV is carried out free of charge for all pregnant women during the first trimester. However, HIV tests are not free if they are requested during the second and third trimesters. Rapid HIV tests are also available in maternity wards. Data indicate that 1.1% of all pregnancies receive no antenatal care, and 97.8% of all pregnancies receive an HIV test at some point.

Between 1999 and 2013, 59 cases of vertical transmission of HIV were recorded, with the trend increasing over time. In 2013, 68.1% of the HIV-infected mothers delivered in Riga. Most HIV-infected mothers gave birth by caesarean section (80%). This rate has steadily increased over the last years (2013: 74.5% in Riga, 86.4% in the regions).

Between 2011 and 2012, 43 cases of HIV infection in pregnant women were registered. In 32 cases the transmission route was heterosexual, in seven cases it was through IDU, and in four cases the transmission route

was unknown. 2011 and 2012, it was estimated that 10% of the HIV-infected pregnant women in Latvia did not receive antenatal care, and 44% received insufficient antenatal care. There are some regions in Latvia (which already have a high HIV incidence) where the number of women with no antenatal care is up to three times higher than the Latvian average. These women frequently come from marginalised groups such as injecting drug users and ethnic minorities.

The most common transmission route of HIV among pregnant women in Latvia was intravenous drug abuse (73% of cases). Data presented to the mission show that some HIV-infected pregnant women are also infected with HCV (54%) and syphilis (28%).

There are several possible reasons for the continued high level of vertical transmission of HIV, e.g. low adherence to treatment for those who present to antenatal care, and late or non-attendance of antenatal care (especially sex workers and PWID). Some women refuse treatment because they do not believe in the usefulness of ARV or claim they feel healthy. Others refuse medication because their husbands told them it is supposedly bad for the baby; still others said it was against their religious beliefs.

Many HIV-positive pregnant women say that it is very difficult to receive antenatal care because many GPs or gynaecologists, especially those outside Riga, immediately refer them to the Infectology Centre in Riga – despite national guidelines on how to manage HIV-positive pregnant women.

ARV drugs for the prevention of mother-to-child transmission are usually only stocked at the Riga hospital. For the other hospitals to access these drugs, they would first need to organise a medical consultation and then collect the drugs from the Riga hospital.

Main conclusions/findings

- Vertical transmission of HIV is on the increase.
- The proportion of HIV-infected women who receive insufficient or no antenatal care is unacceptably high.
- Many women diagnosed with HIV during pregnancy also have a history of drug use.
- Targeted services – and better coordination of these services – for HIV-positive pregnant women (many also drug users) could reduce the vertical transmission of HIV.
- Antenatal care in Riga is better than outside the capital.

Hepatitis B – mother-to-child transmission

Pregnant women are routinely screened for HBV. According to a ECDC survey (2011 data, unpublished), 81% of pregnant women in Latvia were screened for HBV, and 34 women were diagnosed with HBV during pregnancy.

Babies who are born to mothers with HBV infection are vaccinated against hepatitis B, and coverage is good. Immunoglobulin is available and recommended in specific cases but is currently not a reimbursable drug.

Women who test positive for HBV through antenatal screening are referred to the Riga Infectology Centre. Unfortunately, some of the women do not attend their referral appointments, and it is understood that many of these non-attenders are PWID or live outside Riga.

The infectious disease team at the Riga Infectology Centre oversee the care of women infected with HBV but there is no overall coordinator. Data are passed on to the various services (e.g. from the infectology services to the obstetrics team), but not always efficiently.

Main conclusions/findings:

- There is an established HBV screening programme for pregnant women.
- Antenatal care in Riga is better than outside the capital.
- Immunoglobulin for babies born to HBV-infected mothers is not reimbursable, even if medically advised.

4.4 Treatment of HIV

Many PLHIV feel stigmatised when they visit an HIV clinic. Stigmatisation, lack of family support, and fear of disclosure of HIV status are among the most frequently mentioned barriers to accessing early care.

The mission team was informed that 5 867 PLHIV (642 died of AIDS) have been reported since records began in 1987; at current, 957 PLHIV are on ARV. Most international recommendations now propose that ARV is initiated when CD4 counts drop below 500 cells/mm³ as this is associated with a better long-term outcome and significant public health advantages, i.e. reducing the further transmission of the virus. It is likely that in the near future this recommendation will move in the direction of encouraging countries to consider introducing test and treat (irrespective of the CD4 count) policies and also to include providing treatment as prevention for those at high risk of infection (i.e. treatment given to uninfected individuals to prevent future infections) as there is growing evidence that these will have a positive long term impact on reducing the onward transmission of infection.

Broadening the guidelines for ARV treatment (e.g. by lowering the CD4 threshold or introducing preventive treatment for risk groups) would not necessarily cause large overall cost increases because many of the eligible PLHIV would refuse treatment as they feel healthy. Awareness of the benefits of ARV is low, which leads to poor adherence to ARV. In addition, many PLHIV seek alternative therapies. Some PLHIV are deeply suspicious of the doctors who are trying to help them because they believe that treatment is controlled by the interests of 'big pharma'. These attitudes may harm the success of the whole treatment programme. It is therefore important that eligible PLHIV are offered adequate psychosocial support in order to discuss these matters.

Apparently some physicians look down on those who treat PLHIV (stigmatised) and measures to improve the status of HIV doctors and nurses were discussed.

ARV is available in five regions outside Riga, but viral loads and CD4 counts can only be analysed in Riga (samples must be sent to the central laboratory), which makes outpatient care more difficult. Apart from this, infectologists are not evenly distributed around the country so treatment coverage is patchy – resulting in many PLHIV being asked to travel to Riga for treatment.

The morale at the Riga Infectology Centre was found to be rather low. Staff members cited a chronic lack of resources and personnel, and difficulties in maintaining the previous high standards of care since the hospital merger. This negatively affects monitoring the effectiveness of treatment.

An NGO or specialised service with a focus on HIV care for women and children is missing in Latvia. Many women are afraid of revealing their HIV status and avoid attending outpatient hospitals.

Children may require age-appropriate formulations. These formulations and presentations should allow both safe and accurate dose administration. If children with HIV are not given their medications at home, they may have to be sent to foster homes until their treatment shows positive results.

The team did not have the opportunity to look into the treatment of co-infections and co-morbidities.

Main conclusions/findings

- Not enough PLHIV are on treatment, which is likely due to the current restrictive clinical protocols as well as incorrect knowledge about the benefits of treatment.
- Treatment is mainly provided in Riga because of the lack of laboratory support and trained clinicians outside the capital.
- There are many areas for improving resources for treatment, including that of children with HIV.

4.5 Healthcare of hepatitis B and C

Data from state-funded hospitals in 2012 indicate a high (and increasing) number of hospital patients with hepatitis C. For primary care, data indicate a slight decrease in trends for hepatitis C over the last three years.

The mission team visited the Riga Infectology Centre. According to staff members, Latvia has 10 hepatologists who treat people diagnosed with hepatitis B and C. Gastroenterologists and infectious disease consultants do not become involved with this care.

Treatment costs are fully reimbursed for HIV, while people treated for hepatitis B and C treatment only receive 75% reimbursement. The reasons for the recent decline in the amount of financing for HCV reimbursements are not known but may be related to a random reduction in the number of so-called needy persons.

It is clear that people who cannot afford the 25% copayment/deductible for treatment do not even get tested or approach care services – which results in a larger pool of viruses circulating in the population.

Lamivudine is the only drug that is reimbursable in the antiviral therapy for hepatitis C. Other drugs can be prescribed but need to be paid out-of-pocket. For hepatitis C, ribavirin and pegylated interferon are on the list of reimbursable drugs. With the patient having to cover 25% of the costs, this amounts to EUR 210–300 for each month of treatment. The Centre currently treats between 600 and 700 patients a year for hepatitis C. In total, 7 074 patients have received antiviral treatment in Latvia so far, and most of these patients pay out of their own pocket because the drug costs are not covered by any insurance scheme. If the HCV reimbursement level was increased from 75% to 100%, an additional EUR 4.4 million would be required – assuming the current levels of treatment with ribavirin and pegylated interferon. The introduction of second line therapy with Boceprevir or Telaprevir would require an additional EUR 48 million.

Latvia does not have the facilities to perform liver transplantations. With the current rates of hepatitis infection, Latvia will be seeing a huge demand for treatment services for liver failure, including transplantation.

Many PWID are not registered with GPs. PWID who are not registered with a GP cannot be seen at the Infectology Centre by specialists as this requires a full referral from the GP. PWID who obtain a referral, often do not attend their follow-up appointments for confirmatory testing of hepatitis B or C at the Infectology Centre.

Estimates from the last sero-survey in Latvia suggest that there are around 40 000 individuals infected with chronic hepatitis C. The hepatology services have established a register of all hepatitis patients (total: 20 800) who have been diagnosed since 1993.

Approximately 50 acute cases of hepatitis C are diagnosed every year in Latvia. Cases of hepatitis B and C are followed up by the epidemiological team at SPK: detailed epidemiological information is collected and contact tracing is performed. If cases appear to have acquired their infection nosocomially, a full investigation is started. There was an outbreak of hepatitis B linked to surgery in 2008 involving six patients.

The infectology clinic cannot pass information directly to the patient's GP or social worker. Information on the patient's condition is given to the patient in a letter format for the patient to hand carry to the GP. This is seen as a gap in communication between primary and secondary care.

The mission team did not have the opportunity to evaluate the current hepatitis screening policies and programmes and hepatitis B vaccination programme.

Main conclusions/findings:

- The hepatology team at the Riga Infectology Centre provides antiviral treatment for patients with hepatitis B and C, but with a limited range of antiviral drugs; preference is given to drugs included on the national list of reimbursable drugs.
- Antiviral therapy for hepatitis B and C is only reimbursed at 75%.
- PWID who are not registered with a GP cannot be seen at the Infectology Centre by specialists as this requires a full referral from the GP.
- Many PWID are not attending the Infectology Centre for confirmatory testing after receiving the result of their positive rapid test.
- There is no liver transplantation centre in Latvia, and patients have to be sent abroad.
- Only a few referrals from narcology centres are actually treated at the Infectology Centre.
- the Infectology Centre cannot pass on information directly to the patient's GP or social worker.

4.6 General prevention policies

Clinicians are responsible for partner notifications. In consultation with the PLHIV, the doctor will emphasise the importance of partner notifications and ask the patient to sign a statement that he/she will contact partners. It is up to the PLHIV to notify the partner, with no further support provided. There is no psychosocial support (trained nurse counsellors) and there are no offers from doctors/epidemiologists to contact the partner on their behalf. It is likely that a proportion of PLHIV would prefer this option, and such support could significantly limit the further transmission of HIV.

Several interviewed persons stressed the low awareness of HIV and hepatitis infections in the general population. They emphasised the need for a public education campaign to raise awareness of hepatitis and HIV as a public health problem, emphasising the importance of testing and early diagnosis.

The mission team was also informed about sex education in schools. Schools do not teach sex education as a separate subject and teachers do not receive training in this subject.

Main conclusions/findings

- The current system of HIV partner notification does not include any public health support to improve its effectiveness.
- Anecdotal evidence suggests that there is a low level of awareness of HIV and hepatitis in the general population.
- Sex education in the schools is seen as an area where improvements should be made.

4.7 Prisons

There are 12 prisons in Latvia with a total capacity of 6 500 inmates. Currently, 4 895 people are imprisoned. Following a criminal law reform, the number of prisoners was reduced. It is anticipated that the prisoner population will continue to fall because of electronic tagging of offenders. Each of the 12 prisons in Latvia has its own medical unit. The national prison hospital at Olaine was opened in 2007 and has a capacity for 200 prisoners. Olaine prison includes a closed high-security wing, an open-prison wing, and the prison hospital. The whole prison currently has 269 prisoners (29 female, 240 male: 116 male prisoners in the closed wing, 70 prisoners in the open-mixed wing, and 83 male and female prisoners in the hospital.)

About half of the prisoner population in Latvia is Russian speaking. A recent study [7] indicated that 66.1% of the prison population had ever used drugs, and 31.8% of prisoners reported that they had continued to use drugs while in prison. Respondents reported that the majority of drugs they used had to be injected. Drug dealers serve long sentences; the prison governor estimated that the average sentence for women convicted for selling drugs was between four and six years. As in other prison systems in Europe, most of the female prisoners are sentenced for drug-related offences. The average sentence in the closed men's ward was estimated to be 10 years (turnover 10% per year).

A total of 1 330 HIV cases in prisons inmates were registered by the end of 2012 (24.1% of all registered HIV cases by year end 2012 in Latvia). In 2012, there were 456 known cases of HIV infection (9.3%) among prisoners in Latvia. HIV testing is voluntary unless there are clinical symptoms, but prisoners who refuse the test have to sign a form, and almost all people entering prison end up being tested (estimated HIV testing uptake rate is 98%). HIV infections detected among those entering prison constitute a significant proportion of all newly diagnosed infections. Currently, a total of 65 prisoners receive ARV treatment. There were 108 prisoners who received ARV treatment in 2013.

In 2014, 51 prisoners were diagnosed with HBV and 760 inmates were diagnosed with HCV. HBV and HCV tests are only offered to prisoners with HIV, clinical symptoms, or if the prisoner requests to be tested.

Reimbursement rules for HCV treatment were recently changed: now only 75% of the costs are reimbursed, while the remaining 25% need to be covered by the ministry of justice. It is difficult for the prison authorities to pay the remaining 25% out of their budgets. However, a review of prison health policies is underway, and this issue may get resolved in the process.

The prison hospital in Olaine prison served as an alcohol treatment centre during Soviet times (detoxification and treatment). It was fully refurbished, but following the reorganisation of the prison health system in 2009, one of its two wards was closed down due to lack of staff. The hospital services are currently limited to health check-ups on prison entry and a limited range of medical services. According to the medical director, the full functionality of the hospital will soon be re-established.

The prison hospital has several external specialists who come into the prison for consultations, e.g. psychiatrists, gynaecologists and dentists. Dental care is available but prisoners must pay for treatment themselves, with the exception of emergencies.

The hospital at Olaine has an impressive range of equipment for in-house diagnostics (endoscopy and digital x-ray), but most of the equipment appears to be hardly used. The facility also has an intensive care unit, an operation theatre, and a video conferencing facility for court hearings if prisoners cannot attend due to illness. If the staffing situation was resolved, a vast array of medical procedures could be undertaken in the prison hospital, with the exception of major surgery.

Every prisoner receives a health check upon arrival. Around five new prisoners are seen by the healthcare staff every week. The health check consists of a medical examination, mandatory screening for tuberculosis (chest X-ray), and the offer of an HIV test. Almost all prisoners accept the offer to be tested for HIV. Those who are HIV positive are also tested for HCV; prisoners who request a test or who have clinical symptoms are also tested for HCV. HBV testing is offered depending on the prisoner's symptoms.

The main barriers to anti-viral treatment for HCV for infected prisoners are the need to undertake a liver biopsy and unresolved issues on financial reimbursement.

Prisoners' health files are currently paper-based, but there are plans to establish an electronic database in the future. There is a system of data collection established in all prisons which includes diagnoses and care. The health records of prisoners are updated every three months, and include information about diagnoses and treatments, including OST, ARV and DOTS (tuberculosis). A central registry is kept on qualifications of medical staff.

Overall responsibility for prisoners with HIV is assigned to one of the medical doctors in the prison hospital. The care of these patients is shared with the Infectology Centre in Riga. The prison medical doctor attends weekly meetings in Riga with infectology consultants to discuss the care of infected prisoners. The medical files of the prisoners are taken along to these meetings. There are currently 22 prisoners in Olaine who receive ARV for HIV. If a prisoner with HIV is transferred to another prison, his medication is given to the prison officers responsible for transporting the prisoner.

⁷ Veselības ekonomikas centrs. Narkotiku lietošanas izplatība ieslodzījuma vietās Latvijā. Rīga: Socioloģisko pētījumu institūts; 2010. [Centre of Health Economics. The prevalence of drug use in Latvian prisons. Rīga: Sociological Research Institute; 2010.]

At the time of the visit, only one Olaine inmate received OST. It was not possible to investigate the details of the treatment; however, the prison pharmacy did not have methadone. OST is not initiated in the prison setting but continued for prisoners who already received OST before they were admitted.

There is an established collaboration with the Riga Center for Narcology in order to provide OST to prisoners. Methadone is not available through the prison pharmacies and purchased from external providers. Narcotic Anonymous (NA) hold meetings in prisons. A special addiction ward for the treatment and rehabilitation of drug-dependent offenders is planned to be built on the grounds of Olaine prison, partly funded by a grant from Norway, as a result of the above-mentioned study on prevalence of drug use in Latvian prisons (footnote 8). The tender process has been beset with problems, but building work is expected to start in 2015. The ward will take care of addicted prisoners from the entire Latvian prison system, following the 'pathfinder' ward model used in Oslo prisons (<http://www.oslofengsel.no/e-nyhet-stifinnern.html>) and a therapeutic community approach (Minnesota model).

Olaine prison has its own on-site laboratory and all microbiological analyses are carried out at this laboratory (STIs, TB). Serological testing for HIV, HBV and HCV is carried out in Riga.

Main conclusions/findings:

- The prison healthcare system in Latvia offers a comprehensive range of primary and secondary care services and provides a range of in-house diagnostic tests.
- There is a comprehensive system for data collection across prisons.
- The approach to the prevention of drug use and infections in prisons is unsystematic and further hampered by insufficient resources. In-reach harm reduction services for prisoners with problematic drug use is insufficient as there is no NSP and no system for initiating OST in the prison.
- Other primary prevention actions against blood-borne viruses among prisoners (e.g. vaccination, health promotion) appear to be very limited.
- There are no narcological services available for prisoners; OST is only available as a continuation of treatment commenced before the conviction; a programme for the drug-free treatment of drug-dependent prisoners has been in the planning stages since 2010.
- Testing for HIV is established but testing for HCV or HBV is currently limited.
- Anti-viral treatment of prisoners diagnosed with HIV, HCV or HBV is at low levels, and the current system of shared care with the infectology service could be improved through in-reach services from specialists.
- Access to assessment of liver damage for prisoners diagnosed with HCV or HBV is limited.
- The infection control aspects of the prison healthcare system were not fully assessed but any high-risk environment with invasive medical procedures in high-risk prisoners warrants further in-depth scrutiny.

5 Developments since the 2011 mission

Following a request by the Latvian government, ECDC conducted a country visit to Latvia in September 2011, covering HIV and sexually transmitted infections (STIs).

The aim of the 2011 visit was to address specific issues recently identified by the Latvian authorities. The objectives of the mission were to:

- review the national strategies and programmes for HIV and STI;
- discuss the current situation with respect to HIV and STI prevention and control, including surveillance, partner notification and populations at risk; and
- address the current situation with respect to hepatitis B and C and discuss possible steps for future.

In the report compiled based on the evidence collected during the mission that was submitted to the Latvian Government by the ECDC, a number of challenges and gaps were identified. The ECDC issued a list of conclusions and recommendations.

The conclusions and recommendations with regard to HIV were the following:

1. Continued support of the HIV programme: Currently HIV cases are reported to the HIV/AIDS case register held at the ICL, but there are proposals to incorporate HIV notification into the VISUMS system. The surveillance of HIV and the treatment of people living with HIV is well organised, fully covered by state, and includes several infectious disease doctors working in regional centres and prisons. Nonetheless, a very low proportion of PLWHA are on treatment and this has been attributed to both current treatment guidelines that recommend treatment for asymptomatic patients with CD4 cell count of < 200/mm³ and eligible patients refusing treatment. The low threshold centre network is a key factor in the prevention of HIV among people who inject drugs. The overall public health function to prevent and control HIV needs prioritisation.

Recommendations included the following:

- The inclusion of HIV cases into the VISUMS system must be approached with care with special consideration made to ensuring the confidentiality and protection of HIV data held within VISUMS.

- Special emphasis must be applied to ensure that only a selected number of professionals working with the system have access to HIV data with person identifiers. All persons working with VISUMS should NOT by default have access to HIV data, but access should be granted on a separate application basis and for a specific task where access to this data can be specifically justified.
- Current treatment guidelines need to be expanded in line with European standards so that treatment for asymptomatic HIV with CD4 cell count of <350 rather than $<200/\text{mm}^3$ is recommended. Treatment should be assertively recommended by healthcare workers and wider health education of PLWHA of the health benefits of treatment.
- Regulations to allow the use of point-of-care HIV tests in antenatal departments for emergency use and for continuation of well-established use in the LTC system for people who inject drugs should be expedited.
- The overall public health function should be strengthened (either in ICL or in another centre or agency).

2. Maintenance of high vigilance of HIV prevention among people who inject drugs: The LTC system is a key factor in the prevention of HIV-infection among people who inject drugs. Latvia has been an early adopter of this approach of harm reduction services for this vulnerable group. As recommended in the recently published ECDC guidance of prevention of infections for PWID, services need to be maintained at a high coverage level to prevent recurring epidemics as long as injecting drug use remains prevalent.

Recommendation: Support for low threshold services for people who inject drugs should be continued and strengthened to avoid a serious resurgence of HIV infection in this group and high risk of further transmission to the general population through sexual contact. Given the close links between poverty, social exclusion and vulnerability to injecting drug use, the LTC system presents a good return of investment in terms of poor health and high healthcare cost avoided.

3. Men who have Sex with Men: there is a lack of good quality data regarding the MSM population in Latvia, only partially corrected by the EMIS survey. The EMIS survey reported low levels of men 'being out' and of men reporting having tested for HIV in the previous 12 months. The discrimination and stigma of MSM compounds the difficulty of collecting good quality data, especially surveillance data, needed to support the development of services.

Recommendation: Leadership is required to establish specialised services for MSM in Latvia which are currently lacking in Latvia. The ICL should provide this leadership and seek to establish such services in collaboration with MSM community groups.

6. Establish and strengthen engagement with non-governmental organisations (NGOs): There is limited NGO engagement with HIV or STI programmes which is due, at least in part, to limited resources and size of the sector.

Recommendation: ECDC should provide expertise to both statutory and non-statutory sectors in order to enable NGOs to access European and other international funds.

7. Behavioural surveillance: The self-assessment tool within the ECDC behavioural surveillance project was tested in Latvia and considered very useful.

Recommendation: ECDC to invite Latvian counterparts to the first behavioural surveillance workshop in Stockholm in January.

Source: European Centre for Disease Prevention and Control. Country mission Latvia: HIV, sexually transmitted infections and hepatitis B and C, 26–30 September 2011. Stockholm: ECDC; 2013.

5.1. Key progress and remaining gaps

Since the 2011 country mission, Latvia implemented only a few of the main recommendations, and in some areas the situation appears to have deteriorated.

Surveillance of HIV is still not integrated into the generic VISUMS surveillance system, but run in a separate system to which only a limited number of persons have access. In a way, this follows the ECDC recommendation to take into account confidentiality and protection of HIV data. At the same time, this limits the number of personnel who can work on data quality control. Epidemiological HIV surveillance personnel have been reduced, which partially explains the increased proportion of cases labelled 'unknown' under 'transmission category'.

Latvia still follows the outdated threshold of $< 200/\text{mm}^3$ for the commencement of antiretroviral treatment. Most experts believe that this is no longer acceptable, especially as many countries in Europe have switched to a threshold of $< 500/\text{mm}^3$ (following WHO current guidelines) or offer treatment for all patients who so desire. UNAIDS recommend that 90% of all persons with HIV should be on treatment, irrespective of the CD4 count. Use of the current threshold puts Latvian persons living with HIV at a much higher risk of developing complications, with death or disability being much more common compared to most other EU countries.

It seems that the only reason that is keeping Latvia from updating the threshold to $< 500/\text{mm}^3$ lies in the additional treatment costs. Policymakers should revisit this decision, especially as the price for antiretroviral medications has decreased and will continue to fall with new generic preparations appearing in the market in the near future.

In the 2014, there was no evidence that there had been much improvement in the promotion of the point-of-care (POC) tests in antenatal departments, although the use of POC tests has been continued in LTCs (low threshold centres).

After the 2011 country visit, ECDC recommended that national public health functions should be strengthened. Since then, LTCs and the Riga Infectology Centre have been under different management. This is a positive development, because the clinical orientation of the Centre resulted in different priorities, which negatively affected public health action. However, it seems evident that this change in management also resulted in fewer resources for the SPKC and its public health functions.

Latvia's pioneering role in the region regarding the implementation of harm reduction and disease prevention services through a low-threshold service network is internationally well recognised and applauded. Since the inception of the service network, resources have fallen over a number of years to a level which is below the minimum needed. The services fail to have a real impact on the HIV or hepatitis epidemics and some critically important services are still missing. Only one HPP site in Riga has a level which could be described as close to minimally sufficient – the other observed sites are deficient. The major deficiencies that immediately become apparent in a quick visit are:

- too few sites and too little proficient staff
- too few syringes and needles distributed to have a real impact
- missing components in the distributed injection kit (water, mixing cups, filters, etc.)
- missing or ineffective referral processes (to HIV and addiction services)
- lack of a good and easily accessible location for PWID
- testing without proper referral
- lack of other services apart from testing and NSP
- lack of firm link to social services
- lack of female-oriented services
- no vaccinations available
- lack of space.

With the exception of one NGO-led project in Riga, an ECDC recommendation to develop MSM-specific services, was not followed.

The recommendation to strengthen work with NGOs has been partly implemented: the 'DIA+LOGS' centre now receives government funding for its HPP prevention work, albeit at a low level (EUR 80 000/year.). In a city the size of Riga, between three and five centres of the DIA+LOGS type would be needed, in addition to a major increase in the scale of on-site services.

Main changes since 2011:

- The HIV epidemic is not under control but in a state of endemicity where new PWID are becoming infected quite easily and annual AIDS mortality is at an unacceptably high rate.
- Experiences from the Russian Federation demonstrate how an originally drug-use driven epidemic can spread to heterosexual populations if prevention efforts are insufficient. This scenario is becoming more and more likely for Latvia if no action is taken in the very near future.
- There is no clear programme for the development of HPPs (number of service points, offered services, etc.). Since the 2011 mission, some neighbouring countries have successfully implemented comprehensive national plans. These programmes could be used as models for Latvia. Latvia could also tap into EU resources and programmes (i.e. social funds, health programmes, etc.) that could be used to kick-start a national programme and its development.
- Social support and opiate substitution therapy should be scaled up and access thresholds need to be lowered. The current compartmentalised services of OST/narcology and infectology should be redesigned and integrated to better meet the demands of the client.
- Unless the prevention of HIV transmission among PWID is significantly strengthened, the cohort of chronically HIV infected individuals in Latvia will continue to grow, which will drive up healthcare costs in the decades ahead. If HIV treatment is not dramatically improved, Latvia will find itself in the unenviable position as the EU Member State with the highest AIDS morbidity and mortality.

6 Summary of the main recommendations of the mission

The preceding text of this report includes a number of suggestions and options for consideration by the Latvian policymakers. What follows is a list of the more essential recommendations based on the findings of the mission.

6.1 HIV epidemiology and behavioural surveillance

- The recent increasing trend in HIV despite the decline in overall testing rates, indicates that the current level of prevention and control activities is inadequate. The Latvian draft Action Plan contains all essential elements to deal with the epidemic but the envisaged scale of the activities is too modest to have any real impact. More resources and stronger commitment is necessary to ensure that the planned activities are carried out at sufficient scale.
- Increased surveillance efforts are needed to gather more complete data on the route of transmission. These data would help identify where resources should be targeted at.
- Latvia largely lacks a system for routinely carrying out bio-behavioural surveillance among the key populations, people living with HCV, sexual partners of PWID, MSM and sex workers.

6.2 Epidemiology and control of hepatitis B and C in Latvia

- Although the rate of acute hepatitis B infections has been decreasing lately, Latvia still has one of the highest rates of hepatitis B and C in the EU. More resources dedicated to the prevention and control of these infections are needed. It is foreseeable, that the Latvian healthcare system will soon have to confront an unprecedented number of debilitating or potentially fatal complications of hepatitis.
- Nosocomial infection with hepatitis B and C can be avoided if suitable procedures are enforced and adequate disposables are available. Latvian public health authorities should investigate why hospitals fail to curb nosocomial infections and develop a plan to reduce the number of infections. As a continuous intervention, a stronger system of audits for cases of suspected nosocomial transmission of hepatitis should be introduced.
- The collection and quality of epidemiological data needs to be improved. SPKC should review the criteria for classifying cases of hepatitis B in order to better differentiate the cases. Better data are essential for decision-making and the implementation of effective measures.

6.3 Harm reduction

- Latvian public health authorities should increase the number of clients receiving either methadone or buprenorphine to a minimum coverage level of 30% of the target population (1 800–4 300 clients; mid-estimate: 3 000 clients). The current Action Plan 2011–2017 should be adjusted to include this target by 2017.
- The work of HPPs should be expanded to cover the entire country. In areas where the municipality cannot fund these activities, the central government should consider covering the staff costs.
- Syringe provision should be scaled up to adequate response levels, i.e. the free provision of no less than 100 (ideally 200) syringes for each PWID per year (which amounts to between one and two million syringes/year in Latvia) and a similar volume of injecting supplies (water, mixing cups, filters, swabs, citric acid, etc.).
- Basic funding for HPPs and NGOs should be guaranteed in multiyear agreements in order to sustain essential community-based prevention services.
- A national platform for fostering the greater involvement of municipalities should be created. This platform should focus on harm reduction activities and closer collaboration with NGOs. Local fora to promote the involvement of all stakeholders and ensure the collaboration of relevant stakeholders (drug addiction services, health service providers, narcologists and the police) at the municipal level are recommended. Training and knowledge exchange activities involving staff from the field of infectious diseases and drug addiction services should be conducted to improve service quality. A review of current activities based on outreach data collection protocols – which should involving service providers – should be carried out.
- Latvian public health authorities should investigate how to establish conveniently located, user-friendly services for subgroups (for example women, sex workers), ideally with the help of former members of these risk groups.
- Methadone and/or buprenorphine-based substitution treatment should be available at easily accessible locations to increase uptake by the target population. OST should therefore be available in HPPs (NGO-run

or governmental) and at GP practices. Trained nurses could provide OST in the HPPs based on shared-care models as described in this report.

- Generic buprenorphine-based medications for the treatment of opioid dependence should be introduced in Latvia. Treatment should be free of charge or available at a very small cost for the client. Reimbursement of OST costs for the providers should not be based on an average dose of OST medication but on the actual dose of methadone prescribed because averaging out can lead to medication underdosing by providers with an overall decrease in the effectiveness of the programme.
- A continuous campaign to raise public (and political) awareness and support is very important. In addition, social marketing campaigns to destigmatise problem drug users and provide evidence-based information on harm reduction and drug treatment should be run at least once every two years.

6.4 Testing and follow up

- HIV testing policies – as well as hepatitis screening and testing practices – need a full review. A working group should be set up to review recommendations for free testing in order to focus on groups at risk. In addition, routine occupational testing (sailors, etc.) and blood safety testing should be diverted into a separate programme.
- Confirmatory testing for those who test positive for HIV, HBV and HCV should be free of charge. This should also be extended to rapid tests performed in HPPs (open up direct referral, eliminate user fees, consider incentives).
- Partner referral/contact tracing is too limited to be effective. Dedicated counsellors (supported, if necessary, by epidemiologists) are needed to help newly infected people to trace and contact their partners. Alternatively, counsellors can contact partners directly, keeping the identity of the infected person anonymous. This additional service would also improve the completeness and quality of the data derived from notification.

6.5 Vertical transmission

- Following each case of mother-to-child transmission of HIV, a confidential inquiry or critical incident review, led by a small group of senior experts, should be conducted to identify gaps in service provision and improve services. The review group should make specific recommendations to the MoH so actions can be taken to reduce the number of similar transmissions. Extending this review process at a later stage to include the mother-to-child transmission of hepatitis B and C should be considered.
- Latvian public health authorities should consider appointing an antenatal-care coordinator responsible for the prevention of mother-to-child transmission in order to support the management of referrals of infected pregnant women and improve communication between caregivers and other service providers (including narcology, hospitals). This coordinator should also encourage the development of more user-friendly services and support for pregnant women who injecting drug users in order to encourage them to come into care earlier to reduce the risk of mother-to-child transmission.
- A review of the flow of patient data between services involved in the antenatal care of women infected with HIV and HBV should be undertaken to identify the gaps and potential for improvement.
- Immunoglobulin for babies born to hepatitis carriers should be fully reimbursable if there is a medical indication.
- Pregnant women living outside of Riga who are infected with HIV and HBV should receive better support during the antenatal and postnatal period.

6.6 Infectious disease treatment

- Patient reimbursement for infectious disease treatment (including hepatitis B and C) should be at 100% to help reduce onward transmission.
- More integrated treatment services for those most at risk need to be set up. Services should reduce the current fragmentation of services and improve communication between infectologists, dermatovenerologists, outreach workers, narcologists working on drug treatment (including OST), and staff working in prevention and social support. Clinicians working with HIV-positive patients should not be stigmatised and steps should be taken to address this issue.
- In addition to their precarious social situation, PWID are often affected by multiple co-morbidities (HIV, viral hepatitis, tuberculosis, other infectious diseases) and mental health conditions. Integrated services and patient-centred prevention are suited best for the care and treatment of people afflicted with a multitude of health and other problems. In addition, integrated services usually offer better communication.
- In order to encourage more patients with HBV or HCV to receive treatment, access to the Infectology Centre (dropping the obligatory GP referral in certain cases) needs to be improved. In addition, the flow of patient information has to be simplified.

- WHO guidelines on hepatitis C treatment should be followed, also in prisons. Careful consideration should be given on whether new antiviral drugs which have fewer side effects should become reimbursable.
- The increase in AIDS in Latvia suggests shortcomings in treatment coverage and uptake. A review of the current situation regarding treatment indications, treatment locations and the timing of ARV is needed.

6.7 Prisons

- As an alternative to coercive sanctions for drug offenders, properly supervised OST could be used to help reduce the number of prisoners using drugs.
- A health strategy to reduce drug use for prisons should be drawn up. Based on this strategy, the range and delivery of effective drug-related health services (e.g. health education, drug treatment for opiate-dependent prisoners) should be expanded.
- Effective through-care mechanisms between prison and community, including pre-release counselling on overdose prevention and referral to community-based drugs services on release, should be established.
- The involvement of community-based service providers for drug-related health services for prisoners (drug treatment and counselling, infectology, narcology, psychology and psychiatry) would probably improve these services.
- National infection control guidance for prisons should be developed. Guidelines should address the safe disposal of sharps, the decontamination of medical equipment, and the handling of blood spills and needle-stick injuries. A system of governance should oversee the implementation of this guidance.
- All prisoners should be offered the test for hepatitis C on reception to the prison on a voluntary basis (incentives could be considered to increase response).
- All prisoners and prison staff should be vaccinated against HBV (and consider also HAV).
- Prisoners diagnosed with chronic HCV should be assessed for antiviral treatment and treatment provided in line with WHO recommendations (a system of prioritisation may need to be considered).
- The degree of liver fibrosis and cirrhosis in prisoners could be assessed using alternative techniques to liver biopsy (including the Fibrotest, elastography or the aminotransferase/platelet ratio index or the FIB4).
- All prisoners diagnosed with HBV or HCV should be offered behavioural alcohol reduction interventions.
- Prison healthcare staff should regularly participate in training courses on HIV, HBV and HCV. A training programme could be developed by the Riga Infectology Centre for all primary healthcare staff dealing with clients at risk of HBV, HIV and HCV.
- It is important to ensure the full engagement of prison staff in the further development/implementation of the National Action Plan for the elimination of HIV, HCV and HBV.

6.8 HIV prevention among other risk groups

- HIV prevention should be strengthened in the other high-risk groups (MSM, sex workers) to avoid further increases in transmission among these populations. The Latvian SPKC should be responsible for the provision of services to these key risk groups because the municipalities are unlikely to prioritise MSM and sex workers in their prevention efforts.
 - With regard to MSM, it is essential to: a) expand the services of the MSM Checkpoint and make it an official HPP supported by the Latvian SPKC; b) expand health promotion messages (TV, social media, gay dating websites, dating apps); c) improve access to the MSM Checkpoint; d) expand provider training and establish a list of gay-friendly providers which covers the entire country; and e) offer peer support/counselling to MSM.
 - With regard to sex workers, it is essential to: a) open HPPs (with the help of mobile outreach services) in locations convenient to street-based sex workers. HPPs should provide condoms, needles and syringes, testing (HIV, hepatitis and syphilis testing), and information on prevention; b) focus on women's health by offering referrals to gynaecologists, obstetricians, and narcology services.

The outpatient treatment for STIs is not free, which is a major treatment barrier. Authorities should consider a full reimbursement for priority STIs as this would help to reduce infections among partners.

Annex 1. Programme of the mission

Programme for Day 1 of the joint ECDC/EMCDDA Latvia country mission on HIV and hepatitis

2 September 2014

9.00	Meeting at the Radisson Blu Elizabete Hotel, Elizabetes 73, Riga
9.00–9.30	Walk to the Ministry of Health
Venue:	Ministry of Health, Brīvības iela 72, Riga, room 309
9:30–10:00	Welcome – Egita Pole, MoH Introductions Nicole Werner-Keišs, SPKC Why are we here? Scope and mandate of the visit – Andrew Amato, ECDC
10:00–11:00	Session I: Overview of the epidemiology of HIV and hepatitis in Latvia
15 min	Description of the surveillance system and key epidemiological trends for HIV/AIDS and hepatitis B and C, overall and within key populations Speaker: Dr Irina Lucenko Head of Infectious Diseases Surveillance and Immunization Unit, Department of Infectious Diseases Risk Analysis and Prevention SPKC
15 min	Overview of drug use prevalence (high-risk drug use) and patterns in Latvia Speaker: Linda Sīle, Public Health Analyst, Reitox National Focal Point, Addiction Monitoring Unit, SPKC
15 min	Data from behavioural surveillance PWID and prisoners. Sexual partners of PWID and other heterosexuals at-risk Sex workers MSM (ie from EMIS results or other surveys targeting MSM) Speaker: Anda Karnīte, MPH, PHD National DRID expert Reitox Focal Point, SPKC, Assistant Professor, Department of Public Health and Epidemiology, Riga Stradins University
15 min	Discussion
11:00–11:15	Coffee break
11:15–13:00	Session II: Update on health and drug dependency services related to HIV and hepatitis in Latvia
15 min	Health systems and services, with a focus on HIV and hepatitis – overview and recent changes Speaker: Assoc. Prof. Dr Māris Taube, Director of the National Health Service
15 min	Drug treatment services: access, funding and coverage Speaker: Linda Sīle, Public Health Analyst, Reitox National Focal Point, Addiction Monitoring Unit, SPKC
25 min	Drug-related health responses in prison & correctional institutions: access, funding, coverage of the target population. Challenges. Speaker: Vadims Viktorovs,

	Head of Medical Unit, Latvian Prison Administration
15 min	Harm reduction services, HIV and hepatitis testing policies and practices: access, costs, community-based testing, challenges Speaker: Ilze Straume Head of Health Promotion Unit (HPP), SPKC
20 min	Discussion
13:00–14:15	Lunch
14:15–15:00	Session II (continued)
15 min	Antenatal screening Speaker: Prof. Dr Dace Rezeberga, Chief Gynecologist at Riga Maternity Hospital, Head of the Gynecological clinic at Riga East Clinical University Hospital, Head of Latvian Association of Gynecologists and Obstetricians
15 min	Priorities for action for Hepatitis B and C Speaker: Jana Feldmane Head of Unit for Environmental Health, Public Health Department, Ministry of Health
15 min	Discussion
15:00–15.15	Coffee break
15:15–16.15	Session III: Update on prevention of HIV/hepatitis, including community interventions
10 min each speaker	Support services for PLHIV, Key NGO actors to present their programmes/services/challenges Speakers: Inga Upmace, Baltic HIV Association Aigars Cepītis, AGIHAS Ruta Kaupe, DIA+LOGS Aleksandrs Molokovskis, HIV.LV
15 min	Final Discussion and closure
16:15–17:15	Closed session – Mission team meeting with civil society – (possibly off-site):

Programme for Days 2 and 3 of the joint ECDC/EMCDDA Latvia country mission on HIV and hepatitis

3 September 2014

Experts and Latvian team divided into three groups

Time			
	Group 1 – Bauska group Andrew Amato, ECDC Anastasia Pharris, ECDC Ilze Straume, SPKC Nicole Werner-Keišs, SPKC	Group 2 – Olaine group Dagmar Hedrich, EMCDDA Erika Duffell, ECDC Līva Grāmatīna, SPKC Lubova Vinogradova, SPKC (interpreter)	Group 3 – Riga group Alessandro Pirona, EMCDDA Eleni Kalamara, EMCDDA Mika Salminen, ECDC/THL Linda Sīle, SPKC
8.30	Departure from hotel		
9.00		Departure from hotel	
9.30			Departure from hotel
10.00	Visit of HPP in Bauska Dārza iela 12b Meeting: Tatjana Kalniņa, MSc,	Visit of prison and Latvian prison hospital in Olaine Rīgas iela 10 Meeting:	Riga Centre for Psychiatry and Narcology Tvaiku iela 2, Riga Meeting:

11.30	responsible for the harm reduction programme, nurse and social worker Igors Girnis, Street worker Daiga Supe, Social Services, Municipality of Bauska Departure from Bauska back to Riga	Vadims Viktorovs, Latvian Prison Administration	Astrīda Stirna, Head of Narcological Support Service
12.00–13.00		Lunch	Lunch
13.00	Andrew Amato Working Lunch with Aiga Rūrāne, Head of WHO Office Latvia Pils iela 21, Riga	Visit of HPP in Olaine Zemgales iela 57 Meeting Jūlija Madušēvica, responsible for the harm reduction programme, social worker person Irina Vasīleva, responsible for OST, social worker	Alessandro Pirona, EMCDDA Eleni Kalamara, EMCDDA Mika Salminen, ECDC/THL Meeting with Mārcis Trapencieris and Linda Sīle at SPKC, Dunties iela 22, Riga
14.30 (+/-)	Andrew Amato Meeting with Vivita Kīkule, Municipality of Riga, Welfare Department, Baznīcas ielā 19/23		Visit of HPP of the SPKC Klijānu iela 7, Riga Meeting: Inga Bulmistre, Public Health organisator, SPKC Participants: Alessandro Pirona, EMCDDA Eleni Kalamara, EMCDDA Anastasia Pharris, ECDC Mika Salminen, ECDC/THL Ilze Straume, SPKC
16.10	Participants of the last two visits meet at the HPP Women-SW, Deglava iela 10		
16.15	Women-SW (Baltic HIV Association/Youth with Mission) Deglava iela 10, Riga (Lienes/Asara ielas tuvumā) Meeting: Inga Upmace Maija Broša, gynaecologist, Riga 1. hospital, Sandra Darkēvica or Aiga Apse, social workers, Evi Carney, narcologist all involved in project of Papardes zieds with women-SW Participants: Dagmar Hedrich, EMCDDA Eleni Kalamara, EMCDDA Anastasia Pharris, ECDC Mika Salminen, ECDC/THL Erika Duffell, ECDC Andrew Amato, ECDC? Inga Bulmistre, SPKC		
18.00	Checkpoint for MSM (Baltic HIV association/Mozaika) Stabu 19, k2, Riga Meeting: Inga Upmace Daina Semjonova, dermatovenerologist (involved in BaltHIV project with MSM, and in project of Papardes zieds previously), Pauls Aldiņš, infectologist, Stradiņš University (BaltHIV projects) Participants: Some experts joining the DIA+LOGS mobile unit Dagmar Hedrich, EMCDDA Eleni Kalamara, EMCDDA Anastasia Pharris, ECDC Mika Salminen, ECDC/THL Erika Duffell, ECDC Andrew Amato, ECDC Inga Bulmistre, SPKC Return to hotel		
4 September 2014			
Experts divided into two groups			
	Group 1 – Infectology Center Mika Salminen, ECDC Andrew Amato, ECDC	Group 2 – DIALOGS Dagmar Hedrich, EMCDDA Alessandro Pirona, EMCDDA	

	Erika Duffell, ECDC Anastasia Pharris, ECDC Nicole Werner-Keiss, SPKC	Eleni Kalamara, EMCDDA Līva Grāmatīna, SPKC Ilze Straume, SPKC
9.30	Departure from the hotel (by bus)	
9.45		Departure from the hotel (by feet)
10.00–11.30	Rīga Eastern Clinical University Hospital, Latvian Infectology Center Linezera iela 3, Rīga Meeting: Dr Velga Kūse, Assoc. Prof. Dr Gunta Stūre, Head of HIV/AIDS inpatient clinic ward 6 Doc. Dr Ieva Tolmane, Head of hepatology ward 4 Dr Inga Januškeviča, Head of HIV/AIDS ambulatory clinic ward 2 Dr Ilze Bērziņa Jelena Storženko, Head of National Microbiology Reference Laboratory Tatjana Kolupajeva, Head of unit for molecular biology of viral infections	NGO DIA+LOGS support centre for those affected by HIV/AIDS (HIV prevention and harm reduction program in Rīga) Dzirnavu iela 135, Rīga (entrance from Satekles street) Meeting: Ruta Kaupe, Board Chairperson of DIA+LOGS Agita Sēja, Social and HIV prevention program coordinator of DIA+LOGS Aleksandrs Molokovskis, Board Chairperson of NGO Association HIV.LV
Around 11.30	Departure to the MoH	Walk to the Ministry of Health
Venue:	Ministry of Health, Brīvības iela 72, Rīga, room 424	
12.00–14.30	Internal meeting of experts	
flexible	Coffee break/lunch	
14.30–15.00	Break/moving to room 309	
Venue:	Ministry of Health, Brīvības iela 72, Rīga, room 309	
15.00–17.00	Debriefing	
	Speakers: ECDC and EMCDDA experts Participants: See list Day 1	
17.00	Transfer to the airport for ECDC experts	

Annex 2. List of participants

ECDC–EMCDDA mission team

Andrew Amato-Gauci, head of HIV, Sexually Transmitted Infections and Viral Hepatitis Programme, ECDC

Erika Duffell, expert Hepatitis B and C, ECDC

Dagmar Hedrich, head of sector, Health Consequences and Responses; Consequences, Responses and Best Practices Unit, EMCDDA

Eleni Kalamara, scientific agent; Estimates, statistics and data management sector, Prevalence, data management and content coordination unit, EMCDDA

Anastasia Pharris, Expert HIV/AIDS, ECDC

Alessandro Pirona, MSc, PhD, scientific analyst, health and social responses; Health Consequences and Responses Sector; Consequences, Responses and Best Practices Unit, EMCDDA

Mika Salminen, MSc, PhD; ECDC external expert; Research Professor, Head of Department of Infectious Disease and Surveillance and Control and Head of Virology Unit, National Institute for Health and Welfare; Adjunct Professor of Virology at University of Helsinki, Finland

Latvian participants

Jana Feldmane, Public Health Department, Head of Unit for Environmental Health, Ministry of Health

Irina Lucenko, Head of Infectious Diseases Surveillance and Immunization Unit, NFP surveillance, SPKC

Nicole Werner-Keiss, National Coordinator, SPKC

Aija Pelne, Head of Addiction Monitoring Unit, SPKC

Linda Sile, Public Health Analyst, Addiction Monitoring Unit, Reitox Focal Point, SPKC

Anda Karnite, DRID Expert, Public Health Specialist, Reitox Focal Point, SPKC

Marcis Trapencieris, scientist, part-time expert, Addiction Monitoring Unit, SPKC

Ilze Straume, Head of Health Promotion Unit (HPP), SPKC

Liva Gramatina, Senior Health Promotion coordinator, SPKC

Raina Nikiforova, Epidemiologist, Infectious Diseases Surveillance and Immunization Unit, NFP Alternate HASH Programme, SPKC

Sarlote Konova, Public Health Analyst, OCP Epidemiology HIV Infection and AIDS, SPKC

Santa Livina, Head of Public Health Department, Ministry of Health

Egita Pole, Ministry of Health

Agnese Rabovica, European Affairs, Ministry of Health

Inga Smate, Director of the SPKC, SPKC

Dzintars Mozgis Prof., Deputy Director, Development and Epidemiological Safety, SPKC

Jolanta Gedusa, Ministry of Welfare

Vadims Viktorovs, Head of Medical Unit, Latvian Prison Administration

Maris Taube, Director of the National Health Service ('Health Insurance')

Aiga Rurane, Head of WHO office Latvia

Silvija Simfa, Latvian Association of local and regional governments

Ruta Raude, Municipality of Riga, Welfare Department, Public Health and Health promotion unit, senior specialist, Office of Citizenship and Migration Affairs

Eriks Sika, Ministry of Science and Education

Iona Hartmane, Clinical Centre for Skin and Sexually transmissible diseases

Astrida Stirna, Head of Narcological Support Service, Riga Centre for Psychiatry and Narcology; Narcologists Association

Ilze Berzina, Riga Eastern Clinical University Hospital, Riga Infectology Centre

Gunta Sture Dr med, Riga Eastern Clinical University Hospital, Riga Infectology Centre

Inga Januskevica, Head of HIV/AIDS ambulatory clinic ward 2

Vaira-Irisa Kalnina, Head of laboratory services, Riga Eastern Clinical University Hospital

Ludmila Viksna Prof, infectologist, Riga Eastern Clinical University Hospital, Stradins University, General Practitioners Association

S. Rubins, Association of Dermato-venerologists

Aigars Ceplitis, Ivars Kokars, AGIHAS

Ruta Kaupe, DIA+LOGS

Edgars Jersovs, Mozaika

Inga Upmace, Baltic HIV Association

Rita Kubulina, Papardes zieds

Aleksandrs Molokovskis, Apvieniba HIV.LV

Laila Stale, Red Cross Latvia

Agnese Zeb-Veisbeiga, Ministry of Interior

Laura Sevienko, CDPD

Lubis Paulins, Ministry of Health

Gunta Grisle, Ministry of Health

Annex 3. Bibliography

PowerPoint presentations given or made available during the visit:

Baltic HIV Association (2014) Check point for MSM

Ceplitis A (AGHIAS) AGIHAS Support Group of People living with HIV/AIDS

Feldmane J (Ministry of Health): Public Health System in Latvia

Feldmane J (Ministry of Health): Priorities for action for prevention HIV/AIDS, STI and Hepatitis B and C

Karnite A (Riga Stradins University) HIV and hepatitis – data from behavioural surveillance (studies among people at-risk)

Kaupe R (DIA+LOGS) DIA+LOGS support and resources center for those affected by HIV/AIDS

Lucenko I (SPKC): HIV/AIDS. Epidemiological situation in Latvia

Lucenko I (SPKC): HIV/AIDS, hepatitis B and C in Latvia. Surveillance system and key epidemiological trends

Molokovskis A (HIV.LV): Association HIV.LV Main activities

Perevoščikovs J (SPKC): Surveillance of infectious disease in Latvia

Rezeberga D (SPKC) Antenatal screening

Sile L (SPKC): Overview of drug use prevalence (high-risk drug use) and patterns in Latvia

Sile L (SPKC): Drug treatment services: access, funding and coverage

Šmate I (SPKC): Centre for Disease Prevention and Control

Straume I (SPKC): HIV prevention in Latvia

Straume I (SPKC): Harm reduction services, HIV and hepatitis testing policies and practices

Taube M (National Health Service) Health care system and services with a focus on HIV and hepatitis – overview and recent changes

Upmace I (Baltic HIV Association): Women, ethnic minorities, drug-help services- Papardes zieds

NN (SPKC): Drug Use Behaviour and Trends in Latvia

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