EVALUATION OF THE ACCESS TO HIV/AIDS TREATMENT AND CARE IN LITHUANIA

Prepared by

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April 2010
# GLOSSARY

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>3TC</td>
<td>Lamivudine (NRTI)</td>
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<td>ABA/ABC</td>
<td>Abacavir (NRTI)</td>
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<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<td>ART</td>
<td>Antiretroviral Therapy</td>
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<td>ARV</td>
<td>Antiretroviral</td>
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<td>ASAP</td>
<td>AIDS Strategy and Action Plan</td>
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<td>ATV</td>
<td>Atazanavir (PI)</td>
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<td>ATV/r</td>
<td>Atazanavir boosted with Ritonavir (PI)</td>
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<td>AZT</td>
<td>Zidovudine (NRTI)</td>
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<td>CD4</td>
<td>A measure of the number of a particular type of white blood cells</td>
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<td>DRV/r</td>
<td>Darunavir boosted with Ritonavir (PI)</td>
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<td>EFZ</td>
<td>Efavirenz (NNRTI)</td>
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<td>EMCDDA</td>
<td>European Monitoring Centre for Drugs and Drug Addiction</td>
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<td>FPV/r</td>
<td>Fosamprenavir boosted with Ritonavir (PI)</td>
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<td>FTC</td>
<td>Emtricitabine (NRTI)</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>IDU</td>
<td>Injecting Drug User</td>
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<td>IDV</td>
<td>Indinavir (PI)</td>
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<td>LTL</td>
<td>Lithuanian Litas</td>
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<td>LPV/r</td>
<td>Lopinavir boosted with Ritonavir (PI)</td>
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<td>NGO</td>
<td>Non-Governmental Organization</td>
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<td>NHIF</td>
<td>National Health Insurance Fund</td>
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<td>NNRTI</td>
<td>Non- Nucleoside/Nucleotide Reverse Transcriptase Inhibitor</td>
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<tr>
<td>NRTI</td>
<td>Nucleoside Reverse Transcriptase Inhibitor</td>
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<td>NVP</td>
<td>Nevirapine (NNRTI)</td>
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<td>PEP</td>
<td>Post-Exposure Prophylaxis</td>
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<tr>
<td>PI</td>
<td>Protease Inhibitor</td>
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<td>PLHIV</td>
<td>People Living with HIV</td>
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<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
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<td>RTV</td>
<td>Ritonavir (PI)</td>
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<tr>
<td>SQV/r</td>
<td>Saquinavir boosted with Ritonavir (PI)</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<tr>
<td>TDF</td>
<td>Tenofovir (NRTI)</td>
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<tr>
<td>TRIPS</td>
<td>Trade-Related Aspects of Intellectual Property Rights</td>
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<td>UNAIDS</td>
<td>Joint UN Programme on HIV/AIDS</td>
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<td>UNDP</td>
<td>United Nations Development Programme</td>
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<td>UNGASS</td>
<td>United Nations General Assembly Special Session</td>
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<td>UNODC</td>
<td>United Nations Office on Drugs and Crime</td>
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<tr>
<td>VAT</td>
<td>Value-Added Tax</td>
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<tr>
<td>VL</td>
<td>Viral Load, measure of the severity of a viral infection</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>ZDV</td>
<td>Zidovudine (NRTI)</td>
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At time of writing 1 Lithuanian Litas (LTL) was worth approximately €0.29
ACKNOWLEDGEMENTS

The team would like to express their thanks to all those who made this trip and report possible. In particular, we would like to thank all those who met with us and shared their views and experiences so freely.

The mission was jointly supported by WHO and UNODC. The team would particularly like to thank the WHO Country Office in Lithuania, the UNODC Project Office for the Baltic States and the Lithuanian Ministry of Health for all their support and assistance. Particular thanks are due to Dr Robertas Petkevicius, the head of the WHO Country Office in Lithuania for all his support and input into the team's work.
SUMMARY

This report is the result of a visit to Lithuania in March 2010 by an international team contributed by UNODC and WHO as a response to a request made by the Lithuanian Ministry of Health.

Lithuania’s aim in responding to HIV has been to maintain low HIV prevalence in the country. Has this been achieved?

Although HIV prevalence among the general population has remained low, there is evidence of significant ongoing HIV transmission concentrated among particular key populations, such as injecting drug users. Although some sexual spread of HIV is occurring between injecting drug users and their sex partners and among men who have sex with men, the epidemic continues to be largely driven by unsafe injecting drug use. Focusing effective prevention, care and treatment services on injecting drug users and their sex partners will not only control the spread of HIV in Lithuania among IDUs, it will also protect the entire population from the risk of HIV transmission.

**HIV transmission among IDUs is not yet under control.** The number of men infected through injecting drug use remains at an unacceptable level. Much more needs to be done. Essential services for drug users, such as the provision of sterile injecting equipment and pharmacotherapy of drug dependence are currently under threat. Yet, these not only need to be maintained. They also need to be significantly expanded across the country. Despite the commitment that health services in prisons should be equivalent to those available in communities, needle-syringe programmes and pharmacotherapy for drug dependence remain absent from Lithuanian prisons. There is an urgent need for these services. The continued absence of these services in prisons means that there is a critical gap allowing transmission of HIV and other blood-borne infections among individuals who could have been protected.

**Antiretroviral therapy** is being received by around 150 people in Lithuania. Officially, ART is accessible to all who need it. Yet, Lithuania reported that only just over half (52%) of those needing treatment were receiving it in 2008 and 2009. Some NGOs estimate that as many as 500 to 1000 people may need treatment now. There is consensus that the number of people needing ART is going to increase with time and there is need to plan now for expanded ART provision. This will require making more rational choices on which ARVs to purchase and taking steps to lower prices paid.

Another way of looking at the issue of ART coverage is to look at rates of late diagnosis and/or late access to treatment. If ART coverage is high, rates of late diagnosis/late access to treatment would be expected to be low and vice versa. Officially, rates of late diagnosis are said to be low. The proportion of PLHIV presenting with advanced clinical disease was reported to be only 6%. However,
other figures show extremely high rates of late diagnosis. Based on official figures reported to ECDC (ECDC and WHO, 2009), in 2008 more than one fifth (22%) of people with new HIV diagnoses had a CD4 count <350 at time of diagnosis. This figure rose to more than a third (39%) of those who had a CD4 count performed at the time of diagnosis. It appears that late diagnosis of HIV infection is much more common than officially recognized.

One reason for late diagnosis is the difficulties experienced by those most at risk of HIV infection in accessing HIV testing. There is no overall strategy on HIV testing. As a result, most people who wish to have an HIV test need to pay, including members of key populations, such as IDUs. There are also concerns that many people who are diagnosed as HIV positive are lost to medical follow-up. Such people are unlikely to start ART as promptly as they should.

Lithuania has adopted ART guidelines, but these do not reflect internationally-recognized best practice. As a result, there is no clear distinction between first and second-line ARV regimens. This is resulting in suboptimal treatment and increased costs. The ART guidelines should be revised and brought in line with international best practice. Appropriate use of ARVs needs to be promoted and monitored.

There are specific concerns about the ability of IDUs to access ART. Although the proportion of IDUs receiving treatment in Lithuania is increasing with each year, this proportion (38% in 2006) is much lower than the proportion of HIV infections resulting from injecting drug use. There is evidence of significant barriers to IDUs receiving ART. These barriers include missed opportunities for HIV testing, stigmatizing attitudes of health staff, the cost of some services and very limited access to pharmacotherapy.

The essential and vital role played by civil society in responding to HIV is acknowledged in Lithuania. However, there is no shared understanding of the roles that civil society should play. Such roles are likely to include advocacy and, reaching key populations to build trust, provide entry into health system and to ensure continued engagement with services. In addition, there is no predictable, long-term funding for NGOs, e.g. through the state. As a result, NGOs are highly-focused on securing short-term, project funding. They have extremely limited capacity and little long-term or strategic focus.

Perversely, the current global financial crisis presents opportunities for Lithuania to focus its response to HIV on those things that will really make a difference to the scale and extent of the epidemic. Efficiency savings could be made by shifting away from activities with marginal public health benefit and adopting a more rational and strategic approach to ARV prescribing and procurement.
INTRODUCTION AND BACKGROUND

This evaluation is taking place at an important time in the response to HIV in Lithuania. The current economic crisis and problems within the health care system threaten the country’s progress towards universal access to HIV-related services.

Currently, Lithuania does not have an agreed national framework for its response to HIV. The previous national programme expired in 2008. A new national HIV/AIDS and STI prevention and control programme for 2009 to 2012 has not yet been approved. Suggestions made by international reviewers (e.g. ASAP, undated) have not yet been fully incorporated into the draft programme (see p10).

In 2009, major changes were made to the structures of the response to HIV in Lithuania (see Figure 4, p13). In particular, the Lithuanian AIDS Centre and the Centre for Prevention and Control of Communicable Diseases were merged into the Centre for Communicable Diseases and AIDS. Previously, the Lithuanian AIDS Centre had a very wide-ranging role including leading the development and implementation of the National AIDS Programme and providing a range of HIV-related personal and public health care services. The merged centre has been allocated a more circumscribed role focused on HIV-related public health issues.

The Centre for Communicable Diseases and AIDS no longer provides treatment and care for individual PLHIV. Rather, these services are provided through a number of health care institutions, funded through the National Health Insurance Fund (see p30). Because the HIV epidemic in Lithuania is linked to injecting drug use (see p8), a significant proportion of PLHIV spend time in the criminal justice system. Treatment and care of PLHIV within this system is funded separately through the health budget of the Prison Department. Concerns have been raised as to whether these two separate systems present obstacles for the delivery of HIV treatment and care services, and whether they affect the quality and cost of these services. An additional issue is that people do not enter the prison system directly but through ‘arrest houses’ managed by the Ministry of Interior.

This evaluation has been formally requested through the WHO Country Office and the UNODC Project Office for the Baltic States by the Ministry of Health as an integral part of the collaboration between the Government of Lithuania, the World Health Organization and the UNODC project HIV Prevention and Care among Injecting Drug Users and in Prison Settings in Latvia, Estonia and Lithuania. The aim of this evaluation is to provide Lithuania with practical recommendations for the effective implementation of HIV treatment and care in the context of a difficult economic situation and limited resources for the health sector. The evaluation focuses on a number of main areas, including current
health care structures and systems in place; coverage and quality of HIV treatment services; and pricing and procurement policies of ARV therapy.

CURRENT STATUS OF THE HIV EPIDEMIC IN LITHUANIA

Officially, Lithuania has a sophisticated HIV surveillance system (Caplinskas, 2010) based on a system of HIV and AIDS case reporting. Initial positive HIV tests at regional laboratories are confirmed at the National Reference Laboratory for Virology, based at the Centre for Communicable Diseases and AIDS (see p13).

The first HIV case was diagnosed in Lithuania in 1988. By 1st January 2010, a cumulative total of 1,581 new cases of HIV had been diagnosed (see Figure 1). Of these, almost all (83%) were male (MOH, 2010; Centre for Communicable Disease and AIDS, 2010b). The peak of new diagnoses in 2002 reflects an outbreak in Alytus Prison. The apparent increase in 2009 (to 180) is reported to include 40 diagnoses from 2008 whose confirmatory HIV tests were delayed until 2009. However, this explanation is not contained in written documents on the issue (Centre for Communicable Disease and AIDS, 2010b). Concerns were expressed by NGOs that the rate of new infections could be considerably higher because some people with HIV are either undiagnosed or are diagnosed late.

Figure 1: New HIV diagnoses in Lithuania: 1988 to 2009 (disaggregated by sex) (from Caplinskas, 2010)

Lithuania’s HIV epidemic is particularly concentrated among IDUs (see Figure 2). Between 1997 and 2009, almost three quarters of all new HIV infections were reported to have been acquired through injecting drug use (MOH, 2010). In 2009, over two thirds (67%) of all new HIV infections were reported to have been acquired through injecting drug use. Although the number of infections acquired heterosexually has grown (Anonymous 2010c), this is likely to reflect sexual transmission among the sex partners of IDUs. Currently, there is no evidence of significant heterosexual transmission of HIV in Lithuania independent of the
Estimates of the size of the IDU population vary from 3,200 to 7,000 (see Hay, 2007; Mathers et al., 2008). Reported HIV prevalence among IDUs during the period 2005-9 ranged from 1.2-8% (Anonymous, 2010a; Mathers et al., 2008; Expanding Network, 2009). The Drug Control Department under the Government of the Republic of Lithuania considers the HIV prevalence among IDU could be about 9%. Some studies showed more than 20% HIV prevalence among tested IDU.

There are widely diverging views about the size and significance of the HIV epidemic in Lithuania. There are concerns that the case-based surveillance system may be underestimating the scale of the epidemic because of delays in diagnosis, largely as a result of limitations in access to HIV testing (see p17). Nevertheless, official documents emphasize that the country has a low level epidemic. This is clearly the case in terms of Lithuania’s general population. However, others are concerned about the scale of the epidemic among IDUs, describing the situation as ‘disastrous’ (Lithuanian Network of People Living with HIV/AIDS Positive Life, 2010). Figure 3 shows that, of reporting European countries, Lithuania has the fourth highest rate of new HIV infections among IDU.

Figure 2: New HIV diagnoses in Lithuania: 1988 to 2009: Reported transmission mode (from Anonymous, 2010a)

<table>
<thead>
<tr>
<th>Year</th>
<th>Heterosexual</th>
<th>Homosexual</th>
<th>IDU</th>
<th>Unknown</th>
<th>Perinatal</th>
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1 Revised version of diagram with updated figures for 2009 supplied by UNODC regional project office
The experience of this review shows that the available data on HIV and AIDS needs to be more rigorously and critically analyzed. The involvement of a broad range of professionals in this process, including academic institutions and MOH statisticians may improve the current analysis, which too often appears to draw far too positive conclusions from the data available. The frequently-made comparisons with nearby countries such as Estonia, Latvia, Belarus and Russia are misleading and counter-productive. They appear to be focused largely on showing how well the response is being conducted in Lithuania. There is a significant risk that instead of contributing to solving the problem of HIV in Lithuania, such analysis may produce a sense of complacency among political leaders in the country.

There are also divergent views about the adequacy of Lithuania’s national response to HIV. Those officially responsible for the response to HIV consider the country’s response to have been exemplary and the main reason why overall prevalence remains low. This view was shared by the mid-term review of the national HIV programme (Amato-Gauci et al., 2006) which concluded that the responsive had been ‘impressive’ characterized by a broad range of activities, strong leadership and political courage.

However, concerns have been expressed that the response to HIV in Lithuania does not fully match the epidemiology of the country’s epidemic. For example, a group of nine international reviewers, when commenting on the draft national programme for 2009 to 2012, concluded that ‘the main shortcoming is that the

Figure 3: Reported rates of new HIV infections among IDU per million population (from EMCDDA, undated)
epidemic situation does not guide the proposed programs. The strategy would be stronger if the proposed activities closely matched the epidemic situation – i.e., a strong focus on prevention among IDUs rather than general population education.’ (ASAP, undated)

So, which view is correct? To what extent is Lithuania’s response to HIV providing effective services for IDUs at a sufficient scale to make a difference? Lithuania’s official 2010 report on progress in implementing the UNGASS Declaration of Commitment does not contain figures for coverage of prevention programmes among IDUs (Caplinskas, 2010). A recently-published global study (Mathers et al., 2010) reported that in Lithuania, in 2007, 3,399 IDUs accessed needle and syringe programmes regularly. This was a relatively high proportion [68% (52-97%)] of all IDUs. However, the number of needles-syringes distributed per IDU per year [37 (29-54)] was relatively low. In addition, in 2008, 512 IDUs were receiving pharmacotherapy with buprenorphine or methadone. This was a relatively small proportion [10%(8-15%)] of all IDUs.

This problem of limited coverage of effective prevention programmes among IDUs was recognized by the mid-term review of the National AIDS Programme (Amato-Gauci, 2006) which concluded that ‘more needle exchange, methadone and more harm reduction services outside of the main cities is needed if a major epidemic among IDU is to be averted in the near future.’ Although some steps have been made in this direction, e.g. through the activities supported by UNODC, it is of concern that low coverage of these services seems to be tolerated by key officials and political leaders. Indeed, the expansion of much needed harm reduction services has resulted in something of a political backlash so that essential services are, at best, facing an uncertain future, and, at worse, are threatened with closure.

METHOD

Terms of Reference for the evaluation are provided as Annex 3 (p60). Most of the data for this evaluation was collected during a team visit to Lithuania in March 2010. A series of meetings were held with key informants, structured around different topics of the evaluation (see Annex 1, p50). Key informants included various parts of the Ministry of Health, the National Health Insurance Fund, NGOs, Ministry of Justice, Drug Control Department under the Government of the Republic of Lithuania and the Committee on Health Affairs of the Parliament. A number of site visits were made, including to health institutions in communities and in prisons.

In addition, a wide range of documents were reviewed by the team (see Annex 2, p55).
Each team member compiled an individual report on specific areas on which they were asked to concentrate. These were compiled into this overall report by Roger Drew.
FINDINGS

Structures, Systems and Organizational Development.

Healthcare systems connected with services for PLHIV

Leadership and the strategic environment

Clearly, there has been some initial impetus to the response to HIV in Lithuania. The mid-term review of the National AIDS Programme (Amato-Gauci, 2006) – praised the leadership and courage shown in the response to HIV in Lithuania, particularly the early introduction of needle-syringe programmes and pharmacotherapy of drug dependence.

However, the response is facing serious challenges. The current economic environment means that budgets are being reduced yet the need for services is rising. For example, it is reported that the health budget fell 9% from 2009 to 2010. Such falls in budgets are one reason why the political environment in Lithuania is currently hostile towards HIV-related services for IDUs. Despite the known health benefits of such services, political and public opinion is quite hostile towards needle and syringe programmes and pharmacotherapy with methadone. This has been seen in negative press articles regarding low threshold centres and negative political pressure placed on the Drug Control Programme’s support for low threshold centres. As result, some NGOs have been strongly critical of the current national response - ‘Lithuanian government and politicians jeopardize the health and well-being of Lithuanian citizens and violate the constitutional and human rights by cutting the funding, creating barriers to access medical and other services, transferring costs onto the clients.’ (Lithuanian Network of People Living with HIV/AIDS Positive Life, 2010).

There is also the danger that continued low HIV prevalence among the general population in Lithuania could lead to a sense of complacency, based on the belief that the epidemic has been controlled by actions taken to date, especially in the face of more pressing health and economic problems. Yet, there is clear evidence of significant transmission among IDUs. This is eminently preventable with bold and targeted actions. Unchecked, there is a risk of a significant epidemic among IDUs, their sex partners and even beyond.

It is unclear who has responsibility for taking a strategic overview of the HIV epidemic and the response to it. Lines of responsibility, e.g. between central government and municipalities over who funds what, are reported to be unclear. The Public Health Department of the Ministry of Health (see Figure 4 and Annex 4, p64) presented an overview of HIV-related law and policy to the review team (Ašokliénė, 2010). It would be a welcome development if they were taking the lead on the response to HIV within the Ministry of Health. However, there is need for coordination between ministries and with NGOs but no intersectoral
Figure 4: Governmental structures involved in the response to HIV in Lithuania

Data Source: Anonymous, undated, b
coordination body currently exists. There was a Coordination Council but its remit was limited to the National AIDS Programme. The UNODC project steering committee has been coordinating activities related to their regional project but it is unclear what will happen to that body once the UNODC funding ends. There is a need for a sustainable, national coordination body similar to this. NGOs would like to have at least 25% of all representatives on such a body. More involvement of some ministries, e.g. the Ministry of Social Security and Labour, is needed.

Lithuania has a number of laws and policies which are relevant to the response to HIV (Ašoklienė, 2010; Uždaviniene, 2008). These include the Law of Public Health, the Law of Human Communicable Diseases Prevention and Control (see Republic of Lithuania, 1996), the Lithuanian Health Programme and the National Public Health Strategy. There are specific provisions for services for IDUs in the drug control strategy, a 2006 order of the Minister of Health on harm reduction and a 2007 executive act of the Minister of Health which allows pharmacotherapy with buprenorphine and methadone. There is, however, no formal policy on HIV testing (see p17) and the new ART treatment guidelines are not yet approved (see p42).

A recent review of the legal framework for the HIV response in prisons (Juodkaitė et al., 2008) expressed concern that, Although having signed and/or ratified the main international and regional documents on the fight with HIV/AIDS, Lithuanian Government has not yet fulfilled all the commitments undertaken. Mainly it is questionable that the provisions of the “Dublin Declaration on Partnership to fight HIV/AIDS in Europe and Central Asia” to ensure that by 2010 80% of the persons at the highest risk of and most vulnerable to HIV/AIDS (including prisoners) are covered by a wide range of prevention programmes; the widespread introduction of prevention measures, drug dependence treatment and harm reduction programmes for injecting drug users will be introduced in Lithuania (e.g. needle and syringe programmes, bleach and condom distribution, voluntary HIV counselling and testing, opioid substitution treatment, STI diagnosis and treatment). Although legal acts establish that prisoners should receive health care services equivalent to those provided to other citizens, this is not yet the case. Prisons still do not provide opioid substitution treatment or needle and syringe programmes (for more detail of prisons, see p26).

The National HIV Programme is not a strategic overview of the entire response to HIV in Lithuania. Rather, it has been a supplementary programme focused largely on the work of one centre. The last programme ran from 2003 to 2008 (MOH, 2010) with a mid-term review being conducted in 2006 (Amato-Gauci et al., 2006). Although a new HIV and STI strategy (MOH, 2010) has been drafted, it has not yet been adopted. Reasons for this delay are unclear but may include the reorganization of the Lithuanian AIDS Centre, diverse opinions over drafting and budgetary/financial pressures. Currently, the draft is with government (Government of the Republic of Lithuania, 2010) and it is expected to be approved soon. There are practical implications of the delay in finalizing the
national programme on HIV and AIDS. It is reported that there are insufficient funds for prevention activities.

As a supplementary programme, it does not cover all aspects of Lithuania’s national response to HIV and is therefore lacking in a number of areas as a strategic framework for that response. For example, it includes tasks on general prevention and surveillance but lacks preventative interventions focused on key populations and access to HIV/AIDS treatment and care. If the National AIDS Programme is intended to provide a strategic action framework for the national response to HIV, it is important that these crucial elements of the response are included.

Also, Lithuania established a Drug Control Department under the Government of the Republic of Lithuania in 2004. Functions include coordination, prevention, harm reduction, EMCDDA reporting, data collection and tracking infectious diseases among drug users. Since 2005, the Drug Control Department under the Government of the Republic of Lithuania supported low threshold centres but these are now threatened by the negative political environment mentioned above. A problem seems to relate to the involvement of the Seimas of the Republic of Lithuania Commission for Prevention of Drug and Alcohol Addiction and their asserted doubts over the scientific data supporting substitution treatment. This is quite surprising given that WHO wrote to the Lithuanian Ministry of Health in 2005 (Magnusson, 2005 citing WHO, UNODC and UNAIDS, 2004) to present the large body of scientific evidence in favour of substitution therapy in reducing illicit opioid use; reducing criminal activity; preventing overdose deaths; preventing HIV infections; improving the overall health status of IDU with HIV and improving levels of employment and social functioning. That letter concludes that, ‘the scientific evidence clearly suggests that methadone substitution treatment is the most effective treatment option for the management of opioid dependence with regard to the prevention of HIV transmission and the care of drug users living with HIV/AIDS. Substitution maintenance therapy also offers opportunities for improving the delivery of antiretroviral treatment of drug users living with HIV/AIDS, notably by increasing access to treatment and improving retention in programmes and adherence to treatment.’ Given the Drug Control Department’s under the Government of the Republic of Lithuania leading role in spearheading the introduction of Low Threshold Centres in Lithuania, and the scepticism expressed by the Tabacco and Alcohol Control Agency under the Government of the Republic of Lithuania on the scientific evidence for the benefits of harm reduction, the plans to merge these two bodies must carry considerable risk and perhaps merit further examination.

The plans by the parliamentary health committee to review provision for the health of IDUs by meeting with relevant ministers, e.g. health, legal affairs, national security and drug prevention are extremely welcome. The health committee of the Parliament is rightly proud of its achievements in alcohol and tobacco control. There is a similar opportunity to make significant health gains by
expanding harm reduction among IDUs and thus control HIV transmission among them.

**HIV testing**

HIV testing is important for a number of reasons, not least as the entry point for those needing ART. Data presented on number of HIV tests performed per year in Lithuania varied hugely by data source (see table 1). The reasons for this variation could include the omission of unlinked anonymous testing and blood donors in the ECDC and WHO figures.

<table>
<thead>
<tr>
<th>Year</th>
<th>Ašoklienė, 2010; Caplinskas, 2010</th>
<th>ECDC and WHO, 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>59822</td>
<td></td>
</tr>
<tr>
<td>2005</td>
<td>58424</td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td>118059</td>
<td>52988</td>
</tr>
<tr>
<td>2007</td>
<td>151313</td>
<td>60333</td>
</tr>
<tr>
<td>2008</td>
<td>178245</td>
<td>162381</td>
</tr>
<tr>
<td>2009</td>
<td>190530</td>
<td></td>
</tr>
</tbody>
</table>

Nevertheless, the number of HIV tests being performed in Lithuania is clearly increasing. Table 2 shows that most of the tests are conducted among blood donors, pregnant women and in prisons. For example, in 2009, more than 50 000 tests were performed among 20 939 pregnant women resulting in detection of only eight HIV positive women. This raises the question as to whether these eight infections could have been detected with fewer HIV tests with a more focused testing policy (see p33). Conversely, testing in prisons is highly appropriate. Between 1988 and 2009, almost two thirds (62%) of all new HIV diagnoses were made in the prison system. This does not mean that HIV infection was acquired there. Rather, it simply means that HIV tests were performed there. This raises the question as to whether all opportunities are being taken to test those most at risk of HIV infection in other settings, i.e. outside of prison. It is of concern that there is no clear policy and practice to ensure that the following groups are offered free HIV tests:

- STI patients – in 2009, only 210 of 1047 STI patients were tested for HIV (see table 2)
- IDUs attending low threshold centres and pharmacotherapy sites (UNODC, 2010). Most low threshold centres are apparently not allowed to take blood for HIV testing. They can do rapid tests but mostly do not have funds for this purpose. There are also reports that some centres are prevented from conducting rapid tests because of local regulations requiring a doctor to perform such tests. Some centres are not providing HIV testing at all. Due to funding constraints HIV tests are not available in
several pharmacotherapy sites. There is a strong demand from such centres for training in counselling.
Table 2: Number of HIV test by group: 2009 (Data source: Caplinskas, 2010; MOH, 2010)

<table>
<thead>
<tr>
<th>Group</th>
<th>Number tested</th>
<th>Number HIV positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical indication</td>
<td>1535</td>
<td>16</td>
</tr>
<tr>
<td>STI patients</td>
<td>210</td>
<td>1</td>
</tr>
<tr>
<td>Person who have sex with more than one partner</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>TB patients</td>
<td>1163</td>
<td>5</td>
</tr>
<tr>
<td>Donors</td>
<td>89731</td>
<td>8</td>
</tr>
<tr>
<td>Pregnant women</td>
<td>50018</td>
<td>8</td>
</tr>
<tr>
<td>Apply to medical institution of own will</td>
<td>4859</td>
<td>21</td>
</tr>
<tr>
<td>Prisoners</td>
<td>12874</td>
<td>75</td>
</tr>
<tr>
<td>Occupational contacts</td>
<td>213</td>
<td></td>
</tr>
<tr>
<td>IDUs</td>
<td>1405</td>
<td>28</td>
</tr>
<tr>
<td>Sex workers</td>
<td>79</td>
<td></td>
</tr>
<tr>
<td>MSM</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>Migrants</td>
<td>132</td>
<td>2</td>
</tr>
<tr>
<td>Occupational contacts</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>Person who have sex contact with HIV positive</td>
<td>46</td>
<td>5</td>
</tr>
<tr>
<td>Certificate</td>
<td>4138</td>
<td>3</td>
</tr>
<tr>
<td>Others</td>
<td>24320</td>
<td>8</td>
</tr>
</tbody>
</table>

NGOs raised concerns that for most people in Lithuania, voluntary HIV testing is not free of charge. Rather, it costs between 11-18 LTL.

Given the increase in number of people being tested for HIV, it is perhaps unsurprising that the percentage of people, aged 15-49, reporting that they had been tested for HIV in the last 12 months and knew the results rose between 2008 and 2009. However, the degree of rise from 5.3% in 2008 to 18.3% in 2009 (Caplinskas, 2010) does not seem completely plausible in the light of the testing data provided. Similarly, it is unclear how the proportion of those having been tested for HIV in the last 12 months and knowing their results could have been 41.3% for MSM in 2009, 73% for IDUs in 2009 and 53.4% for sex workers in 2008 given the severe restrictions on HIV testing among these groups.

**ART provision**

In October 2009, HIV/AIDS services were reorganized with the aim of decentralizing treatment and care, making them more available at primary health care level. Instead of being largely concentrated at the Lithuanian AIDS Centre in Vilnius, treatment is now available in five treatment sites across the main cities of Lithuania. In Vilnius, out-patient HIV services are available through the Central Polyclinic. Currently, two of its seven branches are able to provide HIV treatment and care. One of them has an infectious disease specialist, a family physician, and a gynecologist available to serve patients on HIV. Polyclinic staff report that they serve about five to six people per month, mostly for HIV tests. Since October 2009, only five newly-diagnosed HIV patients were identified. Of these,
two reported acquiring the infection through homosexual sex, one through heterosexual sex and two through injecting drug use. Two patients had a CD4 count <350 at time of diagnosis yet only one of these received ART. Another patient did not come back and no follow-up was made.

ART is also available in prisons financed by the Ministry of Justice and in the private sector. However, service costs are high in the private sector and only affordable to a limited number of patients.

There are a number of obstacles to PLHIV receiving ART, particularly for IDUs who constitute around three quarters of all PLHIV in Lithuania:

- Many IDUs do not have an ID card which is required for a person to be eligible for medical and social insurance and for registration in the labour exchange office. The cost of the card (80 LTL) is an obstacle for IDUs accessing treatment and care.

- Many PLHIV could be undiagnosed because of issues relating to HIV testing (see p17).

- Some doctors, including infectious disease specialists, appear to be reluctant to treat PLHIV.

- There may be delays and challenges in being referred from primary health care services to the secondary level of the health system where treatment is available. Time and efforts are required to obtain an appointment with a family physician, to obtain referral to an infectious disease specialist and to visit that specialist.

- Access to care is also limited by the working hours of infectious disease specialists. For example, in Vilnius and Klaipeda, the cities with the biggest number of registered HIV cases, an infectious disease specialist is only available three to four hours per day, three days per week in Vilnius, and three hours per week in Klaipeda.

- It is reported that many IDUs are reluctant to approach health services for fear of being placed on the national addiction registry. This keeps information on identified drug users for five years. There are concerns about the confidentiality of information in this register. Being registered may result in people being denied employment and a driver’s licence.

For those on ART, regular monitoring is needed, including CD4 count and viral load. This is needed, not only to determine when to start treatment, but also to monitor its success. However NGOs were concerned that, outside of Vilnius, tests needed to be paid for by patients. Reported costs were 100 LTL for CD4 count and more for viral load. In addition, medications for treatment of
opportunistic infections and hepatitis C are also offered at the expense of patients. Both, laboratory monitoring and addressing other medical needs should be considered as part of treatment for PLHIV and expenses should be covered by one governmental source.

According to NHIF figures, 190 people received HIV services in 2007, 205 in 2008 and 299 in 2010 (see Table 3, p30). These figures are relatively low and represent a very small proportion of the overall NHIF budget. However, prior to October 2009, many PLHIV received treatment and care directly from the Lithuanian AIDS Centre. So, it is likely that these figures underestimate true levels of service provision and may increase from 2010. Nevertheless, there are concerns that many diagnosed PLHIV are not receiving ongoing care and follow-up. Figures on this issue are not available as there is no overall system for tracking which PLHIV receive ongoing health care. Hospital staff report that all diagnosed PLHIV are under care but that some do not come for that care. This tendency to ‘blame’ patients for non-take-up of services appears fairly common among health professionals.

At the time of this review, approximately 150 PLHIV were on ART, including in prisons. However, there are different estimates as to how many people need treatment. For example, modeling with SPECTRUM estimates that 287 people needed ART in 2009 (see Figure 5). However, those known to need treatment were only 170 (Caplinskas, 2010).

Figure 5: Estimated number of people in Lithuania (aged 15+) needing ART: 2000-2015 (Data from Caplinskas, 2010)
As a result of these differences in the numbers believed to be in need of treatment, calculated ART coverage figures vary widely. Some (e.g. Expanded Network, 2009) estimate that 1% of those with a positive HIV test are receiving ART. However, not everyone with a positive HIV test needs ART. Officially (Caplinskas, 2010; Centre for Communicable Disease and AIDS, 2010b), ART is accessible for all who need it. This claim was supported by NGO UNGASS reports for 2010 which stated that the majority in need of treatment had access (Anonymous, undated,a). Some NGOs claim that only 70% of those who need treatment receive it and that there are no funds for new people to start treatment (Lithuanian Network of People Living with HIV/AIDS Positive Life, 2010). Other NGOs claim that even the SPECTRUM estimates of need are too low and that the numbers needing treatment are between 500 and 1 000. Some NGOs claim that as many as 200 prisoners need ART. Official government UNGASS reports in 2010 (Caplinskas, 2010) give ART coverage as 52% in both 2008 and 2009, down from 79% in 2006 and 75% in 2007. Despite these variations in coverage figures, there is, however, consensus that the number needing treatment will rise above the number of those currently needing treatment and there is need to plan for expanded drug treatment services.

Another way of looking at the issue of ART coverage is to look at rates of late diagnosis and/or late access to treatment. If ART coverage is high, rates of late diagnosis/late access to treatment would be expected to be low and vice versa. Officially, rates of late diagnosis are said to be low. The proportion of PLHIV presenting with advanced clinical disease was reported to be only 6%. Based on figures to 2006, HIV infection was claimed to be diagnosed at the very early stages of the disease in IDUs because the average CD4 at time of diagnosis was reported to be 803 cells/mm³ and initial diagnosis at AIDS stage was made in only 0.5% of cases (Uždaviniene, 2008). However, other figures show high rates of late diagnosis. For example, the median CD4 count at the time of starting ART was reported to be 135 in Lithuania and only 78 in Vilnius (Anonymous, undated, c). . Based on official figures reported to ECDC (ECDC and WHO, 2009), in 2008 more than one fifth (22%) of people with new HIV diagnoses had a CD4 count <350 at time of diagnosis. This figure rose to more than a third (39%) of those who had a CD4 count performed at the time of diagnosis.

It appears that late diagnosis of HIV infection is much more common than officially recognized. This supports those who believe that there are a significant number of people in need of ART in Lithuania who are not yet receiving it. Official explanations of late diagnosis tend to place the responsibility on the patient claiming that they are unaware of their HIV status and that they ignore problems they might have until those problems become so severe that ‘they become more realistic.’ NGOs, however, report that the main concern is that people fear being stigmatized and discriminated against within the health system so that they ‘only use health services when close to death’.
There are concerns that IDUs may have more limited access to ART than other PLHIV. A recent article in the Lancet (Mathers et al., 2010) reported that, in 2006, one sixth (16%) of all HIV positive IDUs were on ART. It is reported that ART for IDUs started in 2004. The proportion of IDUs receiving treatment in Lithuania is increasing with each year. In 2004, it was 15.37% as compared to 26.38% in 2005 and 37.97% in 2006. (Uždaviniene, 2008). This proportion is much lower than the proportion of HIV infections resulting from injecting drug use and led to the recommendation that as many IDUs as possible should be enrolled in the programmes of treatment of dependence diseases and harm reduction programmes from where they could be diverted to receive health care services. This recommendation has not yet been fully implemented. For this to work fully, every opportunity needs to be taken to ensure that IDUs are offered HIV testing on every contact with HIV and other health services.

**Role of NGOs**

NGOs are playing a crucial role in Lithuania’s response to HIV. For example, NGO respondents estimated that more than 75% of HIV prevention services for sex workers, programmes to tackle stigma and discrimination and home based care services are provided by NGOs (Anonymous, undated, a). The figure was 25-50% for prevention services for IDUs but less than 25% for prevention services for young people, testing and counselling and clinical services. NGOs expressed concern that they had not been able to be very involved in supporting the provision of ART. There had been little engagement with medical institutions. It was reported that hospitals were unwilling/unable to give NGOs space to operate in their premises.

In general, NGOs are extremely concerned that the government in Lithuania does not appear to fully recognise the importance of their role in an effective response to HIV. They feel excluded from planning, budgets and reporting. NGO respondents ranked this overall as 0/5 (Anonymous, undated, a). The situation for NGOs working on HIV in Lithuania was described as ‘dire’. NGO respondents ranked the environment in Lithuania for NGOs to be involved in the response to HIV as only 4/10 (Anonymous, undated, a).

NGOs believe they have a huge amount to offer the response to HIV in Lithuania. Possible roles include:

- Advocacy
- Research
- Strengthening political commitment – NGO respondents ranked the contribution made by civil society in this areas as 4/5 (Anonymous, undated, a). They commented that representatives of NGOs have met with the Minister of Health and relevant top officials of the Ministry on several
occasions to discuss topical issues such as ARV treatment and care and support for PLHIV and others. One NGO approached the Minister of Justice to discuss methadone maintenance therapy implementation in prisons. The same NGO informed media about prisoners’ rights to health care.

- Involvement in planning – although NGOs have been involved in planning exercises [ranked 4/5 in Anonymous, undated, a], they reported feeling that their contributions were unwanted and had been ignored. They complained that there were very few formal opportunities for them to participate, apart from the steering committee for the UNODC project.

- Referring clients to health facilities but NGOs report that referrals from them are not given as much weight as referrals from another doctor.

- Provision of key services, for example, low threshold centres, needle exchange services, counselling for methadone maintenance treatment and ART adherence support. NGOs may be better able to provide these services than government because they are more trusted by service users.

- Programmes in prison – however, NGOs reported that sometimes it is difficult to get access to prisons. Those NGOs offering drug-free rehabilitation activities, such as twelve steps programmes are more likely to be allowed into prisons than other groups. NGOs play a crucial role in supporting prisoners on their release. NGOs report that ex-prisoners face extremely high levels of stigma in Lithuanian society.

- Drug free communities – about 12 NGOs are providing these services for around 30-50 people each with funding from the EU. From 2012, such groups will need to be licenced.

However, there are concerns that NGOs working on HIV in Lithuania are weaker than in other countries and in other sectors in Lithuania (Amato-Gauci et al., 2006). They lack adequate human resources. NGOs also recognise that they lack significant diversity. For example, respondents ranked civil society diversity in the response to HIV in Lithuania as only 1/5 (Anonymous, undated, a).

There are reports that NGOs have more involvement in other sectors in Lithuania and have developed stronger capacity in those areas. For example, since 2007 NGOs have selected up to four representatives to the Commission for Equal Opportunities for Women and Men. Those NGO representatives were considered strong partners within that commission and were involved in drafting, implementing and monitoring programmes. NGOs are active participants in a number of programmes providing educational and psychosocial services for women. These include the National Programme for Equal Opportunities for Women and Men, the National Strategy for Combating Violence against Women.
and the Programme for the Prevention and Control of Trafficking in Human Beings. NGO participation in these programmes is financed by government.

Perhaps the main problem relating to NGOs and the response to HIV is the lack of reliable and consistent funding for NGOs for their activities. Mechanisms for channelling government funds to NGOs are not well-developed. This is certainly a major concern for NGOs who report that government support for their activities is limited (Lithuanian Network of People Living with HIV/AIDS Positive Life, 2010). They are concerned that almost all the funding they can access is project-based. There is almost no long-term funding available and it is very difficult to cover core costs using project funding only. NGOs tend to be more focused on immediate and short-term funding needs rather than longer term issues, such as developing fundraising strategies, risk assessments and reserves policies. NGO respondents reported finding it easier to get technical support [ranked 3/5] than financial support [ranked 1/5]. However, NGOs received most of their technical support from UN agencies rather than from government (Anonymous, undated, a). Limited government funding for HIV activities has been available through the Drug Control Department under the Government of the Republic of Lithuania and from individual municipalities.

Funding for NGOs comes from:

- International foundations but this has been very limited since Lithuania entered the EU (Lithuanian Network of People Living with HIV/AIDS Positive Life, 2010)

- Particular foreign embassies, e.g. US and Norway

- Ministry of Health competitions – however, the amounts are small and focused on health overall rather than specifically on HIV

- The Drug Control Department under the Government of the Republic of Lithuania for harm reduction activities. However, NGOs now report that funding through this channel has been ‘blocked’

- Some municipalities for harm reduction services

- The European Commission – however, these funds are very limited and the requirements for getting these funds are reported to be extremely difficult so that only high capacity NGOs can gain these funds

NGOs commented that it is easier to gain funds for service delivery activities than for advocacy. No mention was made of public fundraising as a way of raising fund for NGOs. It appears that NGOs consider this very hard because of a lack of ‘philanthropic mentality’ in Lithuania.
Institutional assessment of key actors involved in HIV treatment

A number of institutional issues affect the key actors involved in HIV treatment. First, there are a number of organizations and institutions involved in the response to HIV, in general, and the provision of HIV treatment, in particular. However, their roles and the mechanisms for coordinating between them are not clearly defined (see p13). In the absence of clear roles for key actors, it is difficult to assess the adequacy or otherwise of their institutional capacity. Issues relating to integration of services are discussed in more detail elsewhere in this report (see p34). However, key problems arise because of the lack of integration between health services in prisons and those in communities at large and between HIV treatment services and those for treatment of drug dependence.

In addition, concern was expressed by some hospitals that budget cuts have adversely affected their ability to provide services. For example, one hospital commented that their budget had been reduced by 20% in one year. As a result, they had had to shed some staff and had also reduced staff salaries.

As mentioned elsewhere (see p23), NGOs report that they believe they are not being utilized to the full extent possible to support the provision of ART to PLHIV. In part, this is because of the perceived weakness and limited capacity of NGOs working in this field in Lithuania.

Management and coordination of HIV treatment in the community and in prison settings

As of March 2010, there were 8,800 prisoners in Lithuania. The number has been rising. For example, in 2008, there were 7,800.

All prisoners are offered HIV testing on entering and on leaving the prison system (see p17). In 2009, 12,874 HIV tests were conducted in prisons (see table 2, p19). This intensive testing policy in prisons has meant that since 1988, almost two thirds (62%) of all HIV diagnoses have been made in prisons although this does not mean that infections were acquired there. This testing policy has meant that it has been possible to detect outbreaks that occur in prisons, e.g. in Alytus in 2002. It has also made it possible to detect ongoing transmission of HIV in prisons. In 2008 and 2009, 11 infections were documented within Lithuanian prisons.

Staff from the prison health department report that around 3% of prisoners decline to be tested for HIV. As a result, they would favour the introduction of mandatory testing of new prisoners for HIV and other communicable diseases, such as TB. However, international agencies, such as UNAIDS, UNODC and WHO consider mandatory HIV testing of prisoners unethical and ineffective (WHO, 2001; WHO, 2007; WHO et al., 2007a/b; UNODC et al., 2009).
As of March 2010, there were 298 PLHIV in Lithuanian prisons. Of these, in 2009, there were reported to be 26 ‘AIDS patients’. Twenty five people received ART although by the end of 2009, 19 were on treatment. These were all men apart from one. The number of prisoners receiving ART is reported to have risen steadily from 2 in 2005 to 12 in 2007 to 25 in 2009. There are strongly divergent views as to whether or not all those needing ART in prisons receive it. The prison authorities report that this is the case. However, NGOs believe that the numbers needing treatment are much higher, perhaps as high as 300 currently. They claim that provision of ART to prisoners who need it is the ‘exception’ rather than the rule (Lithuanian Network of People Living with HIV/AIDS Positive Life, 2010). For example, they report that prisoners are more likely to receive ART if they are receiving it when they enter the prison system rather than if the need for it is discovered while in the prison system. However, this claim does not appear to be substantiated by data provided to the review team. In 2009, of eight new PLHIV started on ART in prisons, three of them had been receiving ART before being imprisoned and five had not. In 2008, five PLHIV continued their ART treatment in prison and a further nine started treatment. In 2007, four PLHIV continued their ART treatment in prison and a further eight started treatment. A daily observed treatment strategy is used for ART and TB treatment in prisons.

In principle, it is accepted that the same health services should be available in prisons as in the community. There is international agreement (e.g. WHO et al., 2009b) on the programme elements needed for effective responses to HIV among IDUs. These include:

- Needle and syringe programmes (NSPs)
- Opioid substitution therapy (OST) and other drug dependence treatment
- HIV testing and counselling (T&C)
- Antiretroviral therapy (ART)
- Prevention and treatment of sexually transmitted infections (STIs)
- Condom programmes for IDUs and their sexual partners
- Targeted information, education and communication (IEC) for IDUs and their sexual partners
- Vaccination, diagnosis and treatment of viral hepatitis
- Prevention, diagnosis and treatment of tuberculosis (TB).

A key challenge in Lithuania is that the prison health system is completely separate from the main community health systems (Juodkaitė et al., 2008). It is administered by the Ministry of Justice rather than by the Ministry of Health. In principle, there has been agreement that responsibility for health services in prisons should be taken over by the Ministry of Health. A working group was established two to three years ago to look into this but it was described as ‘stuck’. Consequently, the Prisons Department commissioned a feasibility study looking into this issue. It is reported that the reform of prison health services should be covered by a modernization strategy which is due for completion by 2017. This should cover what institutions provide what services to who and using what.
financing mechanisms. Some joint training of staff has been conducted, e.g. with
support of Project Hope, but medical staff in prisons operate in a completely
different system from those in the community.

The Prison Health Department is facing a number of serious challenges in
fulfilling its responsibilities to provide health services for prisoners. These include:

- Funding pressures – for example, the medicines budget was reduced by
  over 20% from 2.3m LTL in 2008 to 1.8m in 2009. The budget for the
  entire prison health system was reduced from 240m LTL in 2008 to 210m
  in 2009 and to 186m in 2010. The Prison Health Department reported that
  salaries, nutrition and medication had been protected from cuts.

- The salary differential between Ministry of Health and prison health staff. It
  is reported that lower salaries in the prison health sector make it difficult to
  attract staff.

- The fact that the Ministry of Justice pays a higher rate of VAT on drugs it
  procures (21%) than NHIF (5%) (see p35). This is one powerful argument
  for joint procurement of drugs through NHIF.

- High numbers of drug users in prisons. Currently, there are a reported
  1646 registered drug users in prisons. These account for around one fifth
  of all prisoners. This percentage has risen from around 6.6% in 1998 but
  fell from 21.1% in 2008 to 19% in 2009. More than three quarters (80%) of
  these inject drugs and opioids are the single commonest type of drug used
  (Juodkaité et al., 2008).

There are significant differences between the health services, particularly those
available to IDUs, in communities and in prisons. One particular issue is the
continued lack of pharmacotherapy with methadone in prisons. This deficiency
means that Lithuania is out of step with most EU countries that provide this
service in prisons. In principle, the Ministry of Justice is willing to provide
methadone to prisoners who enter the prison system when already on
methadone. To date, they have not been willing to consider starting methadone
for those dependent on opioid drugs but who have not yet started on methadone
prior to entering the prison system. In practice, prisoners have not been able to
access methadone even if they were receiving it in the community prior to
imprisonment. A major problem has been that people do not enter the prison
system directly. Rather, they enter through arrest houses administered by the
Ministry of the Interior. As methadone was not available in arrest houses,
treatment was interrupted there so people who entered prison were no longer
considered to be receiving methadone. Although there has been some progress,
with the Ministry of Justice and the Prisons Department engaging in open
dialogue about pharmacotherapy and the Ministry of Interior agreeing, in March
2010, to allow the supply of methadone to people in arrest houses, it is of grave
concern that some influential people, e.g. prison doctors are still strongly opposed to pharmacotherapy with methadone despite the overwhelming evidence of its benefits. In addition, the mid-term review of the National AIDS Programme (Amato-Gauci, 2006) raised concerns about the lack of clean needles in prison.

In addition, there are concerns about the continuation of services for those discharged from prison. A study into the availability of services for those being discharged from prisons (Uscila and Malinauskaité, 2009) in Alytus and Klaipeda concluded that:

- Municipalities are particularly inactive in implementing the provisions that are mandated by the laws and legal acts
- There are problems in transfer of patient information between an institution of incarceration and organizations and institutions that provide health care services on the community level
- Minimal attention is given to preparation of prisoners for their return to community – those getting probation do get some information but this is often fragmented and limited
- Employees of the municipal departments of social assistance have negative attitudes towards ex-prisoners
- Clients are sent from one organization to another
- Ex-prisoners are often given limited information about services provided by NGOs
- Ex-prisoners often lack a case manager
- Support groups for ex-prisoners are largely lacking
- Pharmacotherapy is not available in Alytus
- Prisoners, especially those who have used drugs, face considerable stigma and discrimination on release from prison, e.g. when seeking employment.

These findings are supported by the work of others (Juodkaitė et al., 2008) who concluded that ‘there is an obvious problem in ensuring continuity of care and treatment upon the transfer between different penal establishments and upon the release of a person from the prison. Unsupervised transfers or release of HIV positive inmates are likely to contribute to the spread of HIV in the social networks these people get into. There is hardly any communication and exchange of information with service providers outside the prison system.’
One particular issue noted by the review team is that there is no shared, electronic system of patient records between prison and community health services. Hard copies of records are simply given to those discharged from prison. The system relies on those records being transferred by the ex-prisoner to the health provider in the community.

**National funding plans and financial flow for HIV testing and treatment**

It is reported, based on 2007 figures, that Lithuania spends 6.2% of its Gross Domestic Product on health care. Spending on health accounts for 13.2% of overall public expenditure. Mechanisms for funding responses to HIV and TB in Lithuania are summarised in Figure 6.

**Figure 6: Organisation of Provision and Public Finance for HIV-TB Interventions and Related Services in Lithuania (from Alban and Kutzin, 2006)**

Since its formation in 1997, the main funder of health care in Lithuania is the National Health Insurance Fund\(^2\) (NHIF, 2008). Compulsory health insurance is funded by employer/employee contributions and state contributions for different groups, including children, retired people and the registered unemployed. Approximately one third of those covered are covered by employer/employee contributions and around two thirds by state contributions. Although the level of benefits are the same, financial contributions by the state per person are much lower than those made by employed people (see Figure 7). For example, in 2008, they were less than one fifth (18%) of per person contributions made by 

\(^2\) Labelled State Health Insurance Fund (SHIF) in Figure 6
employed people. The NHIF’s main way of working is to pay for services to contracted providers. It covers outpatient consultations and inpatient care. However, there are limits to what it will cover. For example, it does not cover all forms of treatment for opportunistic infections. For outpatient services, the agreed price includes three visits and all laboratory tests and investigations (Kriaucia, 2010). This system may create a financial disincentive to providers for conducting expensive investigations because they are not reimbursed separately but have to be paid for from the consultation fee. Some services, e.g. primary health care and mental health care are remunerated on a per capita basis.

Figure 7: Financial contributions to NHIF per person by employed people and from state contributions: 2000-2010 (From NHIF, 2010a)

Under the Health Insurance Law, people living with HIV are automatically covered for all personal health services even if they are not insured (Uždaviniene, 2008). However, they are not covered prior to HIV diagnosis, e.g. for HIV testing. Also, this cover has to be renewed annually although legally there is no requirement for annually renewed diagnosis. Table 3 presents NHIF data on HIV-related services provided from 2007 to 2009.
Table 3: Number of patients receiving HIV-related services through NHIF: 2007-2009

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Patients</th>
<th>Number of In-patient Services</th>
<th>Number of Services (total)</th>
<th>Total Sum (LTL)³</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>190</td>
<td>37</td>
<td>411</td>
<td>52 197</td>
</tr>
<tr>
<td>2008</td>
<td>205</td>
<td>21</td>
<td>504</td>
<td>48 597</td>
</tr>
<tr>
<td>2009</td>
<td>299</td>
<td>24</td>
<td>700</td>
<td>79 048</td>
</tr>
</tbody>
</table>

In addition to the mechanisms mentioned above, the NHIF procures ARVs through a central tender purchasing mechanism. Although costs are high per person (see Table 4), this accounts for only around 0.1% of the NHIF budget of 5b LTL. The NHIF annual budget for compensated drugs was 743m LTL in 2009 (see p35).

Table 4: NHIF annual budget on ART: 2007-2012 (Adapted from Kriauza 2010 – all figures in LTL⁴)

<table>
<thead>
<tr>
<th>Year</th>
<th>NHIF budget allocation for ART</th>
<th>Number of patients</th>
<th>ART cost per person</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>2m</td>
<td>80</td>
<td>25000</td>
</tr>
<tr>
<td>2008</td>
<td>2.5m</td>
<td>120</td>
<td>20833</td>
</tr>
<tr>
<td>2009</td>
<td>2.5m</td>
<td>130</td>
<td>19231</td>
</tr>
<tr>
<td>2010</td>
<td>2.8m</td>
<td>138</td>
<td>20290</td>
</tr>
<tr>
<td>2011⁵</td>
<td>4m</td>
<td>150</td>
<td>26667</td>
</tr>
<tr>
<td>2012⁵</td>
<td>5m</td>
<td>180</td>
<td>27778</td>
</tr>
</tbody>
</table>

Some services are paid directly from the state budget, e.g. confirmatory HIV tests and ART monitoring (CD4 and VL). Funding for the work of addiction centres is particularly complex. Principles for ensuring this funding were established in 2004. There is a dependence disease programme within the NHIF. This covers basic components and ensures that pharmacotherapy with methadone is free for patients. Previously, patients had to pay. Payments existed in some centres until 2004 and in others until 2007. However, centres also receive funds from either the state budget or the municipality. In Vilnius, for example, approximately 10% of the centre’s funding comes from NHIF. A centre’s funding does not depend on the number of people treated. It is reported that a working group was established to explore the possibility of introducing a system of case-based funding. Needle-syringe programmes and low threshold centres are funded as projects by municipalities, UNODC and the Drug Control Department under the Government of the Republic of Lithuania. Such project funding is much more vulnerable to

³ At time of writing 1 Lithuanian Litas (LTL) was worth approximately €0.29
⁴ At time of writing 1 Lithuanian Litas (LTL) was worth approximately €0.29
⁵ All figures for 2011 and 2012 are projected
changes in public and political opinion than funding which is embedded within a system, such as the one operated through NHIF.

NHIF estimates that 1-2% of the population are not insured. It is reported that uninsured people can get emergency care provided they are living permanently in Lithuania. However, data suggests that almost two thirds (65%) of IDU in Vilnius are not insured (Expanded Network, 2009). Social workers at addiction centres help address this by taking IDUs to register as unemployed, because registered unemployed people receive health insurance paid for by the state.

It is reported that the Department of Statistics performed a study that showed that out-of-pocket expenditure accounted for 26-30% of health expenditure. This includes fully private services and co-payment for medicines.

The prison health system (see p26) is funded by a completely different system through a Ministry of Justice budget (Uždaviniene, 2008). Various factors have been identified for lower standards of health care in prisons. These include limited budgets and negative public opinion towards the health of prisoners (Juodkaitė et al., 2008).

Since the start of the financial crisis in 2008, it is reported that the contribution of the working population to the overall health budget fell from 75% to 64% as a result of rising unemployment (WHO et al., 2009a). Responses to the current financial crisis have included:

- Reorganizing public administration looking for efficiency gains through consolidating mandates and reducing number of agencies in the public system.
- Moving from regional administration to the smaller municipalities as administrative focal points.
- Reductions in budgets, e.g. for NHIF (see p35), prisons (see p26) and individual hospitals.

However, there are a number of other areas where cost savings could be realized in ways which would strengthen rather than weaken the response to HIV. These include:

- Greater scaling up of effective prevention programmes for IDU and other key populations because this would result in a reduction in future treatment costs. It is cheaper to provide needle-syringe programmes and pharmacotherapy for IDU than to provide them with ART.
- Reducing the number of HIV tests conducted among HIV negative pregnant women (see p16). A more focused HIV testing policy could
detect the small number of HIV positive pregnant women in Lithuania with a much smaller number of HIV tests.

- A more coordinated approach to ARV purchasing (see p35). At the very least, this would reduce the amount of VAT paid by the Prisons Department when purchasing ARVs (see p28).

**Organizational development of coordinating institutions and service providers**

There are a number of structural and systemic issues which need to be addressed through organizational development of coordinating institutions and service providers if ART is to be provided in a more effective way in Lithuania. Key steps would include:

- Clearly defining the roles and responsibilities of different actors, e.g. different departments of the Ministry of Health.

- Ensuring adequate financial resources for actors to fulfil their roles and responsibilities.

- Building the capacity of the Ministry of Health to lead, coordinate and monitor the national response to HIV.

- Integration of the prison health care system into the general system of the Ministry of Health.

In general, NGOs are weak and appear to have done little work on organizational development, for example the development of strategic plans and fundraising strategies.

**Integration of services**

There are a number of areas where services are not as well-integrated as they could be. Perhaps the most striking relates to prison health services (see p26) which operate completely separately from health services in the community. Key services, such as pharmacotherapy and needle-syringe programmes are not available in prisons. There are concerns that ART may be interrupted on discharge from prisons as those being discharged are only given two days supply of medicines.

It is unclear the extent to which the private sector is providing HIV treatment services as no information from that sector is collected nationally.

Links between HIV treatment services and those treating drug dependence could be stronger. In Lithuania, drug treatment services are provided as outpatient
services through primary health care facilities, mental health centres, psychiatric clinics and private centres. Inpatient services are provided through addiction centres in Vilnius, Klaipeda, Siauliai, Panevezys and Kaunas. Drug-free programmes include outpatient services in Vilnius, Panevezys and Kaunas. There are 17 long-term drug rehabilitation centres with 312 places. Numbers of people in these centres rose from 319 in 2005 to 510 in 2008. Pharmacotherapy is provided in centres in Vilnius, Klaipeda, Kaunas, Druskininka, Panevezys, Telsiai (from 2007), Kedainiai (from 2007), Mazeikiai (from 2008), Solute (from 2008) and Siauliai (from 2009). Numbers receiving pharmacotherapy varied from 436 in 2004, 410 in 2005, 381 in 2006, 395 in 2007 and 512 in 2008 (EMCDDA and Drug Control Department under the Government of the Republic of Lithuania, 2009). Vilnius Centre for Addiction Disorders reports that 562 people were receiving pharmacotherapy by the end of 2009 (Anonymous, 2010a).

Figure 8: Number of patients receiving pharmacotherapy for drug dependence in Lithuania: 2004-2009

Funding mechanisms for HIV treatment services and those treating drug dependence are different (see p30). Although addiction centres can supply methadone to people admitted to other hospitals, the situation is complex. There are, however, some examples of good practice. For example, the addiction centre in Vilnius operates a team approach with a social worker acting as a case manager for 30 patients. The team includes a psychiatrist, psychologist and nurse. The case manager mediates with other hospitals, the labour exchange, NHIF and on legal and educational issues. The centre also collaborates with NGOs. However, this positive experience of case management has not been

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6 Information about sites in Panevezys and Kedainiai provided by Vilnius Centre for Addiction Disorders and confirmed by UNODC project office.
widely practiced in other cities of Lithuania. ART and pharmacotherapy are available in one location for outpatients in Vilnius Central Polyclinic. This was reported to have been a positive development following the restructuring of the Lithuanian AIDS Centre in 2009 (see p13). There are severe limitations on availability of HIV tests through addiction centres (see p17). This failure to offer HIV tests to all IDUs on each contact with the health services is a significant missed opportunity.

Historically, HIV and TB services have been provided separately in Lithuania. There have been some steps to address this. For example, in Vilnius, the infectious diseases hospital and four TB hospitals have been integrated into one hospital.

**Involvement of PLHIV**

There is a national network of PLHIV in Lithuania. They have a headquarters in Vilnius and three branches in other locations in Lithuania. They have around 20 active members excluding clients and people contacted through their website. They also reach out to Lithuanians outside of the country. Members provide counseling services and the network is planning a brochure for PLHIV.

This network was actively involved in drafting the new HIV programme (see p13) and was also represented on the coordination council for the previous national HIV programme. However, PLHIV within this network report that their views are not taken seriously by government and they feel largely ignored.

The network produced a report highlighting its concerns related to Lithuania’s response to HIV prior to this review (Lithuanian Network of People Living with HIV/AIDS Positive Life, 2010). These concerns included:

- Low coverage of ART (see p19)
- Limited access to ART in prisons (see p26)
- Reduced hours of medical services (see p19)
- No free-of-charge access to blood tests, including HIV testing (see p19)
- Lack of other services, such as counselling, psychosocial support and palliative care (see p41)
- Low threshold centres being forced to close because of lack of funding (see p16)
- A lack of activities for MSM

The network is concerned to ensure that all activities on HIV in Lithuania are not provided for IDUs only. There is also a need for services for PLHIV, in general, and MSM, in particular.
ARV drug procurement and prices

Lithuania purchases a number of drugs, e.g. ARVs and some oncological drugs through a centralized budget administered by the NHIF. In 2009, the total budget for central procurement of drugs was 75m LTL\(^7\). The budget for ARVs was 2.8 million LTL (see Table 4, p32). This budget accounts for less than 0.1% of the total budget of the NHIF and less than 0.3% of the total NHIF drugs budget (see p32). This purchase is done through a public tender according to national legislation. In addition, the Ministry of Justice also purchases ARVs for use in the prison system (see p26 and p30).

The NHIF budget provides ARVs for 138 people (see Table 4, p32). However, there are estimates that more people need/will need ART (see p19). According to some of these estimates, Lithuania needs to provide ART for 800-1 000 people. If this were the case, the budget would need to increase six-fold if prices remained unchanged. This would require NHIF to spend nearly 2% of its drugs budget on ART. Currently, the Ministry of Justice is purchasing ARVs for 20-25 people.

Over the past 10 years, the NHIF’s medicines budget for ambulatory care has been gradually growing. In 2009, this amounted to 743m LTL\(^8\). However, due to the financial crisis, the budget for 2010 has been reduced to 643m LTL. Measures proposed to make these cuts and make medicines use more efficient include:

- Addressing issues of pricing and reimbursement of medicines
- Reducing wholesale margins
- Controlling the sales of medicines
- Promoting rational prescribing by doctors

Apart from those medicines procured centrally by NHIF, hospitals buy medicines directly. They cover the costs of these medicines from the service costs they receive from NHIF. Hospitals can decide which drugs to buy. There is not a single national list to determine the subsidy for medicines in the whole health sector, only for the outpatient system. The estimated annual expenditures on medicines in hospitals is 100-200m LTL.

Lithuania’s State Medicines Control Agency (Jankunas, 2010) is responsible for registration of pharmaceuticals in the country and for monitoring their consumption. In general, pharmaceuticals are authorized by the European Commission or by an individual country. For HIV medications that involve a new active substance, these need to be authorized by the European Commission.

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\(^7\) At time of writing 1 Lithuanian Litas (LTL) was worth approximately €0.29
\(^8\) At time of writing 1 Lithuanian Litas (LTL) was worth approximately €0.29
Hospitals can purchase unlicensed medicines for their patients, as long as they and their physicians assume responsibility for this. Indeed, the State Medicines Control Agency reports that some hospitals do use this approach to purchase some medicines directly from manufacturers abroad.

Currently, Lithuania is paying prices for ARVs that are in the range paid by other EU countries (NHIF, 2010b). However, these prices are significantly higher than those paid by other middle income countries outside the EU and in some cases are higher than in Western European countries (WHO, 2010). This situation is the result of the price convergence of patent-protected medicines in the EU countries, and the absence of generic ARVs in the EU market.

The issue of affordability of ARVs in the new EU member states has been under discussion for many years. Both WHO and the European Commission have convened numerous meetings on the topic. The German EU presidency in 2007 specifically addressed the issue, and adopted the Bremen declaration calling for universal access to treatment and care for AIDS patients and increased access to ARVs.

In 2009, ARVs purchased by NHIF had a discounted VAT rate of 5%. However, this reduction is scheduled to end at the end of 2010. It would be important to maintain and extend this VAT reduction to include ARVs purchased for use in prisons (see p26). WHO recommends reducing the VAT rate for centrally-purchased and reimbursed medicines even further to zero.

However, high prices for ARVs do not currently present a major affordability problem for NHIF as they represent only a very small portion of total drug spending (<0.3%). However, if the number of people requiring ART increased significantly, the burden would be higher and would make the need for containing costs more urgent. The current adverse financial climate and the reduction in budget available to NHIF for drugs overall also provide incentives for more rational ARV prescribing and for price reductions. Issues relating to treatment regimens and rational prescribing are discussed elsewhere (see p42).

Options available to Lithuania to purchase ARVs at lower prices may include the following:

- Lithuania is member of the World Trade Organization and a signatory to the TRIPS agreement. This allows countries a set of safeguards to guarantee access to medicines by facilitating the entry of generics into the market. The government can decide to use these safeguards for public health reasons. EU legislation in its articles 5, 6 and 126 allows possibilities for the import of unlicensed medicines, including generics, for ‘justified public health reasons’ and these articles could be used in principle for importing cheaper drugs from outside the EU.
• It is not clear which ARVs have a valid patent in Lithuania and this may need to be clarified. As patents on ARVs start running out, companies producing generic products will be able to register these on the EU and Lithuanian market.

• Parallel import from other EU countries where ARVs prices may be lower. Information on ARV prices in other countries is available through existing European networks on medicines pricing and reimbursement.

• Direct negotiations with industry, particularly if combined with price comparisons with other EU countries. However, it is reported that direct negotiation and purchasing from manufacturers is not permitted under Lithuania’s public procurement law. Currently, the Ministry of Health and NHIF already make some price comparisons, e.g. with Latvia, Poland, Czech Republic, Slovakia, Bulgaria and Romania. However, it is reported that companies are reluctant to offer Lithuania lower prices because of the country’s status as a ‘reference’ country. Companies fear that lower prices in Lithuania and other new EU countries would lead to lower prices elsewhere. It was reported that companies may insist that information on lower prices is not shared with other countries or they provide some medicines free rather than reduce the price of their products.

• Exploring possibilities for direct hospital purchases or direct import by NHIF from outside the EU on a named-patient basis. EU legislation in its articles 5, 6 and 126 allows possibilities for the import of unlicensed medicines, including generics, on a named patient basis by hospitals and these articles could be used in principle for importing cheaper drugs from outside the EU.

This issue is politically highly sensitive, and it is recommended to re-start the discussions at the EU level. However, it may be appropriate to indicate that if no solution is forthcoming at that level, individual countries could well use the existing EU legislation and national legal means to lower the cost of medicines that are needed to treat HIV. This is a crucial issue for the EU. The future cost of not controlling the HIV epidemic in Baltic States will be much higher than ensuring access to ARVs now.
Access to HIV Treatment and Care, Coverage and Quality of Services.

Health care of PLHIV

In 2009, a major review of services for PLHIV was conducted (Gurevičius et al., 2009) involving in-depth interviews with 20 PLHIV. This recognized a range of experiences relating to:

- Personal environment
- Educational environment
- Labour market
- Health care system
- Other settings including housing, social work and prisons

One major concern expressed by PLHIV and NGOs was the need for IDUs wishing to access addiction services to register as an ‘addict’. Being included in this register has implications, such as not being allowed to drive. Once registered, names remain on the register for three years for those dependent on alcohol and for five years for those dependent on illegal drugs. It is reported that IDUs are ‘afraid’ of that registry and some go to private services to avoid being registered. Fear of discrimination against PLHIV is reported as a major barrier for people to access health services.

PLHIV and NGOs also expressed concerns about recent moves to integrate HIV-related services into the general health services. One NGO commented ‘The patients are in the general healthcare system, which doubled by stigma at the medical setting and corruption, places PLHIV/IDUs at a lost position of a patient who is not needed and not welcome to treat.’ PLHIV reported that their needs were specific enough to merit special, separate services. There are concerns that GPs lack sufficient knowledge to treat PLHIV, not only for HIV, but also for drug dependence, hepatitis C, tuberculosis and STIs. In addition, the current system makes it unclear as to where to get information and services. PLHIV have concerns about the confidentiality of their medical records and the ability of individual medical centres to adhere to internationally-recognized standards of treatment and care. PLHIV would like to see teams of specialists in primary and secondary centres able to offer a range of services to PLHIV in an integrated manner. Such specialists would need to include an addiction specialist, an infectious diseases doctor, a TB doctor, a psychologist and a counsellor.

Particular concerns were raised about the lack of social workers and psychologists to work with PLHIV and the limited number of doctors who were sensitive to the issues of PLHIV. Concerns were also raised about the lack of services for PLHIV who are not IDUs.

NGOs raised concerns that PLHIV are being asked to pay for a wide range of services including laboratory tests, such as a CD4 count. This is reported to cost
around 100 LTL. There are also concerns that NHIF does not cover full costs of treatment for opportunistic infections (Centre for Communicable Disease and AIDS, 2010b). Other services that need to be paid for include gynaecologist services, STI treatment, cervical smears and HIV/hepatitis C viral load and hepatitis C genotyping.

However, NGOs expressed the view that the majority of those in need had access to ART, paediatric AIDS treatment, STI management, HIV testing and counselling for TB patients, TB screening for HIV-infected people and post-exposure prophylaxis. This was not the case for other services, including nutritional care, psychosocial support for PLHIV and their families, home-based care, palliative care and treatment of common HIV-related infections, TB preventive therapy for HIV-infected people, Cotrimoxazole prophylaxis in HIV-infected people and HIV care and support in the workplace.

**Psychosocial support to PLHIV and case management**

Organizations of PLHIV are concerned that key services such as pre- and post-counselling, peer counselling, psychosocial support, case management and palliative care for PLHIV largely still do not exist. (Lithuanian Network of People Living with HIV/AIDS Positive Life, 2010). Limited peer counselling is available through Positive Life outreach counselors in three sites, funded through a UNODC regional project.

**Physical accessibility to treatment**

ART is reported to be available in the major cities of Lithuania, i.e. Vilnius, Kaunas, Klaipeda, Panevezys and Siauliai. A recent report commented that these locations make it ‘possible to embrace the entire territory of Lithuania’ (Uždaviniene, 2008). Methadone is reported to be available in 11 of the country’s 60 municipalities (5 biggest cities and Vilnius region, Druskininkai, Kedainiai, Telsiai, Silute, Mažeikiai municipalities). Expansion of pharmacotherapy sites has been strongly supported by a UNODC regional project (Drew, 2009). Concern was expressed about the ability of PLHIV in small towns to access information and services.

**Principles of equity and non-discrimination**

Although Lithuania aims to promote principles of equity and non-discrimination, these are undermined in a number of ways. For example, the negative public attitude towards services for injecting drugs users, in general, and for harm reduction services, in particular, means that gains made in expanding essential services, such as pharmacotherapy and needle-syringe programmes risk being undermined through political interference in these essential health programmes.
Compliance with WHO clinical protocols and good practice

Guidelines on ART provision are important. They help ensure the appropriateness of treatment provided by defining which ARVs should be used, in which combinations and when. Access to effective ART will be enhanced when appropriate guidelines are in place and those guidelines are followed. Good practice will include patient monitoring focused on ensuring that the treatment provided has been effective.

Lithuania first developed guidance for the provision of ART in 2004 (Minister of Health, 2004). These were revised in 2009 by a group involving clinicians and NHIF, but these guidelines have not yet been formally adopted (Minister of Health, 2010). Although the NHIF reported that the content of the guidelines had largely been determined by clinicians, the reverse was reported to be the case by clinicians, who reported that key issues, such as at what CD4 count level to start treatment, had been determined on financial grounds by NHIF. Public health specialists were not involved in formulation of the guidelines. There are some issues with the proposed guidelines:

- The guidelines do not conform with international standards (WHO, 2009) on initiating treatment for all PLHIV with a CD4 count less that 350 cells/mm$^3$. A recommendation that this should be done (Uždaviniene, 2008) has not yet been implemented.

- It is a legal document, focused on defining which ARVs can be purchased by NHIF. In addition to such a document, there is need for a separate document providing guidelines to medical practitioners on which ARVs to use when.

- The guidelines do not give clear and stepwise guidance on which ARVs to use. Rather, they are more a presentation of options with too many choices and no clearly presented treatment steps.

- The emphasis on the need for willing and motivated patient seems to overlook the role of health workers in motivating the person in need of treatment.

- There is little information about antiretrovirals for PMTCT and PEP. In particular, there is no provision for non-occupational PEP. There is a need for guidelines to cover issues relating to PMTCT, management of opportunistic infections, management of HIV/hepatitis B, HIV/Hepatitis C coinfections, management of HIV-infected IDUs, sexual and reproductive health, paediatric ART, immunization for PLHIV, and PEP.
• A number of critical issues with respect to ART in adults are not addressed in the guidelines. These include:
  o Counselling and preparedness of patients for ART
  o Decisions with regards to first line and second line regimens including deciding on what constitutes treatment failure and when to switch regimens.
  o Clinical and laboratory monitoring of patients
  o Monitoring of adherence
  o Management of ARV toxicity and side effects

Although the guidelines were developed through a working group involving medical specialists and representatives of the NHIF, there does not appear to be a clear development process with a structured committee with defined terms of reference and a systematic approach to identifying the scope of the guidelines, the retrieval of evidence, the formulation of recommendations, peer review and a clear decision-making process regarding the final recommendations.

It is also not clear how final purchasing decisions are made based on these guidelines. NHIF report that they follow the recommendations of medical specialists on which ARVs to buy and in what quantities. However, clinicians report that their recommendations are not followed, and that NHIF, in consultation with the Ministry of Health, purchases cheaper ARVs because of budgetary constraints.

Currently-applied treatment schedules are reflected in the 2010 procurement plan for ARVs, provided by NHIF (see Table 5). This shows 21 ART regimens for 135 patients. Although some patients are on recognized first line treatment regimens, according to WHO guidance, there is still wide variation. Particular concerns about the treatment regimens include the following:

• Planned ART regimens do not allow any evaluation of ART successor failure because of failure to distinguish between first and second line ART regimens.

• Only just over one third (36%) of patients are expected to receive first line ART, as recommended by WHO, that is two NRTIs and one NNRTI.

• A significant number of patients are expected to receive PI-based regimens (55%). Although this could reflect failure of NNRTI-based ART, this seems unlikely at this scale. It is more likely to reflect physicians’ preferences as evidence by the use of five different PIs. This lack of a strategic approach to ARV prescribing has significant budgetary implications with more expensive medicines being procured and used.
Ten patients are expected to receive combinations of ARVs not recommended by WHO. These include three NRTIs, unboosted PIs and a combination of one NRTI with two PIs.

Two patients are expected to receive the most expensive PI, Darunavir, which is recommended by WHO for use only as part of a ‘salvage’ when resistance to other PIs has been confirmed.

There are a number of issues on specific drugs:

- The HLA-B*5701 test is performed only if it is provided by GlaxoSmithKline, not provided by the state. A case was reported when a patient was prescribed Abacavir, the test was not performed before starting treatment. After developing severe adverse respiratory symptoms the treatment was stopped and when the test was available it was performed showing hypersensitivity to Abacavir.
• The fixed combination of Tenofovir and Emtricitabine will only be introduced as a first-line drug in 2011 or 2012.

It appears that there is a need for a more coordinated and strategic approach to treatment regimens. Clinicians appear to make their choice of ART based on personal preferences rather than on an evidence-based strategy. Clinicians indicated that treatment failure is rare, and few patients need to be shifted to second line treatment.

The review team asked for more data about ART in Lithuania including the number of PLHIV currently alive, the number of PLHIV seen by medical services at least once per year because of HIV infection, the number of PLHIV who initiated treatment, the number of PLHIV discontinuing ART and the reasons for stopping. However, the Ministry of Health has indicated that it can not provide these figures.

**Monitoring, evaluation and quality assurance systems**

Although the new Centre for Communicable Diseases and AIDS is playing a key role on HIV epidemiology, some concerns were raised about difficulties in professionals gaining access to this information. It appears that such requests are processed very slowly and in an excessively bureaucratic manner. Clearly, this epidemiological information is of huge importance in guiding the focus of the national response to HIV. It is essential that this be seen as public information which is widely shared, rather than the exclusive property of one or more specific individuals.

Civil society reports feeling excluded from monitoring processes (Anonymous, undated, a). Although claims were made internationally that NGOs would be involved in monitoring of the Dublin Declaration, this did not happen. Although NGOs were asked to fill in part of the UNGASS report, they did not see the final report before it was submitted.

NGOs also expressed concern about the lack of ARV resistance testing. However, it is reported that this is available after the second treatment failure. No-one has overall responsibility for the quality assurance of key services, such as harm reduction programmes. Consequently, this role falls largely to funders. It would be more appropriate for this role to be carried out by the Ministry of Social Security and Labour or the Drug Control Department under the Government of the Republic of Lithuania for needle-syringe programmes and by Ministry of Health for pharmacotherapy of drug dependence.

Currently, no public health analysis is conducted from the individual patient treatment records, including analysis of:

• ARVs used as the first line regimen
• History of different regimen use
• Duration of first line treatment after its initiation
• Reasons and time after initiation of treatment for regimen switches
• Drop-out rates and reasons
• Follow-up
• Compliance
• Death rates

However, a national patient monitoring system, such as the one that exists in the Netherlands, would be possible in Lithuania, because of the small size of the country and the patient numbers. Since many different treatment schemes have been used in Lithuania, it would be a good opportunity to compare the outcomes of different regimens.

There is currently no system for HIV drug resistance prevention, monitoring and surveillance. This would require a focus on early warning signs by monitoring:

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

WHO recommends forming a national committee or working group on HIV drug resistance. This should include experts responsible for HIV surveillance, HIV care and treatment and an HIV drug resistance laboratory. Specific action points for this group are listed in Annex 5 (p65).

WHO does not recommend individual HIV drug resistance testing until a national HIV drug resistance strategy is in place. Testing for treatment decisions is only needed if the second line treatment fails without an identified reason9 (WHO, 2009).

Independent quality assurance schemes for services are not yet established. In order to improve quality of services provided, the emergence of hepatitis C as a serious public health issue has to be addressed because most cases of hepatitis C occur among IDUs.

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9 Such as poor adherence or adverse drug reaction/interaction
CONCLUSIONS

Lithuania has a significant HIV epidemic, concentrated among injecting drug users. HIV transmission among injecting drug users is continuing, including within Lithuania’s prison system.

The government’s initiative in 2009 to begin restructuring the national response to HIV by forming the new Centre for Communicable Diseases and AIDS is extremely welcome. However, there is need to further clarify the roles and responsibilities of different bodies. It is highly appropriate that the Public Health Department of the Ministry of Health take a lead technical and supervisory role in the national response to HIV. However, to do this, it will need enhanced capacity and a budget overview. It would be helpful if Lithuania developed a strategic action framework for its entire response to HIV. This would need to go beyond the scope of the proposed National AIDS Programme, which does not cover all aspects of the response, e.g. care and treatment. It would also be helpful for there to be a coordination body which included representatives of all concerned ministries, e.g. Ministry of Justice and Ministry of Social Security and Labour and representatives of civil society and PLHIV. Adopting a more strategic and focused approach to the response to HIV would allow for efficiency savings to be made, e.g. by ensuring more integration of financial flows, e.g. by procuring all ARVs through central NHIF procurement, including those for use in prisons.

This could be a useful first step in greater integration of prison and general health system. It might be useful for Lithuania to examine lessons from other countries relating to integration of prison and general health systems. Several countries have successfully moved in this direction. Examples include Norway, France, Spain, Georgia and England and Wales. In the last case, the process took around 5 years and was well-documented.

Based on official figures, only just over half of those people needing ART currently receive it. Of those on treatment, many started late because they were diagnosed late. In 2008, more than one third of those with a CD4 count at the time of diagnosis were already in need of treatment at the time of diagnosis. As the number of new HIV diagnoses is continuing to increase, the number of people needing treatment in Lithuania will continue to rise. Given all of this, there is a need to further scale-up the provision of ART in Lithuania. This scale-up is likely to involve recruiting other actors to play a role in treatment provisions, e.g. working with NGOs to prepare people for treatment and to provide support to their adherence once treatment has started. It should also involve further integration of different services including ART, TB treatment and pharmacotherapy of drug dependence. There is a pressing need to address barriers for treatment, such as limited service hours and the current addiction registry. There is a need for continuity of services between prisons and the community. There is a need to increase the capacity of health care workers who,
following decentralization of services, are expected to provide HIV treatment and care.

Although Lithuania has guidelines for ART, these need to be updated to reflect best practice internationally. In particular, this should include the commitment to provide treatment to all those with a CD4 count below 350 cells/mm$^3$. The guidelines should clearly outline the first and second-line regimens to be used in Lithuania including clear strategies for switching regimens. There is a need to clearly link guidelines, ART regimens and ARV procurement. The high cost of ARVs in Lithuania is largely related to being part of the single European market. However, a number of possible options for reducing price could be explored. Guidelines reflecting other health needs of PLHIV should also be developed.

Although Lithuania has some HIV-related services for IDUs, these are not yet provided at sufficient scale to halt the spread of the epidemic in the country. Access to HIV testing needs to be improved. IDUs should be offered a free HIV test at every contact with health and social services. It is of extreme concern that public and political opinion in Lithuania fail to recognize the importance of HIV prevention among IDU in the country, not only for IDUs themselves, but as a way of reducing risk of spread of HIV to the general population. Not only do existing needle-syringe and pharmacotherapy programmes need to be maintained, they need to be further expanded. There are continued systemic barriers for IDUs receiving the services they need. These include negative attitudes of staff towards IDUs and the punitive system of registering drug users still used in Lithuania. These barriers need to be identified and addressed. IDUs themselves should not be blamed for non-uptake of services. Rather, it is the responsibility of the service provider to make the services more accessible. Continuity of these services is needed, particularly for those IDUs in the prison system. Lithuania needs to plan and prepare for the expected increase in IDUs requiring ART in the near future.

Although the number of HIV tests conducted in Lithuania has been increasing, this is largely among blood donors, pregnant women and prisoners. There is need for the government to adopt a more strategic approach to HIV testing. This should include free tests for those most vulnerable to HIV infection, namely IDUs, MSM and sex workers. There is need to ensure all opportunities are taken to offer HIV testing to IDUs. This could include ensuring that Low Threshold Centres can offer tests to their clients. Resources for additional testing among IDUs could be obtained by efficiency savings on unnecessary tests, e.g. by detecting same number of HIV positive pregnant women with fewer tests.

The essential and vital role played by civil society in responding to HIV is acknowledged in Lithuania. However, there is no shared understanding of the roles that civil society should play. Such roles are likely to include advocacy and, reaching key populations to build trust, provide entry into health system and to
ensure continued engagement with services. In addition, there is no predictable, long-term funding for NGOs, e.g. through the state. As a result, NGOs are highly-focused on securing short-term, project funding. They have extremely limited capacity and little long-term or strategic focus.

RECOMMENDATIONS

1. Lithuania need to **expand HIV-related services** for those populations particularly affected by the epidemic, such as IDU. These services need to include needle-syringe programmes, pharmacotherapy of drug dependence and improved access to HIV testing.

2. Lithuania needs to **clarify roles and responsibilities** of the key actors in the national response to HIV. This should include development of a clear and comprehensive strategic action framework and the establishment of a multi-stakeholder coordination body which has a remit beyond one project or programme.

3. Lithuania needs to **expand the provision of ART** to all who need it both now and in the future. Steps to be taken to ensure this include:
   
   - A more strategic approach to HIV testing ensuring that IDU are offered a free HIV test on each contact with health and social services
   - An integrated approach to ART provision in prison and community health services, including joint ARV procurement
   - Ensuring treatment is provided to all those with a CD4 count below 350 cells/mm$^3$
   - Ensuring more equitable access to ART for IDU, for example by reforming the current addiction registry
   - Expanding hours available to see doctors
   - Expanding role of NGOs in treatment preparedness and adherence support

4. There would be huge benefits in **integrating the health services provided in prisons and the community**. A useful first step would be joint centralized procurement of ARVs through the NHIF.

5. There is a need to ensure that the **ART guidelines** reflect international best practice, including starting treatment for all who have a CD4 count below 350 cells/mm$^3$ and ensuring clear distinction between first and second line regimens. Guidelines reflecting other health needs of PLHIV should be developed.
ANNEX 1: SCHEDULE OF PEOPLE INTERVIEWED

Evaluation of the Access to HIV/AIDS Treatment and Care in Lithuania
March 22 - March 26, 2010
Vilnius

Composition of the mission team:
Ulrich Laukamm-Josten, Communicable Diseases Unit, WHO/EURO (Team leader)
Irina Eramova, Senior Medical Officer, Care and Country Support, WHO/EURO
Kees de Joncheere, Regional Adviser Health Technology and Pharmaceuticals, WHO/EURO
Luis Mendao, Vice-chair of European AIDS Treatment Group (EATG)
Signe Rotberga, Regional Project Coordinator UNODC Project Office for the Baltic States
Maria Skarphedinsdottir, Health Policy and Aid Coordination, WHO/EURO
Roger Drew, Health and Development Consultant, UK (also Report Editor)

Monday, March 22

Venue: Ministry of Health of the Republic of Lithuania (MoH). (Address: Vilnius str.
33, Room No.318)
15.00 – 17.00 Introduction to the Mission
Working Language: English

Participants:
Romalda Baranauskienė, Director of Health Care Department MoH
Viktoras Meižis, Head of EU Affairs and Foreign Relations Division MoH
Rima Vaitkienė, Deputy Head of EU Affairs and Foreign Relations Division MoH
Daiva Dudutienė, Chief specialist of EU Affairs and Foreign Relations Division MoH
Alvyda Naujokaitė, Chief Specialist of Health Care Department MoH
Audrius Ščeponavičius, Director of Public Health Department MoH
Loreta Ašokliena, Deputy Head of Public Health Strategy Division of Public Health Department MoH
Gita Kruškinienė, Director of Department of Pharmacy MoH

Monday, March 22
Jolanta Iždonienė, Director of Health Policy and Economics Department MoH
Virginija Ambrasevičienė, Head of Health Policy Division of Health Policy and Economics Department MoH
Saulius Čaplinskas, Director of Center for Communicable Diseases and AIDS under the MoH
Gintautas Barcys, Director of State Medicines Control Agency under the MoH
Algis Sasnauskas, Director of State Patients’ Fund under the MoH
Vytautas Kriausza, Deputy Director of State Patients’ Fund under the MoH

Issues to cover:
- clarification on mission’s tasks and expected results, time schedule. Signe Rotberga, Ulrich Laukam-Josten
- national HIV policy. Audrius Ščeponavičius (tbc)
- national funding plan and financial flow for HIV testing and treatment. Algis Sasnauskas (tbc)
- registration and distribution of medications. Gintautas Barcys, Algis Sasnauskas

Tuesday, March 23

9.00 – 11.00 State Patients’ Fund under the Ministry of Health
(Address: Kalvarijų str. 147)
Participants:
Algis Sasnauskas, Director
Vytautas Kriausza, Deputy Director
Rima Vaitkienė, Deputy Head of EU Affairs and Foreign Relations Division MoH

11.30 – 13.30 National Tuberculosis and Infectious Diseases University Hospital
(Address: Birutės str. 1/20)
Participants:
Arvydas Šilys, Director
Arvydas Ambrozaitis, Professor, Head of the Clinic of Infectious Diseases, Dermatovenerology and Microbiology of Vilnius University
Alvyda Naujokaitė, Chief Specialist of Health Care Department MoH

13.30 – 14.30 Lunch

15.00 – 17.00 Meeting with NGOs at UNODC Project Office
(Address: Goštauto str. 40A)
Participants:
Svetlana Kulsis, Demetra
Jurgis Andriuška, Positive life
Ramūnas Ragalinskas, Lithuanian positive group
Janina Kulšienė, Social Risks Prevention Centre
Jurgita Poškevičiūtė, Coalition “I can live”
Anna Zakowicz, EATG
Rūta Šulcaitė, EHRN  
Loreta Stonienė, National Project Officer  
Rima Vaitkienė, Deputy Head of EU Affairs and Foreign Relations Division MoH

**Wednesday, March 24**

**10.00 – 12.30 Ministry of Justice**  
(Address: Gedimino ave. 30 / A.Stulginskio str.1)  
Participants:  
Gytis Andriulionis, Vice-minister  
Marius Rakštėlis, Superior of Division of Criminal Justice of Administrative and Criminal Justice Department Ministry of Justice (MoJ)  
Saulius Vitkūnas, Director of the Prison Department under the MoJ  
Kęstutis Širvaitis, Deputy Director of the Prison Department under the MoJ  
Vladas Kasperūnas, Head of Health Care Division of the Prison Department under the MoJ  
Gediminas Berūkštis, Director of the Prison hospital  
Rima Vaitkienė, Deputy Head of EU Affairs and Foreign Relations Division MoH  
Viktoras Meižis, Head of EU Affairs and Foreign Relations Division Ministry of Health

**12.30 – 13.30 Lunch**

After lunch team of experts will be divided into two groups:

| 14.00–17.00 | Prison  
(Address: Rasų str. 6)  
Participants:  
Kęstutis Širvaitis, Deputy Director  
Vladas Kasperūnas, Head of Health Care Division  
Gediminas Berūkštis, Director of Prison hospital  
Rima Vaitkienė, Deputy Head of EU Affairs and Foreign Relations Division MoH | 14.00–15.00 | State Medical Audit Inspection under the Ministry of Health  
(Address: A.Smetonos str. 5)  
Participants:  
Ramunė Navickienė, Director  
Daiva Dudutienė, Chief specialist of EU Affairs and Foreign Relations Division MoH |
|---|---|---|---|
| 16.00-17.00 | State Health Care Accreditation Agency under the Ministry of Health  
(Address: Žalgirio str. 92)  
Participants:  
Juozas Galdikas, Director  
Daiva Dudutienė, Chief specialist of EU Affairs and Foreign Relations Division MoH |
Team of experts will be divided into two groups:

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<tr>
<th>Time</th>
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<tr>
<td>9.00-10.30</td>
<td><strong>Vilnius Centre for Addictive Disorders</strong></td>
<td><strong>The State Medicines’ Control Agency under the Ministry of Health</strong></td>
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<td>(Address: Gerosios Vilties str. 3)</td>
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<td><em>Emilis Subata, Director</em></td>
<td><em>Gintautas Barcys, Director</em></td>
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<td><em>Algirdas Mižutavičius, Deputy Director</em></td>
<td><em>Daiva Dudutienė, Chief Specialist of EU Affairs and Foreign Relations Division MoH</em></td>
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<td><em>Odeta Vitkuniene, Chief Specialist Health Care Department, Ministry of Health</em></td>
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<td><strong>The State Medicines’ Control Agency under the Ministry of Health</strong></td>
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<td><em>Gintautas Barcys, Director</em></td>
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<td><em>Daiva Dudutienė, Chief Specialist of EU Affairs and Foreign Relations Division MoH</em></td>
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<td>11.00-12.30</td>
<td><strong>Vilnius Centrum Polyclinics</strong></td>
<td><strong>Commission for Prevention of Drug and Alcohol Addiction of the Seimas of the Republic of Lithuania</strong></td>
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<td>(Address: Pylimo str. 3/1)</td>
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<td><em>Kęstutis Štaras, Director</em></td>
<td><em>Audronė Astrauskiienė, Director</em></td>
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<td><em>Vilma Uždavinienė, Family doctor</em></td>
<td><em>Daiva Dudutienė, Chief Specialist of EU Affairs and Foreign Relations Division MoH</em></td>
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<td><em>Raimonda Matulionytė, Infectologist</em></td>
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<td><em>Rima Vaitkiienė, Deputy Head of EU Affairs and Foreign Relations Division MoH</em></td>
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<td>12.30-13.30</td>
<td><strong>Lunch</strong></td>
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<td><strong>Vilnius Territorial Patients’ Fund</strong></td>
<td><strong>Committee on Health Affairs of the Seimas</strong></td>
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<td><em>Vytautas Mockus, Director</em></td>
<td><em>Antanas Matulas, Member of the Parliament, Chairman of the Committee</em></td>
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<td><em>Kęstutis Speičys, Deputy Director</em></td>
<td><em>Ana Bernotiene, Head, Office of Health Affairs Committee,</em></td>
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<td><em>Daiva Dudutienė, Chief specialist of EU Affairs and Foreign Relations Division MoH</em></td>
<td><em>Jolanta Bandziene, Egidijus Jankauskas</em>, Advisers, Office of the Health Affairs Committee,*</td>
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<td><em>Saulius Čaplinskas</em>, Director of the Centre for Communicable Disease and AIDS,*</td>
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<td><em>Viktoras Meižis</em>, Head of EU Affairs and Foreign Relations Division MoH*</td>
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<td>15.30-17.00</td>
<td><strong>Centre for Communicable Diseases and AIDS under the MoH</strong></td>
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(Address: Nugalėtojų str. 14D)

Participants:
Saulius Ėaplinskas, Director
Oksana Strujeva, Head of
HIV/AIDS/STI Epidemiological
Surveillance Division
Loreta Ašoklienė, Deputy Head
of Public Health Strategy
Division of Public Health
Department MoH
Alvyda Naujokaitė, Chief
Specialist
of Health Care Department MoH

Friday, March 26

Venue: Ministry of Health (Address: Vilnius str. 33, Room No.318)

8.30 - 10.00 Debriefing at the Ministry of Health
Working Language: English/Lithuanian

Participants:
Nora Ribokienė, Viceminister
Representatives from the Ministry of Health, national experts, including NGOs, met in
previous days.
ANNEX 2: DOCUMENTS REVIEWED


Anonymous (undated, a) *National Composite Policy Index: Part B: 2010*

Anonymous (undated, b) Document entitled *Evaluation of Access to HIV/AIDS Treatment and Care in Lithuania* which gives details of the institutions involved in the HIV response

Anonymous (undated, c) Unlabelled slides showing median CD4 count at time of starting ART [Lithuanian]


ASAP (undated) *ASAP Review of the National HIV/AIDS Programme of Lithuania 2009-2012*

Ašokliene, L. (2010) *HIV Policy in Lithuania* PowerPoint presentation to evaluation team


Centre for Communicable Disease and AIDS (2010b) *Overview of HIV/AIDS Epidemic*


EMCDDA (undated) *Table INF-104. HIV Infections Newly Diagnosed in Injecting Drug Users, by Country and Year of Report, 1992 to 2007: Part(i)- (a) Cases per Million Population, (b) Number of Cases and (c) Population Sizes* Excel file


Jankunas, R. (2010) *Marketing Authorisation and Consumption of Medicinal Products used for the Treatment of HIV* PowerPoint presentation to evaluation team


Kriaūza, V. (2010) *Resources from National Health Insurance Funds Budget Allocated for HIV/AIDS Treatment* PowerPoint presentation to evaluation team
Lithuanian Network of People Living with HIV/AIDS Positive Life (2010) *Appeal to International Community*


Minister of Health of the Republic of Lithuania (2004) *Order on Approval of Methods for Diagnosis and Outpatient Treatment of Diseases Invoked by Arthritis, Human Immunodeficiency Virus, Chlamydia Trachomatis, Budgeted by the Obligatory Health Insurance Fund*

Minister of Health of the Republic of Lithuania (2010) *Orderliness Schedule of the Diagnostics and Treatment of Human Immunodeficiency Virus Infection Budgeted by the Obligatory Health Insurance Fund* Unapproved draft


National Health Insurance Funds (2008) *Patients Funds: Overview of 2007*

National Health Insurance Fund (2010a) *Extract of the NHIF Presentation* PowerPoint presentation to evaluation team


Republic of Lithuania (1996) *Law on the Amendment to the Law on Prevention and Control of Communicable Diseases in Humans*

UNODC, UNAIDS and WHO (2009b) *HIV testing and counselling in prisons and other closed settings: Technical paper*


WHO (2001) HIV in Prisons: A Reader with Particular Relevance to the Newly Independent States


WHO (2009) Rapid Advice: Antiretroviral Therapy for HIV Infection in Adults and Adolescents


WHO (undated) National Health Accounts: Ratios and Per Capita Levels: 2003-2007 Untitled Excel file


WHO, UNODC and UNAIDS (2009b) Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users

Some additional Lithuanian documents were provided as hard copies by the Central Polyclinic giving details of ARV regimens.
ANNEX 3: TERMS OF REFERENCE

Background:

During the health care system reform in Lithuania in 2009, Lithuanian AIDS Centre which was the main HIV/AIDS prevention and care institution providing personal and public health care services was merged with the Centre for Prevention and Control of Communicable Diseases and is now called Centre for Communicable Diseases and AIDS. This centre is currently providing public health care services; meanwhile the treatment of people living with HIV/AIDS is assigned for personal health care institutions. HIV treatment in the community is compensated from the State Patient Fund under the Ministry of Health, whilst the treatment and care of people living with HIV/AIDS who are in prison settings is funded from a separate budget allocated for Prison Department and managed by this institution. This causes additional obstacles which may determine the quantity of the provided services and influence the quality as well. Another important aspect – price differences of antiretroviral drugs (further ARV) used in the community and in prison settings. Therefore, there is a need to look for the possibilities to procure ARV drugs centrally. It is clear that there is a lack of joint regulation and coordination between the Ministries of Health, Justice and Interior, as well as a clear division of roles and responsibilities in providing health care in the prison system.

Currently the main policy document on HIV/AIDS prevention and control in Lithuania – national HIV/AIDS prevention and control programme for the year 2003-2008 – has expired A new national HIV/AIDS and sexually transmitted infections’ prevention and control program for the year 2009-2012, which was prepared by the work group and coordinated with the strategic partners, is not approved yet. The new programme was prepared taking into consideration only part of the recommendations provided by United Nations Office on Drugs and Crime (UNODC) and the AIDS Strategy and Action Plan (ASAP) Service. There are more and more signs that the current situation in the health care system and economic crisis has caused funding and planning problems, and there are serious obstacles for reaching universal access to HIV/AIDS treatment and care services in Lithuania.

The aim of the evaluation is to provide practical recommendations for Lithuania on effective implementation of HIV treatment and care in the near future, in the context of difficult economic situation and limited resources for health sector. For that the evaluation needs to analyse, assess and give recommendations on three main areas: current health care structures and systems in place, coverage and quality of HIV treatment services, pricing and procurement policies of ARV therapy. Such evaluation has been requested by the Ministry of Health of the Republic of Lithuania implementing UNODC project “HIV prevention and care among injecting drug users and in prison settings in Latvia, Estonia and Lithuania”.

Areas and key questions of evaluation:

1. Structures, systems and organizational development.
   1.1. Healthcare systems connected with services for PLWHA;
   1.2. Institutional assessment of key actors involved in HIV treatment;
   1.3. Management and coordination of HIV treatment in the community and in prison settings;
   1.4. National funding plans and financial flow for HIV testing and treatment; with particular focus on the main groups-at-risk;
   1.5. Organizational development and capacity building of coordinating institutions and service providers.

   Questions to be answered when investigating each of the areas 1.1-1.5:
   1. What is the capacity of the Lithuanian health care systems and organizations in place?
   2. How has the capacity in the area developed in recent years?

3. Do present structures support the needs for ensuring universal access to HIV treatment in Lithuania?
4. What are the strong and weak parts of the developed systems?
5. Are there areas that need revision/restructuring, gaps to be filled or unnecessary practices that need to be dropped?
6. What is needed to achieve universal access to HIV treatment?

1.6. Integration of health care services.

Questions to be answered when investigating area 1.6:
1. To what extent are HIV and AIDS services integrated to other services needed (TB, drug dependence treatment, HCV, STIs, antenatal care, etc) and related to each-other?
2. What are the main gaps and positive developments in integrating different services?
3. Is continuity of HIV treatment ensured between community, territorial police arrest houses and prisons, and vice versa?

1.7. Involvement of PLWHA.

Questions to be answered when investigating area 1.7:
1. Are PLWHA involved in planning, decision making and monitoring?
2. Are PLWHA and other NGOs involved in education and provision of support and care?

1.8. ARV drug procurement and prices.

Questions to be answered when investigating area 1.8:
1. Is the current procurement system effective to ensure quality and cost-effectiveness of treatment?
2. What are the possibilities to reduce treatment costs in Lithuania?

2. Access to HIV treatment and care, coverage and quality of services.

2.1. Health care of PLWHA – patient monitoring, monitoring of early warning signs of HIV Drug Resistance, ARV supply, relation to TB, HCV and STIs, getting PLWHA to the health care system;
2.2. Psychosocial support to PLWHA and case management;
2.3. Physical accessibility to treatment (geographic distribution, hard to reach locations like prisons);
2.4. Principles of equity and non-discrimination (existence of exclusion criteria, e.g. health insurance status, substance use status, employment etc.);
2.5. Compliance with WHO clinical protocols and good practice for HIV treatment;
2.6. Monitoring, evaluation and quality assurance systems.

Questions to be answered when investigating each of the areas (2.1-2.6):
1. Is HIV treatment available to all who need it, including IDUs and prisoners?
2. What are the hindering factors related to accessing the services?
3. Is the quality of services sufficient for achieving the treatment goals?
4. What is needed for improving the quality of services?
5. What are the gaps in present quality assurance systems?

Methods

Methods for evaluation:

- Desk review of documents, reports and other materials related to HIV/AIDS issues in Lithuania. Materials will be provided by the relevant national institutions (namely, Ministry of Health; State Patient Fund under the Ministry of Health; Centre for Communicable Diseases and AIDS; National Tuberculosis and Infectious Diseases University Hospital; State Medical Audit Inspectorate under the Ministry of Health; State Health Accreditation Agency under the Ministry of Health; State Medicines Control Agency under the Ministry of Health; Ministry of Justice; Prison
Department under the Ministry of Justice; and other) in advance and during by the mission by MoH, UNODC and WHO Country Office.

- Interviews with key informants in selected organizations with visits to service provision sites in Lithuania. Key informants will be relevant government officials in different ministries and Ministry of Health; State Patient Fund under the Ministry of Health; Centre for Communicable Diseases and AIDS; National Tuberculosis and Infectious Diseases University Hospital; State Medical Audit Inspectorate under the Ministry of Health; State Health Accreditation Agency under the Ministry of Health; State Medicines Control Agency under the Ministry of Health; Ministry of Justice; Prison Department under the Ministry of Justice; NGO’s. Organizations will be chosen in cooperation of evaluation experts and the Ministry of Health.

Expertise needed:

- Organizational development;
- System analyses (including financial systems);
- National level programme planning and delivery;
- Capacity building in public health;
- Institutional support for NGOs;
- NGO structures and capacity;
- HIV treatment and care;
- Reaching and influencing target groups;
- Health care systems;
- Infectious diseases related to HIV/AIDS.

Partnerships:

- World Health Organization Regional Office for Europe and Country Office in Lithuania;
- Independent health care system, HIV treatment, funding and pharmaceuticals procurement experts;
- UNODC Project Office for the Baltic States;
- Ministry of Health;
- State Patient Fund under the Ministry of Health;
- Centre for Communicable Diseases and AIDS;
- National Tuberculosis and Infectious Diseases University Hospital;
- State Medical Audit Inspectorate under the Ministry of Health;
- State Health Accreditation Agency under the Ministry of Health;
- State Medicines Control Agency under the Ministry of Health;
- Ministry of Justice;
- Prison Department under the Ministry of Justice;
- NGOs, examples: Association “Pozityvus gyvenimas”, Association of HIV Affected Women and Their Intimates “DEMETRA”, other

Timeframe:

- February/March 2010: Preliminary review of provided documents, study results, etc; preparing the structure of appointments in Lithuania.
- 22-25 March 2010: Site visits and interviews in Lithuania with key stakeholders.
- Presentation of report and discussion with main stakeholders.

Output

At the end of the mission in Lithuania, a meeting will be organized to clarify the draft report and results. The meeting will take place with all stakeholders in the Ministry of Health. The output of the evaluation mission is a written report, which must be structured according to all the areas specified in the TOR. Under the section of any area answers
should be given to the questions listed in the TOR and recommendations given. The report has to contain a list of organizations and people interviewed and documents reviewed.

The individual reports by the mission members will be collated, edited and summarized by Roger Drew according to WHO EURO Style Guide and Writing for EURO.
ANNEX 4: ORGANOGRAM OF THE MINISTRY OF HEALTH OF LITHUANIA  (Approved 11 September 2009)

- Minister
  - Chancellor of the Ministry
    - 3 Vice Ministers
    - 4 Advisers
    - Attaché for Health
    - 2 senior advisers to MoH
    - Internal Audit Division
      - Corruption Prevention Division
      - Health Policy and Economics Dep.
        - Health Policy Division
        - Strategy Planning Division
        - Investment and Programme Division
      - Legal and Personnel Dep.
        - Legislative and Law Evaluation Division
        - Representation and Law Application Division
        - Personnel Division
      - Personal and Health Care Dep.
        - General Medical Care Division
        - Specialized Medical Care Division
        - Family Health Division
        - Health Care Resources Management Division
      - Public Health Dep.
        - Public Health Strategy Division
        - Public Health Care Division
        - Health Promotion and Resort Division
      - Department of Pharmacy
        - Pharmacoeconomics and Prices Division
        - Pharmacy Activities Division
        - Pharmacies and Pharmacy Specialists Division
      - General Affairs Dep.
        - Public Procurement Division
        - Information Technologies Division
        - Documents Management and Reception Division
        - Maintenance Division
      - Finance and Property Management Division
      - Public Relations Division
      - EU Affairs and Foreign Relations Division
      - EU Support Division
      - Secretariat
ANNEX 5: PROPOSED TERMS OF REFERENCE AND ACTION POINTS FOR A WORKING GROUP ON HIV DRUG RESISTANCE IN LITHUANIA

The recommended terms of reference for such a working group include the development and implementation of a national HIV drug resistance prevention, surveillance and monitoring strategy and development of a budget for activities.

Specific action points for the working group on HIV drug resistance should include the following:

1. The Working Group should take responsibility for reviewing a national approach to measures for the prevention of the development of HIV drug resistance and the development of a plan for the monitoring of ‘early warning’ signs related to development of HIV drug resistance, e.g. monitoring of drug prescription practices, quality assurance of ART, population adherence, survival, treatment failure, stock-out rates, etc.

2. One specialized national HIV molecular diagnostic laboratory should be responsible to provide guidelines and recommendations for HIV drug resistance genotyping and a standard QA/QC programme for Lithuania’s laboratories.

3. A national virologist should be responsible for the maintenance of the laboratory and the performance of the HIV drug resistance testing.

4. Conduct national studies as recommended by WHO (below).

5. Annually, a report on the assessment of HIV drug resistance in the country should be written in order to inform all stakeholders of the results. This report should also give guidance on the interpretation of the results and suggest possible action points for the national ART scale up program to further minimize the emergence of HIV drug resistance and potentially to influence national ART guidelines and policy.

WHO does not recommend individual HIV drug resistance testing for treatment decisions until a national HIV drug resistance strategy is in place.

WHO recommends two types of studies to be conducted as the first step in assessing Lithuania’s HIV drug resistance situation:

1. **Surveillance of Transmission of HIV drug resistance:**
   - **Aim:** to define to what extent HIV drug resistance is currently being transmitted
   - **Objective:** to estimate the prevalence of HIV drug resistance in recently HIV-infected populations in specific geographic settings
- **Population for study**: specimens from recently-infected populations will be collected.
- **Study design**: HIV drug resistance threshold survey
- **Sites**: initially one site could be selected (Vilnius)
- This threshold study to be repeated in the following year with an additional site.

2. **Monitoring of HIV drug resistance prevalence and incidence in populations eligible for ART**

- **Aim**: to monitor how successfully resistance is prevented in national standard ART programmes
- **Objective**: to monitor programme indicators to evaluate if ART programmes are functioning to minimize the emergence of HIV drug resistance and to evaluate patterns of drug resistance mutations emerging with first line regimens in sentinel centers
- **Population for study**: specimens from populations eligible for and starting first ART treatment
- **Study design**: observational cohort analysis with viral load and HIV drug resistance evaluation at 12 and 24 months or at time of switch to second-line ART. Cohort size to be decided depending on power analysis of study design (estimated: 100-200 patients)
- **Sites**: Sentinel sites chosen to represent a variety of treatment services in specified geographic areas. Ideally, CD4 and viral load count for the follow-up of patients should be available. Also, a system for the monitoring of individual patient care and treatment must be in place.