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*Mid-term evaluation of the Estonian
national HIV/AIDS strategy 2006 – 2015
and national drug prevention
strategy 2012*

Report

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GLOSSARY

AIDS	Acquired Immunodeficiency Syndrome
ECDC	European Centre for Disease Prevention and Control
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EMIS	European MSM Internet Survey
EU	European Union
HIV	Human Immunodeficiency Virus
MDR-TB	Multidrug-resistant Tuberculosis
MSM	Men who have Sex with Men
NGO	Nongovernmental Organization
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization
XDR-TB	Extremely Drug Resistant Tuberculosis

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The current report is an integral part of the Biennial Collaborative Agreement between the WHO Regional Office for Europe and the Government of Estonia for 2010–2011 to support public health and health care development.

The report was prepared for the WHO Regional Office for Europe by Ulrich Laukamm-Josten, Roger Drew, Signe Rotberga, Shona Schonning, Brenda van den Bergh and Risards Zaleskis.

SUMMARY

Estonia has demonstrated strong political commitment to respond effectively to HIV and TB. Overall leadership to the response has been provided by the Ministry of Social Affairs and this has improved since previous evaluations. The National Institute for Health Development has managed the national programme well, and has established a strong reputation with high levels of capacity. In particular, the Institute managed the difficult issue of reduced budgets, as a result of the international financial crisis, extremely well by prioritizing the most important services and focusing the cuts elsewhere. There has been good collaboration between the Ministries of Social Affairs, Interior and Justice over providing HIV services in prisons, for example on opioid substitution therapy and tuberculosis control. The introduction of opioid substitution therapy into Estonia's arrest houses and prisons is an extremely positive step. Proposals to shift away from harsh administrative penalties for drug users to more supportive treatment options are positive. There is good coverage with needle and syringe programmes in Tallinn and Ida Virumaa with evidence that these are having an effect in reducing HIV transmission among people who inject drugs in these areas. Steps taken to deliver essential services for people who inject drugs, such as opioid substitution therapy, tuberculosis treatment and antiretroviral therapy, from a common location in some places are positive.

This is the latest in a series of evaluations of Estonia's response to HIV conducted jointly by WHO and UNODC. The most recent one was conducted in 2008. Since then, there have been remarkable achievements. Most of the suggested recommendations have been accepted and acted on. The national programme has become much more focused, better prioritized and better managed. Valuable lessons have been learned, that are useful beyond the HIV programme. Overall, the HIV programme in Estonia can be considered a very successful modern public health programme in Europe.

Overall, the HIV and drug prevention strategies are appropriate for the Estonian context. However, there is an opportunity currently to seek to ensure that these are linked more closely together. Overall, the response to HIV is well coordinated by the Ministry of Social Affairs and the National Institute for Health Development. However, there has been relatively weak involvement of some ministries in the response to HIV, for example the Ministry of Education. The integration of the provision of health services in prisons with those provided in Estonia as a whole could be further improved, especially when it comes to continuity of care. It is unclear how well the HIV Commission is working, particularly in terms of holding organizations accountable for delivering on their commitments and responsibilities. The continued funding of NGOs by government, despite the difficult international economic situation, to provide essential HIV services is extremely encouraging. However, there is a need for better participation of implementing agencies in management of the response, for example through round table meetings and functioning working groups. There have been some management bottlenecks within the National Institute for Health Development which have resulted in the introduction and expansion of some services being delayed. Examples include overdose prevention, expansion of opioid

substitution therapy and production of opioid substitution guidelines. There is need for more delegation and joint working in some parts of the National Institute.

There is limited availability of services for people who inject drugs outside Tallinn and Ida Virumaa. Coverage of opioid substitution therapy remains low and the service is regulated excessively, for example the requirement that only psychiatrists may prescribe methadone. There is reported to be a waiting list for opioid substitution therapy in some centres and the guidelines for this therapy are still not finalized. Buprenorphine is not available in state-financed substitution therapy programmes. Naloxone is not yet available for community-based drug overdose management. There is limited availability of drug detoxification services, and rehabilitation services are poorly defined, limited, fragmented and poorly funded. There has been limited integration of other services, such as targeted HIV testing, into harm reduction programmes. There has been little development of pharmacy-based services for people who inject drugs.

Although the introduction of opioid substitution therapy in prisons and arrest houses is welcome, availability needs to improve. It is important that people are able to start this treatment while in prison and not only continue it if they were already receiving it outside of prison. In addition, methadone should be available on a continuous maintenance basis and not only as a tapering dosage aimed at withdrawal. In prisons, access to condoms is limited and there is no provision of sterile injecting equipment. There is very limited provision for continuity of care of prisoners on release. Access to treatment for hepatitis C in prison is also very limited. At the time of the evaluation, only one person was receiving this treatment in Estonian prisons.

Overall, in Estonia, TB services, in general, and management of TB/HIV co-infection, in particular, are strong. Nevertheless, there are still too many cases of late detection of TB among people living with HIV and those who inject drugs. As a result, people continue to die of TB. Current WHO guidelines recommend that all people living with HIV with TB should receive antiretroviral therapy regardless of CD4 count. The evaluation team encountered a few situations where this was not the case. There is also currently no policy of providing isoniazid preventive therapy to people living with HIV. This is recommended by WHO.

Although there has been an increase in the number of HIV tests conducted in recent years, the targeting of this testing remains poor. Key populations have limited access to HIV testing. For example, there is limited availability of rapid HIV tests in low threshold centres and there are inappropriate regulatory barriers which limit the ability of civil society organizations to offer rapid HIV testing. Data on HIV testing is limited. The Health Insurance Fund cannot currently provide data on the number of HIV tests it has financed. It does not currently specifically fund rapid HIV testing. Estonia's case reporting system still does not allow accurate monitoring of transmission mode.

Significant numbers of people with HIV are diagnosed late, that is with a CD4 count that is already less than 350. Reasons for this and ways to address this are unclear. Various suggestions have been proposed including routine testing of everyone in health settings and/or more targeted testing through low threshold centres. More

evidence is needed about missed opportunities for testing for this group of people living with HIV before programmatic decisions are made.

Although the number of people living with HIV receiving antiretroviral therapy has risen, the limited availability of opioid substitution therapy restricts access of people who inject drugs to treatment and also makes adherence more difficult. Although antiretroviral therapy is funded through the state budget and provided free of charge to all, it is reported that people without health insurance find it difficult to obtain treatment for opportunistic infections. There are also reports of interruptions in availability of essential laboratory monitoring, such as CD4 counts. Although there is no formal antiretroviral therapy protocol, there is good practice related to defining and prescribing first and second line regimens. However, monitoring of people living with HIV on treatment is weak and there is no drug resistance prevention plan. In addition, people living with HIV have limited access to psychosocial support.

INTRODUCTION AND BACKGROUND

Estonia's response to HIV is conducted within the framework of the National HIV and AIDS Strategy 2006-2015 (Government of Estonia, 2005). This strategy not only covers activities in health and other sectors but also how activities between sectors are coordinated. In Estonia, the issues of drug use and HIV are closely linked. Estonia's national HIV epidemic has to date been largely driven by behaviours related to injecting drug use. Estonia's response to drug use among its population is conducted within the framework of the National Drug Prevention Strategy 2012 (Anonymous, undated, b).

Since the end of Global Fund support to Estonia's HIV response in 2007, almost all financial resources for the implementation of the HIV strategy have come from domestic resources. Some funding has also come from external sources including the European Social Fund, UNODC and WHO. As a result of the global financial crisis, since 2008, state budget allocations for the implementation of national public health strategies, including for HIV and drug prevention, have been reduced. This resulted in priorities being reviewed in order to ensure continued delivery of the most critical services, including needle and syringe exchange, opioid substitution therapy, HIV testing and counselling, and TB treatment.

This evaluation has been requested by the Ministry of Social Affairs. The evaluation forms an integral part of the collaborative agreement between the Estonian Government and the World Health Organization to support scaling up of the response to HIV in Estonia. The evaluation is being conducted under the joint auspices of UNODC and WHO. It builds on a range of previous UNODC and WHO work to support the response to HIV in Estonia, including a previous evaluation conducted in 2008 (Drew et al., 2008).

This evaluation focuses on the three-year period from 2008-2010 and also seeks to look forward and give a perspective beyond 2015, the end of the current strategy. As specified in the terms of reference (see Annex 1), the evaluation had two main areas of focus the integration of coordination and services under two national strategies - HIV and drug use; and the integration of HIV-related services and the continuum of services.

As with previous evaluations, this evaluation report is structured around two main areas:

- Structures and systems
- Coverage and quality of services

A distinctive feature of this evaluation is that it is focused on the implementation of both the HIV and drug prevention strategies.

SITUATION ANALYSIS

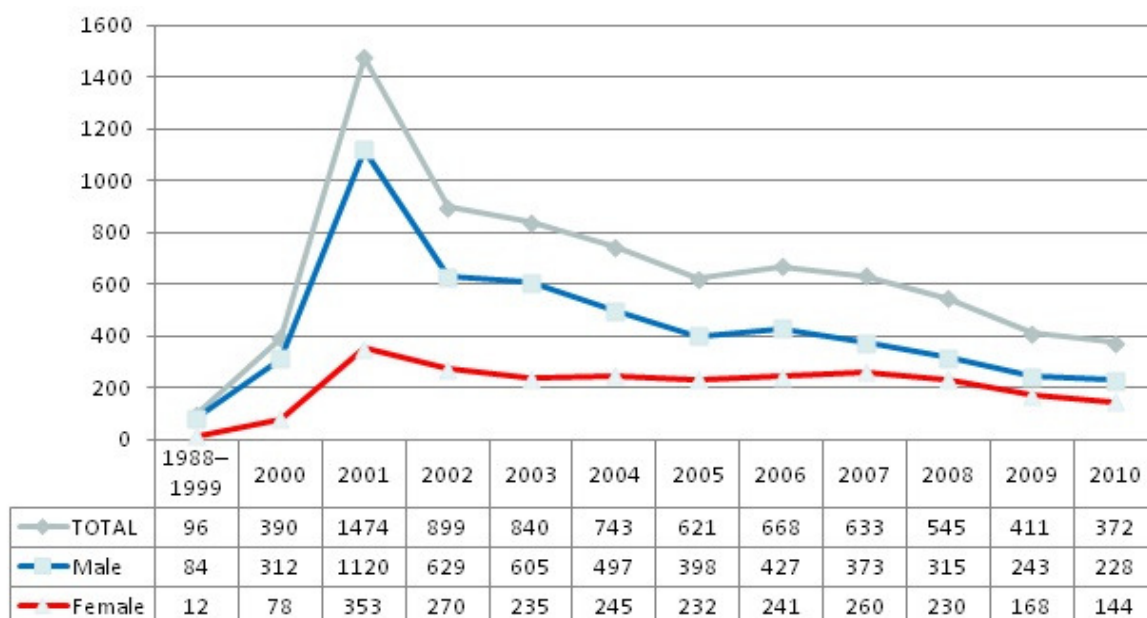
This section presents a brief summary of the current situation relating to HIV, TB and illegal drug use in Estonia.

HIV

Overall, the national analysis of the HIV situation in Estonia is very strong and highly appropriate. It is well summarized in the recent triangulation report (Rüütel et al., 2011).

By the end of 2010, a total of 7,699 cases of HIV had been registered in Estonia. Of these, more than two thirds (68%) were among men¹. The number of newly-registered cases has been reducing since 2001, particularly among men (see Fig. 1).

Fig. 1: Distribution of newly-registered HIV cases by sex: 1988-2010



Source: National Institute for Health Development, 2011

The HIV epidemic in Estonia has largely spread through injecting drug use with secondary sexual spread from men who inject drugs to their female sexual partners. Two geographic regions, Tallinn and north east Estonia have been particularly affected. This pattern has not changed. There is currently no evidence of the epidemic ‘generalizing’, that is affecting a large number of men who have not injected drugs, had sex with a woman who has injected drugs or had sex with another man.

¹ 5,231 male, 2,468 female

The decline in new cases is encouraging. There is evidence that measures introduced in Estonia are having a positive effect (see Box 1).

Nevertheless, more than 200 new HIV infections continue to be registered annually in men. Information on the transmission routes for these infections is inadequate. As a result, it is unclear if, for example, these new cases represent new infections among men who inject drugs or perhaps unrecognized transmission among men having sex with men. In a recent internet survey among MSM in Estonia:

Box 1: Expanded syringe programmes and reduced HIV infection among new injecting drug users (from Uusküla et al., 2011)

Studies conducted among people who inject drugs in Tallinn in 2005, 2007 and 2009 showed a significant decline in HIV prevalence among new injectors from 21% in 2005 to 12% in 2009.

This decline coincided with the implementation of large-scale syringe exchange programmes. Between 2005 and 2009, the number of syringes exchanged annually more than trebled from 230,000 in 2005 to 770,000 in 2009

- 1.7% of 612 respondents reported being HIV positive (EMIS, 2011a)
- Of 594 participants answering the question, more than one third (35%) reported possible HIV transmission risk in the last 12 months (EMIS, 2011b).

Clearly, more information is required. In particular, there is a need to distinguish between old and recent infections. There is also a need to understand where the more recent infections are occurring in order to better focus prevention efforts. It is also important to understand reasons behind the decline in reported new infections among women as this differs from patterns seen in other countries with HIV epidemics driven by injecting drug use where the number of women with HIV rises as a result of sexual transmission from men infected as a result of injecting drugs.

However, in the meantime, evidence-based, harm reduction activities to prevent HIV among people who inject drugs need not only to be maintained but to be expanded further. These activities should also include 'positive prevention' activities to prevent sexual transmission of HIV from men who inject drugs to their female sexual partners. Evidence from other countries, e.g. western Europe, shows that HIV transmission through injecting drug use can be completely controlled by effective prevention measures, such as comprehensive harm reduction interventions. These measures not only protect those who inject drugs, but also the entire population.

Regardless of the progress made on prevention, the number of people requiring antiretroviral treatment will continue to rise as more of those already infected with HIV require therapy. It is estimated that a total of 2,750 people may require treatment next year (Lai et al., 2009) with up to an additional 3,500 needing treatment over the next five years. There is an ongoing significant issue of late diagnosis of HIV infection. Around 40% of all HIV diagnoses are considered to be late although data on CD4 counts at time of diagnosis is not collected systematically. Late diagnosis of HIV means that people get treatment later than required risking higher rates of illness and death.

Tuberculosis

Estonia is one of 18 priority countries regarding TB in the WHO European Region. These countries are selected because of high TB burden, in general, and high rates of multidrug-resistant (MDR) TB, in particular. Although TB notification rates in Estonia have declined over the last ten years, they remain high, particularly among people in economically-productive age groups. For example, in 2010, a total of 306 TB cases were reported, reflecting a notification rate of 22.8 per 100,000 population. Of these, almost three quarters (73%) were among men with 41% of people diagnosed with TB reporting a history of alcohol abuse and 7% reporting a history of illegal drug use. TB remains a significant issue in Estonian prisons among populations with high prevalence of HIV, including people who inject drugs and those with a history of alcohol abuse.

Although rates of MDR-TB are stable, they remain very high. Estonia is among the three countries with the highest rates of MDR-TB in the European Union. For example, in 2009, almost one quarter (22%) of new TB cases were found to be MDR-TB. Around 10% of those with MDR-TB were found to have extensively drug resistant TB (XDR-TB).

Rates of HIV testing among people diagnosed with TB in Estonia are high (90%). Rates of HIV infection among people diagnosed with TB in Estonia are also high and have risen from 0.15% in 1997 to 12% in 2010. During that period, a total of 257 people were diagnosed with TB/HIV co-infection. The majority of these were men who inject drugs in Tallinn, Kohtla-Järve and Narva. Based on evidence from Estonia, Latvia and Moldova, MDR-TB also appears to be more prevalent among people with HIV infection than among those who are HIV negative.

Late detection of TB among people living with HIV and people who use drugs is common. As a result, advanced forms of TB are seen among these population groups. In addition, between 2006 and 2009, 31 people with HIV died from TB before it could be treated. This group constituted almost one fifth of all people with HIV diagnosed with TB during that period. To address this issue, health services, both primary and specialist, need to work collaboratively with harm reduction services to improve detection and treatment of TB among people living with HIV and people who inject drugs.

Overall, Estonia has the potential to reach the target in the current National TB Plan for 2008-2012 of reducing TB incidence to 20 new cases per 100,000 population by 2012. In order to achieve this, Estonia needs to control the TB epidemic among people living with HIV and stop the spread of MDR and XDR-TB.

Illegal drug use

Estonia reports regularly to EMCDDA on issues relating to illegal drug use (see EMCDDA, 2010) according to EMCDDA guidelines and indicators. Topics covered include the drug situation, responses and policy development. The national report includes data on drug-related infectious diseases, including HIV. The report's

approach to HIV focuses mostly on the extent of HIV infections among people who inject drugs and the availability of HIV-related services for them. Although Estonia has some data regarding changing patterns of drug use, the extent to which this may have an effect on HIV transmission has not yet been fully analysed. For example:

- According to population surveys, the proportion of people reporting ever having used illegal drugs rose in most age groups from 2003 to 2008. The rise was particularly marked in the 25-34 year age group, from 17% in 2004 to 36% in 2008. However, these figures include cannabis use so their relevance to HIV transmission is unclear.
- There are no up-to-date estimates of the number of people who inject drugs in Estonia. In 2004, it was estimated that there were almost 14,000 injecting drug users². New estimates are expected to be available by the end of 2011.
- There is some evidence of increasing use of amphetamines and fentanyl. However, figures vary from study to study³ and it is unclear if these differences reflect changes over time, differing use patterns in different geographical areas or a combination of both factors. Changing patterns of drug use are likely to be very important with regard to HIV transmission risk. For example, a study⁴ in Estonia showed that fentanyl injectors were three times more likely than those who injected amphetamine to be HIV positive and that this reflected more frequent injecting behaviour, more frequent sharing of needles/syringes with a person known to be HIV positive and more frequent filling of syringes from a syringe that someone had used previously to inject themselves. Conversely, people who inject amphetamines may be less amenable to treatment, for example with methadone. There may also be other health issues, such as increasing overdose rates with rising fentanyl use.
- There are reports of an increasing proportion of women and Estonian speakers among people who inject drugs.

Illegal drug use is a significant issue within the Estonia's prison system. The last survey of knowledge, attitudes and behaviours related to HIV and drug addiction was conducted by the NIHD in 2008. The survey revealed that the convicts use drugs also in the custodial institutions (28%), half of them injected drugs and nearly one-fifth shared injection materials in the prison environment (Lõhmus & Trummal, 2009). According to the Drug Monitoring Report of 2009 however, only 26 cases of illegal drug use were reported to have occurred within the prison system during 2009.

² In commenting on this report, the National Institute for Health Development cites a study by Uusküla et al, from 2007. However, this study does not appear to be among documents provided to and reviewed by the evaluation team.

³The National Institute for Health Development reports that cross-sectional surveys carried out amongst IDUs in Estonia show that between 13-71% of drug addicts surveyed used amphetamine as the primary drug in the previous four weeks. Studies cited include *Uusküla et al, 2006, Uusküla et al, 2007, Uusküla et al, 2005, Lõhmus et al, 2007, Uusküla 2010, NIHD 2010 and Lõhmus et al, 2011*. However, these studies do not appear to be among documents provided to and reviewed by the evaluation team.

⁴ In commenting on this report, the National Institute for Health Development cites a study by Talu et al, from 2009. However, this study does not appear to be among documents provided to and reviewed by the evaluation team.

Drug prevention efforts were initiated within the prison system in 1998. The Ministry of Justice is seeking to further expand drug services for drug dependent prisoners, mainly through the provision of opioid substitution therapy and through establishing drug rehabilitation units. The prison system has established drug rehabilitation units with the purpose to treat and rehabilitate drug dependent prisoners. The first rehabilitation unit was established in Tartu Prison in 2006, currently including 174 places (see p25), divided into 4 sections. The prison system is using social rehabilitation programmes (example *Lifestyle Training for Offenders*), supporting and recovering group work activities (AN group, “12 steps method”) and individual work to achieve the goals. Viru prison and Harku and Murru prison currently also include drug rehabilitation units (8 places for women).

METHOD

This evaluation was conducted by a team of consultants working under the joint auspices of UNODC and WHO. The team conducted a one week visit to Estonia in September in order to conduct this evaluation. The people interviewed for this work are included in Annex 3 (p51). Full terms of reference for the evaluation are presented in Annex 1 (p44).

Methods used to gather information for the evaluation included:

- Review of key documents. A list of all documents reviewed is presented in Annex 2 (p48).
- Interviews with key informants, both as individuals and as small groups. A list of people interviewed is presented in Annex 3 (p51).
- Field visits to low threshold centres, prisons and arrest houses, opioid substitution treatment sites, drug rehabilitation centres and hospitals.

A debriefing session was held at the end of the visit with staff of Ministry of Social Affairs and the National Institute for Health Development to check facts and to present and discuss initial results.

The working language of the evaluation team was English.

FINDINGS

The evaluation's findings are grouped into two main sections.

The first focuses on systems and structures and is divided into six subsections focused on strategies; management and coordination; systems for service delivery; financial flows; monitoring, evaluation and quality assurance; and organizational development and capacity building.

The second focuses on delivery of services and is also divided into six subsections focused on assessment of service need; availability of services; health care of people living with HIV; health care of people who use drugs; integration of different services; and improving quality of services.

Systems and structures

Strategies

Overall, Estonia has demonstrated **strong political commitment to respond effectively to both HIV and TB**. Estonia's HIV response is guided by the national HIV and AIDS strategy 2006-2015 (Government of Estonia, 2005) under the overall leadership of the Ministry of Social Affairs (see p19) and the inter-ministerial HIV Commission (see p20), for which the Ministry of Social Affairs acts as secretariat. The strategy covers a range of HIV-related services including prevention of HIV transmission and provision of services for people living with HIV. The strategy is implemented through action plans and budgets. However, these were not reviewed by the evaluation team, as they are only available in Estonian.

Also, Estonia has a **National Strategy for Prevention of Drug Addiction** (Anonymous, undated, b) which covers the period from 2005 to 2012. In 2009, the Ministry of Social Affairs started development of an Action Plan for the strategy for 2010 to 2012. In March 2011, an abridged version of the Action Plan was approved by the Government. However, the Action Plan was not shared with the evaluation team and therefore no comments can be provided.

The National Strategy for Prevention of Drug Addiction covers six areas, each with specific objectives:

- Prevention – to reduce the lifetime prevalence of drug use and increase the age of first use
- Professional drug treatment – to develop a network of health and social services for adults and children relating to drug use
- Harm reduction – to reduce the risk behaviour of drug users
- Drugs in prison – to establish a well-functioning system to prevent the smuggling of drugs into prison and provide drug users in prison with treatment and rehabilitation services

- Supply reduction – to reduce the availability of illicit drugs, confiscate criminal income and introduce more advanced technical equipment
- Monitoring and evaluation – to collect reliable and comparable data on drug use, its consequences, responses to drug use and policy development

Overall, the drug strategy has a **good balance between the areas of demand and supply reduction**. Some parts of the strategy are long descriptions of various service types, which would be more appropriate in an operational document or guidelines. Some indicators are inconsistent and some are controversial. For many indicators, baseline data is missing and/or performance data is not collected. As a result, it will be impossible to assess whether the objectives have been achieved. It is not specified what is meant by risk behaviour of drug users. Some important objectives mentioned in the EU Drugs Strategy and Action Plan (EU, 2004; EU, 2008) are missing, e.g. participation of civil society in drug policy; overdose prevention..

There are **plans, from 1st January 2012, to change the administrative penalties applied to people who use drugs including more use of referral to rehabilitation services**. This change is being jointly financed by the Swiss (85%) and Estonian (15%) governments and should result in 90 additional places being made available in residential rehabilitation centres. The programme is aimed at:

- Working out an integrated system for treatment, rehabilitation and social re-integration of drug-addicted offenders; and
- Providing treatment and rehabilitation services for drug addicts whose sentence to imprisonment has been replaced by a treatment programme or who have been released from prison on parole.

The programme will consist of a range of services, from methadone substitution treatment to long term rehabilitation. The treatment period is estimated to be 9 months on average.

Although such a move is broadly positive, there are concerns among providers of rehabilitation services about their capacity to provide these expanded services and the change in ethos that might result if people are referred to them as an alternative to prison rather than the current situation where people enter these services voluntarily.

There is a **specific budget attached to the national Action Plan**. The overall budget has decreased during the last four years from EEK⁵ 36m in 2007 to EEK 21m in 2010. In 2010, more than three quarters (76%) of the total budget was allocated for drug demand reduction activities, with the remaining amount for supply reduction, including services for drug users in prisons.

There is currently no strategy in Estonia relating to preventing alcohol abuse. In addition, there are concerns about the extent to which the HIV and drugs strategies are linked to and contribute to **a broader public health strategy**. In addition to

⁵ Estonia adopted the Euro from 1st January 2011. Prior to that the Estonian kroon was fixed to the Euro at €1 to EEK15.65.

improving outcomes as a result of HIV prevention, early diagnosis, treatment and care, implementation of the HIV strategy might be expected to contribute to broader health outcomes through initiatives to reduce vulnerability to HIV infection and drug use, and removing structural barriers to access services. It might be possible to achieve more of this if there was a more integrated system of public health, of which HIV was a part. Such an approach would need to ensure that HIV-specific expertise, developed in the country, was not lost. If developed, it would provide a mechanism through which lessons learned in the response to HIV could be shared more broadly. For example, other disease areas, such as noncommunicable disease, might learn from the response to HIV the importance of involving people living with the disease in the response and the need for inclusion of both prevention and care elements. The challenge will be to identify and understand the real successful innovations that have happened in Estonia and how to transfer this knowledge to other chronic disease services (Rabkin and El-Sadr, 2011; WHO, 2011a).

As the national drugs strategy ends in 2012, there is **an opportunity now to bring the HIV and drugs strategies closer together**. For example, harm reduction services, such as opioid substitution therapy have been implemented largely from a point of view of HIV prevention not with a view to specifically tackling drug use⁶. The possibility of integrating the two strategies into a broader, overall public health strategy is under discussion. However, this proposal is highly contentious. Staff of the National Institute for Health Development believe that there could be benefits of approaching HIV through a broader health strategy because people with HIV are now living longer on antiretroviral therapy and are likely to require more treatment and care for chronic diseases, such as diabetes, hypertension etc. But, they are unclear how a common public health strategy would address issues of health system delivery where HIV care is provided by infectious diseases specialists and treatment of chronic illnesses by family practitioners financed through the Health Insurance Fund. For real progress to be made, there is a need to involve family practitioners in HIV care and also to ensure that people without health insurance can also access treatment of chronic diseases. There are also fears that HIV, TB and drug use could receive less focus than previously and that the valuable intersectoral collaboration that there has been with other ministries, such as Ministries of Justice and Interior, and with national agencies⁷ risks being lost. However, there are also opportunities for greater sharing of experience across subsectors, for example between communicable and noncommunicable diseases (Smart, 2011). Following the evaluation visit, the evaluation team were informed that the Ministry of Social Affairs had decided to include all national health strategies into an overall population health strategy. It was initially understood that this would be a new, comprehensive strategy that would cover HIV, TB, drug use, cardiovascular disease and cancer prevention. However, follow-up communication implies that this is an existing strategy (Ministry of Social Affairs, 2008) that covers a wide range of topics, including social coherence and equal rights, safe development for children and youth, healthy environment for studying and working, healthy lifestyles, and development of the health care system.

⁶ In commenting on this report, the National Institute for Health Development report that this situation reflected that these services were developed with Global Fund financing and that, since 2009, the focus has been shifting away from opioid substitution therapy as only HIV-related harm reduction to a broader view of it as a drug treatment service.

⁷ Such as the Police and Border Guard Board, Tax and Customs Board and Estonian Forensic Science Institute.

Management and coordination

The **Ministry of Social Affairs is providing leadership in the country on issues relating to health, in general, and HIV, in particular**. For example, reformed health service structures have improved performance. In addition, the introduction of health impact assessments, the ambitious e-Health project and the successful use of EU Structural Funds in the health system are all indications of improvements. Consistency and retention of HIV-focused staff within the Ministry of Social Affairs have resulted in greater engagement of the ministry in processes related to the HIV response.

The **National Institute for Health Development has an excellent reputation and considerable capacity related to its role in the national responses to HIV, TB and drug use**. It has developed into the leading public health authority in Estonia related to HIV prevention. It has conducted commendable work through various studies, health indicator assessments and analysis of available strategic information. Even those stakeholders who were previously critical of the Institute now recognize the positive role it is playing. It has a very strong working relationship with the Ministry of Social Affairs and other ministries involved in the implementation of national health strategies. However, there are still some issues related to the Institute both developing and implementing policy. It is also unclear how the Ministry of Social Affairs will strengthen coordination between the Institute and the Health Board, responsible for health care, health protection and chemical safety.

The **Institute managed issues relating to reduced budgets for HIV particularly well** by appropriately prioritizing the most essential services. Such prioritization and focus is in line with current investment frameworks (Schwartländer et al., 2011). As a result, there were no disruptions to essential services despite a 20% reduction in the HIV budget from 2008 to 2010. There have, however, been some management bottlenecks within the Institute which delayed the expansion of some services, for example, overdose prevention and opioid substitution therapy. The production of guidelines on providing opioid substitution therapy was also delayed. In the view of the evaluation team, such bottlenecks could be overcome by greater delegation and more joint working within and outside the Institute⁸.

⁸ In commenting on the report, the National Institute for Health Development commented that not all of these examples can be attributed to what is classically called "management bottleneck", since there was limited capacity of not one component/actor, but of several leading to slower than planned developments:

1. Expansion of services - main reason in 2007-2010 was lack of budget, not lack of delegation. In 2011 negotiations to expand the services to new regions were not successful due to low financial motivation of providers.
2. Guidelines on opioid substitution therapy – the National Institute for Health Development repeatedly proposed to the Estonian Psychiatric Union that they take the lead in developing the guidelines. This offer was declined but the Estonian Psychiatric Union agreed to review the guidelines if these were elaborated by the National Institute for Health Development. Guidelines have been developed and reviewed and will be presented to providers in early 2012. This is a general issue of human resources not a delegation problem.
3. Overdose prevention – as identified, legal changes have to be made to allow naloxone-based overdose management and political approval has to be ensured. The national drug strategy has to be amended to include naloxone-based overdose management. Otherwise it is not possible to use naloxone.

In addition to its work on HIV, **the Institute also has responsibility for implementing an action plan on drugs**. Although there are separate action plans on HIV and drugs, the Institute implements these jointly. As a result, there is a good deal of coherence and coordination between the Institute's work on HIV and its work on drugs.

There has been **excellent cooperation between some ministries** in the response to HIV, for example, the Ministries of Social Affairs, Justice and Interior on issues relating to TB control and introduction of opioid substitution therapy in prisons. However, some ministries, such as the Ministry of Education, have shown relatively weak engagement with the national response to HIV. The Ministry of Education was slow in taking on their responsibilities in relation to responding to HIV. In particular, they took an excessively long time to develop appropriate policy and curriculum for sexual and reproductive health and drugs. In addition, there are concerns that basic education in Estonia does not address issues of drugs. There have been some attempts to address such issues through health education but implementation was very dependent on interest of individual teachers. A new curriculum was introduced in 2011 which includes compulsory education on preventing drug use. However, it is reported that teachers are poorly prepared for this.

Health services in prisons remain the responsibility of the Ministry of Justice.

As a result, these services are managed and largely funded separately⁹ from other health services in the country. Although there has been some discussion of bringing funding and responsibility for these services under the Ministry of Social Affairs, there has been no recent progress on this matter. There is little sharing of data between ministries. However, the National Institute for Health Development report that the Ministry of Justice has been very cooperative in sharing data on prison health. It was reported to the evaluation team that the Ministry of Social Affairs cannot get access to health data held by Ministry of Justice because of confidentiality of medical data. However, as the Ministry of Social Affairs needs only aggregated data and not personalized medical records, it is unclear why the issue of confidentiality would be an obstacle to such data sharing.

It is **unclear how effectively the National HIV Commission and its working groups are functioning**. A key role for the Commission should be to monitor implementation of the national strategy and action plan. However, it is unclear how much this is being done as much of the work is now seen as routine and is managed effectively by the National Institute for Health Development.

The **Government Committee on Drug Prevention** is chaired by the Deputy Secretary-General on Health of the Ministry of Social Affairs. It has 11 members from the Ministries of Social Affairs, Interior, Justice and Finance, the Estonian Drug

All these issues are problematic and need to be addressed in the report, but the National Institute for Health Development does not necessarily agree with the delegation-centered definition of the problem.

⁹ Most health services, including emergency services, for prisoners need to be paid for by the Ministry of Justice. Some national programmes do provide services free of charge to prisoners. Examples include the provision of TB treatment and antiretroviral therapy to people living with HIV.

Monitoring Centre, the Estonian Psychiatrists Union, the Estonian Cities Union, the Police Board, and the Board of the Border Guard. Its main tasks are:

- Revising the national drugs strategy and updating it if the need arises
- Drafting action plans for the implementation of the strategy
- Reviewing annual reports
- Evaluating the implementation of the drug strategy
- Drafting an implementation report of the drug strategy for the Government

It may be appropriate to **review the terms of reference for this Commission and the Governmental Committee on Drug Prevention**. One option might be to combine these two bodies. Currently, there is considerable overlap in the membership of these two bodies, at least with respect to government agencies. Both bodies include the Ministries of Social Affairs, Interior, Justice, Education and Finance. As a result, meetings of the two bodies are often held sequentially on the same date. However, NGOs are not currently represented in the Governmental Committee on Drug Prevention although it is reported that they were invited to meetings between 2006 and 2008. The Governmental Committee on Drug Prevention does not have any specific terms of reference for its engagement with civil society. There is a need to revitalize the participatory processes associated with these bodies and their working groups.

One area in which Estonia has been very successful is in **providing governmental support, including funding, to civil society organizations involved in the national response to HIV**. The improved involvement of civil society organizations and the longer term funding available to them are very positive developments. However, there is need for contracts with civil society organizations to be more clearly defined in terms of expected outputs and outcomes, and how these should be measured. Civil society organizations need to be involved in designing and developing evaluation, quality assurance/improvement and auditing systems. Round table discussions or regular working group meetings bringing the National Institute for Health Development and the implementing partners together could give real voice to multiple stakeholders, make implementation more effective and avoid misunderstanding of necessary auditing procedures. Such meetings, e.g. with needle and syringe programmes and low threshold centres, were previously organized by the National Institute for Health Development but it was reported that none had been held recently. In commenting on the draft report, the National Institute for Health Development explained that these meetings were still held but had been redefined. There are still general informational meetings but these take place less frequently than before. From 2011, there have been regular 'interview' meetings which have a specific purpose and are attended by representatives of the National Institute for Health Development if agreed by service providers.

Since 2002, all **Estonia's health care providers have been private**. This includes providers of primary care, emergency services, nursing services and both outpatient and inpatient specialist care. Under this system, infectious diseases services are

available at central and regional hospitals only. There is an extensive and well-developed system of primary care with each family practitioner providing services to around 1,600 people. In relation to primary care, it is reported that there is good geographical access, choice and no financial barriers to receiving these services.

Systems for service delivery

Antiretroviral therapy

The **provision of antiretroviral therapy is centrally managed in Estonia**. The Ministry of Social Affairs has a committee that approves an annual procurement plan and conducts market research. The committee includes representatives of the Ministry of Social Affairs, the Health Board, the State Agency of Medicines, people living with HIV and treatment centres. The main tasks of this committee include developing proposals regarding antiretroviral therapy; proposing approach to national use of antiretrovirals; forecasting numbers; and developing a procurement plan. Factors considered by the committee in these tasks include current treatment guidelines, costs, resistance patterns and available budget.

The **procurement process is regulated by legislation and organized centrally**. The Ministry of Social Affairs negotiates volumes, prices and schedules with the manufacturer. Mostly, drugs have to be registered in more than one EU country, although there are some exceptions, for example, if the drug is pre-registered with WHO. All procurements are done by open tender. In order to bid, organizations must have a wholesale licence.

The **main challenge faced with regard to antiretrovirals is the low volumes required**. Estonia has used the IDA Foundation to procure some generic medicines, for example, zidovudine. However, in general, this route is not seen as offering substantial savings over current approaches. It might be possible to procure antiretroviral medicines jointly with other countries, e.g. Latvia and Lithuania. This approach is already taken with vaccines.

There is currently **a proposal to change the system for procurement of antiretrovirals and to decentralize this to pharmacies**. There are concerns that this would risk less coherent treatment practices and higher prices. It is currently difficult to obtain transparent financial costs related to antiretrovirals in Estonia. The situation is similar in Latvia and Lithuania. Overall, pharmaceutical companies are not transparent about their costs or their use of donations of medicines.

Once medicines have been procured, the **wholesaler delivers the medicines to a central warehouse and is responsible for quantity and quality assurance**. Mostly, the wholesalers negotiate directly with companies. Medicines are then distributed to treatment centres in Tallinn, Tartu, Narva, Pärnu and Kohtla-Järve. There are also treatment centres within the prison system. Treatment is provided according to national guidelines which cover recommended regimens for those people with HIV starting treatment and those needing to switch to second-line regimens.

It is reported that there have been **some stockouts of second-line drugs**. The main problem is that the numbers are so small that even small forecasting errors can result in much higher demand for a particular drug than expected.

TB services

In general, **TB services are well-developed** with multidisciplinary approaches to both TB and TB/HIV co-infection. There are good links between TB services and the overall health system, and to social support and other services. There is good diagnosis and treatment of TB in prisons. There is a well-functioning laboratory system for TB with established quality assurance procedures and availability of rapid tests for TB.

Services for people who inject drugs

Overall, **coverage with needle and syringe programmes is good in Tallinn and Ida Virumaa**. However, services are less available outside these areas. There has been little use of pharmacies in providing services to people who inject drugs¹⁰. Some services for people who use drugs are very limited in some areas, for example opioid substitution therapy in Tartu. One specific challenge in expanding access to opioid substitution therapy is excessive regulation over who can prescribe methadone. Currently, only psychiatrists can prescribe methadone. This regulation is inappropriate and restricts access to essential treatment. Some services, such as buprenorphine substitution and naloxone for management of drug overdose are either available only to paying clients or are unavailable. There is limited availability of detoxification services. Rehabilitation services are poorly defined, limited in capacity, fragmented and poorly funded.

The **integrated delivery (p41), in some settings, of services for people who use drugs, such as antiretroviral treatment, TB treatment and opioid substitution therapy, is a welcome development**. However, there is still relatively little integration of harm reduction and other services. The introduction of opioid substitution therapy in arrest houses and prisons is an extremely positive step.

Prisons

Countries have a responsibility to provide health services to those within their prison system that are equivalent to those available in the community. In Estonia, **the Ministry of Justice is responsible for health services in prisons**. There are five prisons¹¹ and one prison hospital¹² in Estonia. These accommodate around 3,400

¹⁰ In commenting on the report, the National Institute for Health Development referred to a publication by Vorobjov et al., in 2009 which focused on the provision of syringes in the pharmacies. However, this publication does not appear to be among those provided to and reviewed by the evaluation team. Entitled 'Should pharmacists have a role in harm reduction services for injecting drug users? A qualitative study in Tallinn, Estonia' the study concluded that pharmacists reported a readiness to sell syringes to injecting drug users to help prevent HIV transmission. However, negative attitudes toward injecting drug users in general, and syringe sales to them specifically, were identified as important factors restricting such sales. The idea of free distribution of clean syringes or other injecting equipment and disposal of used syringes in pharmacies elicited strong resistance. Injecting drug users stated that pharmacies were convenient for acquiring syringes due to their extended opening hours and local distribution.

¹¹ Tallinn, Tartu, Harku, Murru and Viru. Tallinn, Tartu and Viru cater for pre-trial detention in addition to post-trial detention. Murru is an open prison.

¹² In Tallinn

prisoners, including those in pre-trial detention. This is a rate of 256 people per 100,000 population. Around 5.5% of the prison population are female and about 1% are under the age of 18. In addition, there are 53 detention cells, in which a person can be held for up to 48 hours, and 14 arrest houses, in which a person can be held for up to six months. The Ministry of Interior is responsible for the provision of health services in detention cells and arrest houses. Only three arrest houses employ health professionals. There are difficulties in attracting staff with the required level of skills and knowledge because the level of salaries available is low.

Although the **rate of imprisonment in Estonia has fallen since 2005**, it remains one of the highest rates in the WHO European Region. Reasons for the falling rate include an increasing number of prisoners released on parole and a reduced number of people entering the system. In recent years, there has been significant investment in prison infrastructure in Estonia. There are plans to move prisoners in Tallinn prison to a new building in the near future. There have also been important health-related prison reforms in recent years, including improved HIV testing and introduction of opioid substitution therapy. In 2010 a non-smoking policy in prison cells and wards was implemented, protecting non-smoking prisoners from the harmful effects of cigarette smoke.

Tartu prison specializes in catering for drug dependent prisoners. There is a rehabilitation unit and prisoners can stay there for nine months. Following that, they can go to a post-rehabilitation centre for a further six to nine months before being returned to their 'home' prison or released. Drug-rehabilitation units are also available in Viru prison and in Harku and Murru prison (8 places for women). The unit in Tartu prison is the largest and can accommodate 174 people.

Each prison has its own health care services department. Inpatient medical care is provided in the prison hospital in Tallinn. **On entry into the prison system, all prisoners undergo medical screening**, including a chest X-ray for TB control and voluntary HIV testing. HIV testing is provided upon entry to prison on an 'opt-out' basis¹³. As a result, 99% of all prisoners are tested. In 2010, 4,380 HIV tests were reported in the prison system and 61 new cases were diagnosed upon entry to prison.. By the end of 2010, a total of 1,652 people within the prison system were living with HIV, which was more than one fifth (22%) of all people living with HIV in Estonia.

TB screening through X-ray is mandatory for all prisoners on entry into the system and this is repeated after one year. In 2009, 7%¹⁴ of all TB cases and 15%¹⁵ of all TB/HIV co-infections diagnosed in Estonia were detected in prisons.

TB screening, treatment and infection control measures in the prison system, in general, and the prison hospital, in particular, are strong. People with TB are usually treated in the prison hospital until cured but they may receive ambulatory treatment once they become smear negative.

¹³ In commenting on this report, the Ministry of Justice noted that HIV testing takes place according to the rules of the document 'The Conception of Fight against the Drugs in Prison'.

¹⁴ 30/140

¹⁵ 6/39

Prisoners are vulnerable to HIV infection in many countries for a variety of reasons. People who inject drugs are often arrested and imprisoned. HIV services for people who use drugs, such as access to sterile injecting equipment and opioid substitution therapy, are often less available inside prisons than outside in the community. In addition, anal sex among prisoners is common and access to condoms may be more limited than outside the prison system. In Estonia, the Ministry of Justice reports that:

- In 2010, there were 877 drug dependent prisoners in Estonia. This represents more than a quarter (26%) of the prison population.
- In 2010, a total of 64 prisoners received opioid substitution therapy. In the first six months of 2011, a further 51 prisoners received opioid substitution therapy. The prison system also provides symptomatic relief for drug dependent people, including provision of anti-depressants and painkillers.

In addition, in the first six months of 2011, the Ministry of Interior reports that 104 people in detention cells and arrest houses received **opioid substitution therapy**. However, there are reports that some psychiatrists are only prescribing methadone in tapering dosages aimed at ultimate withdrawal. This is inappropriate. Methadone should be available on a maintenance basis in prisons as in the community. In addition, most of those receiving opioid substitution therapy were on this treatment when they entered the prison system. There has been very limited initiation of this therapy within the prison system despite the fact that imprisonment provides an excellent opportunity to identify drug dependent people and to start people on opioid substitution therapy in a highly-controlled environment. Barriers to scaling up opioid substitution therapy include lack of substitution therapy guidelines, low coverage of substitution therapy in the community and the myths and misinformation that exist among prisoners and prison staff. These myths and misinformation need to be addressed as they mean that people are reluctant to enter treatment and may face stigmatization once they are receiving therapy.

Although needle and syringe and condom distribution programmes are widely implemented in Estonia, this is not the case in the prison system. Although free condoms were provided in prisons when Estonia was receiving Global Fund financing, access to condoms is now very limited in prisons, only in long-term visiting rooms, through the health care services departments and in prison shops. Needle and syringe programmes are not implemented in Estonia's prisons. While recognizing that it has proved difficult for many European countries to introduce needle and syringe programmes in prisons, there is little doubt that such programmes are needed in the Estonian context to prevent the spread of HIV among those who inject drugs while in prison.

NGOs have worked to a limited extent on HIV in Estonian prisons. For example, Convictus has been active in prisons for the last eight years, particularly through organizing support groups for prisoners living with HIV and those who inject drugs.

At the time of the evaluation, there were **about 500 HIV positive prisoners in Estonia**, constituting around 14% of the total prison population. There were 15 TB cases diagnosed in the prison system in 2010, 5 of whom were HIV-positive. Data is

not available on how many of these are people who inject drugs. Antiretroviral therapy is reported to be available in all prisons in the country. At the time of the evaluation, a total of 242 prisoners were receiving antiretroviral therapy. This is 48% of those known to be living with HIV.

At the time of the evaluation, only **one person was reported to be receiving treatment for hepatitis C in the Estonian prison system**. Given the number of people who inject drugs in prison and the high rates of hepatitis C infection among people who inject drugs, it is likely that many more people need treatment. Vaccination for hepatitis B is provided to all prisoners that belong to a risk group and who have not been vaccinated previously.

Continuity of care upon release from prison is an area that could be strengthened considerably. Currently, responsibility for accessing services after release rests almost exclusively with the ex-prisoner. Released prisoners on medical treatment, such as antiretroviral therapy, are only provided with three to seven days of medicines on release. The evaluation team received worrying reports that up to half of all prisoners discontinue their antiretroviral therapy on release from the prison system. There is an opportunity for greater involvement of civil society organizations in offering social support and accompanied referral to health services post-release. Naloxone is not yet available in Estonia. Availability of this medicine is of critical importance for ex-prisoners because of the high rate of drug overdose and related deaths among ex-prisoners in the first few weeks after release.

Financial flows

Estonia has **mandatory health insurance** which accounts for around 70% of all health financing. It is financed largely from salary-based payments made by employers. Health insurance covers around 95% of the population of Estonia. Those covered include: employed people, the registered unemployed and registered disabled (see Estonian Health Insurance Fund, 2010, p33). Those who are not covered by health insurance include those who are not working but are not registered unemployed. Many people who inject drugs do not have health insurance.

Estonia's health insurance is managed by a **National Health Insurance Fund** that was established in 2001 from 17 regional bodies. The Health Insurance Fund is a public company with no shareholders. Any annual surplus is carried forward for future service provision. The Health Insurance Fund contracts and pays health care providers. It also reimburses pharmaceutical purchases and provides maternity and sick pay. The Health Insurance Fund has a board that is chaired by the Minister of Social Affairs. The Fund has a long-term and short-term strategy, a budget and a list and price of services. Services paid for by the Health Insurance Fund include primary services, specialist services, reimbursement of pharmaceuticals, sick and maternity pay, prevention services, long-term care and administration. Reimbursement of pharmaceuticals varies from 50 to 100% depending on the particular medicine. There is an agreed procedure for adding new services. HIV testing is not currently coded separately by the Health Insurance Fund but is listed among other laboratory tests. As a result, it is not possible currently for the Fund to report on the number of HIV tests it has financed. Although some respondents reported that the Health Insurance Fund was reluctant to change this, the Health

Insurance Fund disputed that this was the case but reported that the change could be made but would take some time to implement. Following the evaluation visit, the team were informed that this change was expected to take place in 2012.

Overall, the **system is strong but there are issues of rising numbers of people needing to be covered**, e.g. older people, and a reducing number of people contributing to the scheme through taxation. Some initiatives for broadening the tax base are under discussion, e.g. a social tax for pensioners, but these are politically unpopular.

In 2008, the Health Insurance Fund faced a **budget cut** of €32m. One way it dealt with this was to apply a coefficient to its payments. In 2008, these coefficients were 0.95 for specialist care and 0.97 for primary care. It is currently expected that these coefficients will be abolished in 2012.

Some health services are financed directly from the **state budget** by the Ministry of Social Affairs. These include emergency ambulance services, emergency services for uninsured people and public health programmes, such as responses to HIV and TB, and provision of opioid substitution therapy.

Budgets available to public health programmes have been reduced as a result of the international financial crisis. For example, the budget available for TB and HIV programmes fell from €4.4m in 2008 to €3.4m in 2009 and 2010. The National Institute for Health Development had some flexibility as to how cuts were applied to particular public health programmes. Priority was given to programmes focused on TB, HIV and drugs with lower priority given to cardiovascular disease, cancer and injury prevention. Within the HIV programme, the Institute tried to prioritize essential services, such as harm reduction services for people who inject drugs. Cuts were made to services considered less essential, such as general information campaigns and financial support to municipalities.

In general, respondents reported that **the National Institute manages the budgets of public health programmes extremely well.** The cuts were handled extremely well, the administrative burden is light and organizations are able to have a five year base contract with the Institute. As a result, many organizations reported that they preferred to have contracts with the Institute than with municipalities.

The **state budget also finances prison health services through the Ministry of Justice.** The Ministry of Justice has also faced declining budgets since 2008 but they report that they have maintained services.

Municipalities provide some funding for HIV services, for example, some municipalities finance the running costs for buildings used by some low threshold centres.

Some health costs are also met from **user fees**. For example, patients¹⁶ pay a consultation fee of €3.20. Those receiving long-term services are reported to be

¹⁶ With the exception of pregnant women, children under two years, those receiving primary care and those being treated for TB

required to pay this fee every three months. Although this fee is very modest, respondents report that this is a barrier to receiving services among people with no regular income, such as many people who inject drugs.

Opportunities to access **external donor funds** are very limited for Estonian NGOs. UNODC's regional project has funded some training but this project is ending at the end of 2011. NGOs can also access EU Social Funds. For example, the National Institute for Health Development manages a health programme financed through EU Social Funds and there is an annual call for proposals from NGOs to provide services, such as counselling for drug users and people living with HIV. In addition, the Ministry of Social Affairs operates a similar programme focused on addressing unemployment to which NGOs can apply. However, the management of this programme is reported to be complicated and time consuming.

Monitoring, evaluation and quality assurance

The National Institute for Health Development has developed a relatively **strong system for monitoring elements of the national HIV and TB response** for which it is responsible. This system has allowed quantitative tracking of the level of services provided. However, there are some limitations to this system:

- It says little, if anything, about the quality of service provided. Although Estonia has had some involvement in a European initiative to improve the quality of HIV prevention services (IQHIV, 2011), this experience has not yet been incorporated into practical monitoring of HIV prevention programmes in the country.
- Although, in principle, the Ministry of Social Affairs has oversight of drugs and HIV strategies, there is no obligation for other ministries to report to the Ministry of Social Affairs on the extent to which they are delivering on their obligations in these areas. Neither the Governmental Committee on Drugs Prevention (see p20) nor the Governmental Commission on HIV/AIDS (see p20) have yet been used for this purpose. Nevertheless, there has been some inter-ministerial collaboration on data sharing. For example, the Ministries of Justice and Interior do report on the number of new HIV and TB cases in prisons. Some data on drugs is reported to the monitoring centre.

The **Estonian Drug Monitoring Centre** is responsible for the preparation and submission of annual progress reports on the national drugs strategy to the Government Committee on Drug Prevention (see p20)¹⁷. The reports:

- Describe the drug situation
- Give an overview of the implementation of the action plan in the previous year

¹⁷ According to the Act of the Narcotic Drugs and Psychotropic substance and its precursors, the Estonian Drug Monitoring Centre is to collect and analyze the existing epidemiological and statistical data concerning drug situation and assess the prevalence of drug use (13.04.2005 entered into force 20.05.2005, RT I 2005, 24, 180).

- Give recommendations on actions to be taken.

The annual report drafted for EMCDDA and the financial report are reviewed by the members of the Committee and submitted to the Government by the Ministry of Social Affairs. So far, no evaluation of the Drugs Strategy has been conducted, but a final evaluation is planned in 2012. The **Committee (see p20) cannot hold the responsible institutions accountable for failing to implement the drugs action plan**. The Department of Public Health within the Ministry of Social Affairs is responsible for day-to-day coordination in the drugs field, but there is no officially-nominated drug coordinator within the Ministry.

It is **unclear which institution is responsible for quality assurance of drug prevention and drug treatment services**. The Health Board monitors compliance of methadone maintenance therapy¹⁸ with existing legislation. There is no practice of involving service users in quality assessment.

Organizational development and capacity building

An **effective response to HIV requires involvement of a strong and vibrant civil society in all elements of the response**, including planning, implementation and evaluation. One way of strengthening civil society is by promoting networking and coalition building among civil society organizations, such as harm reduction service providers and organizations that represent people who inject drugs and clients of opioid substitution therapy programmes. Such networking can assist in developing shared advocacy priorities and plans. These networking activities should ideally be led and coordinated from within civil society organizations themselves. In some countries, such work is led and coordinated by an umbrella body representing all such organizations. However, there is no such civil society coordinating body in the HIV/drugs field in Estonia.

The **Estonian Network of People Living with HIV** is represented on the National Commission on HIV (see p20) and its various working groups. Such a model could be used by civil society to mobilize and represent other key populations, such as people who inject drugs, clients of opioid substitution therapy programmes and men who have sex with men.

The **Estonian government provides funding to civil society organizations** working in the national response to HIV through contracts awarded through national tenders. Services provided through such tenders include needle and syringe programmes and provision of supportive services to people who inject drugs and people living with HIV. Estonian NGOs have been pivotal in achieving high levels of coverage with needle and syringe programmes in the most-affected parts of the country. Services provided to people living with HIV by civil society organizations include peer counselling, psychosocial support, adherence support and referrals to medical care (see Box 2). This funding support has not only allowed civil society organizations to provide key services within the national HIV response but it has also allowed them to build their capacity.

¹⁸ As it does for all healthcare services

However, there are **a number of structural factors which are inhibiting the capacity development of NGOs**

working in the national response to HIV. Many of these relate to funding and include lack of consistency in funding, lack of long term guarantees of funding and lack of core funding. NGOs in Estonia find it difficult to attract donor funds because the number of donors willing to provide funding to EU Member States is limited and the administrative requirements of those that do provide

such funding are high. Capacity to raise funds in-country, e.g. from corporate and individual supporters, is reported to be more limited than in some other EU Member States. Limited financial resources mean that NGOs are unable to offer competitive packages to their staff which makes it difficult to attract and retain appropriately-skilled staff. NGOs in Estonia could begin to address these issues themselves, e.g. by developing and implementing appropriate fundraising strategies and by improving their human resource management systems. However, their capacity to address these matters without external support is limited.

Box 2: People living with HIV provide support services at Infectious Diseases Hospital in Tallinn

The Estonian Network of People Living with HIV provides support services to other people living with HIV at the Merimetsa Infectious Diseases Clinic of the West Tallinn Central Hospital. The clinic provides the network with premises and clinic staff meet with network representatives on a weekly basis to discuss issues related to individual clients and more general issues relating to their mutual cooperation

In addition, some inappropriate regulatory barriers are preventing the further expansion of services to key populations affected by HIV. One example of this relates to the provision of HIV testing through low threshold centres and needle and syringe programmes. In order to offer HIV rapid testing, such services would need to be affiliated to a medical institution. As this is not always the case, opportunities to provide members of key populations with HIV testing may be being missed. As low threshold harm reduction services may be the only health service accessed by many people who inject drugs, this represents a very significant missed opportunity which may be contributing to unnecessary delays in diagnosing HIV among these populations. There may also be issues related to people diagnosed with HIV entering programmes that can provide them with medical care and access to treatment. One way of addressing this would be through involvement of harm reduction service providers that they trust to assist and support them to access such services.

Access to services

Assessment of service need

A number of focused services are needed to prevent HIV transmission among the key populations affected by HIV in Estonia.

In general, in order to determine the scale of services needed for particular populations, such as people who inject drugs and sex workers, a country needs **an up-to-date and credible estimate of the population size**. In addition, information is needed about relevant risk behaviours, such as, for people who inject drugs, the type of drugs used. Estonia has some information of this nature and it is understood that results of a further study into these matters will be available at the end of 2011.

Overall, there is a need for:

- Harm reduction services to be available in all areas of the country.
- Harm reduction programmes to offer a comprehensive range of services, for example, including community-based, peer-to-peer distribution of naloxone.
- Harm reduction services to reach out and be tailored to particular subgroups of those who inject drugs, such as women and amphetamine users.
- Significant expansion of opioid substitution therapy.
- Treatment and rehabilitation interventions for amphetamine injectors.
- Significant expansion of HIV prevention programmes for sex workers.
- Targeted low threshold services for men who have sex with men. Initially, such programmes could be supported and developed in Tallinn and then expanded to other cities.

Respondents expressed concern about **the large numbers of people who are being diagnosed late with HIV (see p34)**. There are concerns that those populations most at risk of HIV infection, such as people who inject drugs, sex workers and men who have sex with men have limited access to HIV testing and current practice may result in many low risk people being tested with resultant waste of scarce resources. More focused HIV testing of key populations through low threshold centres might address this issue.

In addition to HIV prevention services, there is a need to provide **treatment, care and support services for people living with HIV**. A range of services are needed including:

- Psychosocial support. NGOs providing low threshold services report high demand for social support, such as assistance to access documents, find a place to live, find work, enter drug rehabilitation, obtain health insurance, support children and deal with debt.
- Access to laboratory monitoring, .e.g. CD4 counts. There are reports of some interruptions in availability of these.
- Treatment of opportunistic infections
- Opioid substitution therapy for people with HIV who also inject drugs. This therapy is an essential adjunct to antiretroviral therapy.
- Access to treatment for hepatitis C. Currently, this treatment is not available to those without medical insurance, such as the majority of people who inject drugs. Also, current guidelines for hepatitis C treatment indicate that a contra-

indication for this is current drug use. This directly contradicts WHO guidelines and is likely to have damaging public health consequences.

In order to provide these services, there is a need to ensure that health services have **adequate human resources**. However, some apparent shortages of certain human resources, such as psychiatrists, may occur because of inappropriate regulations restricting use of certain drugs, such as methadone, to certain groups of medical professional.

A major barrier to people who inject drugs and people living with HIV accessing medical services is if they experience **stigma and discrimination from health staff**. There are some reports that these still exist in Estonia and need to be overcome by providing more client-centred services.

Because of the complex way in which services are provided, respondents commented that there is a need for **case management** of people living with HIV to help them navigate successfully the array of available services. An alternative approach would be to simplify and streamline the provision of services, that is providing more services in the same location (see p41).

Availability of services

Respondents expressed concern about **limited HIV prevention activities in schools**. The Ministry of Education receives criticism for not having continued activities that were started in schools with Global Fund financing. However, the decision taken by the Ministry of Education to focus on introducing HIV into the curriculum rather than providing ad hoc training activities is probably the correct one. However, it took an excessively long time to introduce the relevant curriculum. The evaluation team was not able to assess services related to primary drug prevention as no information was provided on this¹⁹.

Other services are considered in two groups, those that relate mostly to the health of people living with HIV and those that relate to the health of people who inject drugs.

Health care of people living with HIV

Respondents expressed concern that **HIV testing is not sufficiently focused on key populations**. For example, it is reported that many people who inject drugs have still not received an HIV test. However, the number of HIV tests performed in Estonia has risen dramatically from around 100,000 annually in 1998 to around 200,000 in 2004. One change has been the requirement to offer HIV testing to all pregnant women and there has also been more testing for clinical reasons.

¹⁹ In commenting on the draft report, the National Institute for Health Development referred to a study the Estonian Drug Monitoring Centre had conducted in 2011 in order to determine the current situation regarding drug and sex education in schools, the factors that support the teaching process and the problems faced in these areas. The study concluded that it is positive that drug and sex education are included in the national curriculum of basic school and upper secondary schools and that the respective issues are addressed in schools. But, there is need for consistent teacher training

Clinical HIV services are provided almost entirely by infectious disease clinicians in five treatment centres. Family practitioners are still largely uninvolved in providing HIV care.

There is a commitment to provide **antiretroviral therapy** to all people living with HIV that need it and considerable progress has been made to achieve this commitment: For example, the number of people receiving antiretroviral therapy rose from 100 in 2004 to 2,039 in 2011 (see Table 1). This number includes 228 people in prisons, 45 pregnant women and 22 children less than five years old. Antiretroviral therapy is financed directly from the state budget and is available regardless of whether people have health insurance or not. Forecasting how many people require treatment has proved difficult. International models to predict treatment numbers have overestimated numbers. As a result, a different short-term model is being used. It is currently estimated that the number of people needing treatment might rise to 2,750 in 2012 with a further 3,500 people needing treatment within five years.

Table 1: Number of people receiving antiretroviral therapy: 2004-2011

2004	2005	2006	2007	2008	2009	2010	2011
100	250	495	772	1026	1387	1793	2039

Source: National Institute for Health Development, 2011

WHO recommends that **antiretroviral therapy should be provided to all people living with HIV who have associated TB** regardless of CD4 count. However, a few examples were encountered where this was not the case. In these cases, clinicians had decided not to start the patients on antiretroviral treatment because their CD4 count was high and they were considered not to need treatment. This approach is contrary to current WHO guidelines. Respondents commented that many people living with HIV are reluctant to start treatment because they fear losing an important disability pension.

Current treatment guidelines are agreed by a working group and reflect CDC, European and WHO guidelines. The majority of cases are treated with two first line regimens. All patients identified as in need of treatment receive treatment. Although there have been no treatment interruptions, there have been logistical problems and shortages in second line treatment.

A large proportion (30-40%) of **people still present very late in the system (see p32)** with CD4 cell counts below 350. There is relatively high mortality among people living with HIV from TB with occurrence of advanced AIDS-defining diseases, such as generalized TB. Better understanding is needed of the types of people presenting late with HIV. For example, the Estonian Society of Infectious Diseases is seeking to address the issue of late diagnosis by promoting routine testing for HIV in health facilities. This could be an appropriate strategy if there is evidence that people access health services in the months leading up to the time when their HIV diagnosis was made. This would represent a significant opportunity missed. However, alternatives may need to be found if people are currently being diagnosed on their first contact with formal health services. Early case finding through greater involvement of civil society organizations could be one solution. This might not only result in earlier HIV diagnosis but could also result in more of those diagnosed entering the clinical care system. More active collaboration of staff from the five

treatment centres with civil society organizations and family practitioners is needed. However, a limited trial of offering people who inject drugs a small incentive of €5 for seeking treatment after a positive HIV test result did not appear to result in more people accessing medical services.

Although Estonia has had a database²⁰ of HIV patients since 2009, **clinical data available related to people with HIV** is limited. Data is entered by clinicians and there is currently little incentive to enter full and complete data. At the time of the evaluation, the database held information related to 1,283 people living with HIV. However, this database does not have information on antiretroviral regimens used. As a result, information on adherence and treatment failures is not widely available and this makes resistance monitoring very difficult.

Such patient monitoring combined with the use of early warning indicators is needed to prevent drug resistance in Estonia. Research shows that various programme and site factors are closely associated with the emergence of **HIV drug resistance**. Their monitoring can serve as early warning indicators to support appropriate programme and patient management. WHO has identified eight HIV drug resistance early warning indicators (see Table 2). Each of these has an associated recommended target. WHO recommends their annual monitoring in all, or a large number of representative, sites (Bennett et al., 2008; WHO, 2010a) using routinely available data. Estonia still does not have a national plan or working group for the prevention of HIV drug resistance.

Table 2: List of early warning indicators and associated recommended targets

Early Warning Indicator	Target (%)
1. Percentage of initial prescriptions for antiretroviral therapy congruent with national/WHO guidelines	100
2. Percentage of patients lost to follow-up at 12 months	≤ 20
3. Percentage of patients retained on first-line antiretroviral therapy at 12 months	≥ 70
4. Percentage of patients with 100% on-time drug pickups during the first 12 months of antiretroviral therapy, or during a specified time period	≥ 90
5. Percentage of patients who attended all appointments on time during the first 12 months of antiretroviral therapy, or during a specified time period	≥ 80
6. Antiretroviral drug supply continuity during a 12 month period	100
7. Percentage of patient adherence to antiretroviral therapy by pill count or other standardized measure	≥ 90
8. Percentage of patients with viral load <1000 copies/ml at 12 months	≥ 70

Simple treatments, such as Isoniazid preventive therapy and cotrimoxazole prophylaxis, to **prevent opportunistic infections** are not routinely available. WHO currently recommends isoniazid preventive therapy for people living with HIV (WHO,

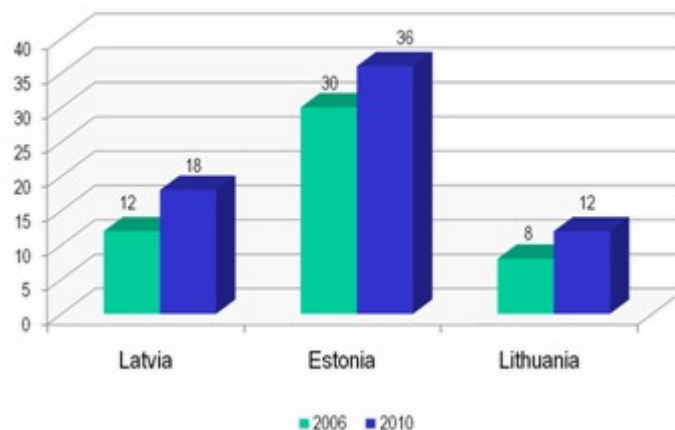
²⁰ In commenting on the draft report, staff of the National Institute for Health Development reported that there are two separate databases – one is a general infectious diseases database which includes all cases and another is a clinical database which includes treatment regimens and other clinical data.

2011b). However, representatives of Estonia's National TB Programme were concerned about poor adherence to the therapy and risk of stimulating antibiotic resistance.

Health care of people who inject drugs

Overall, there is **good coverage of needle and syringe programmes in Estonia**. At the time of the evaluation, there were 36 centres²¹ in the country, having risen from 30 in 2006 (see Fig. 2). This is double the number of centres in Latvia and three times the number of centres in Lithuania. This amounts to one centre per 383 people who inject drugs as compared to one per 450 in Lithuania and one per 1,000 in Latvia. As a result, the coverage of these programmes, in terms of numbers of syringes distributed annually per person who injects drugs is high compared to both Latvia and Lithuania (See Fig. 3). Based on a study conducted in Tallinn, people who inject drugs report that they obtain clean syringes mainly from needle and syringe programmes and pharmacies. They reported that they can obtain syringes relatively easily. However, they emphasized the need for greater access to other injecting equipment. Kits containing a syringe, needle, spoon, filter and sterile sponge were seen positively by people who inject drugs. In other countries, provision of sterile water and sharps containers have been shown to have a positive influence on the behaviour of people who inject drugs. One possibility would be to make sterile water available for sale without prescription.

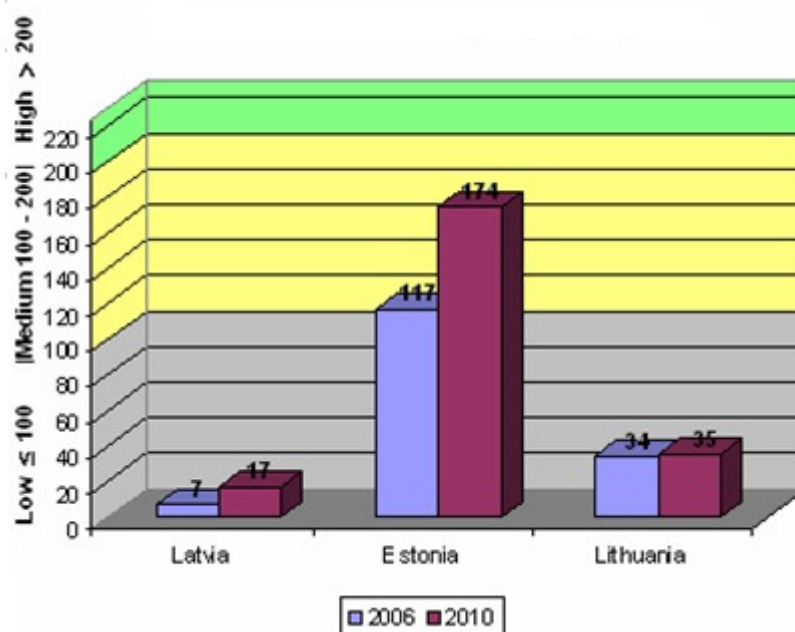
Fig. 2: Number of needle and syringe programme centres in Baltic States: 2006 and 2010



Source: National Institute for Health Development, 2011

²¹ Including outreach teams

Fig. 3: Numbers of syringes distributed per person who injects drugs annually in Baltic States: 2006 and 2010



Source: National Institute for Health Development, 2011

Coverage of people who inject drugs with opioid substitution therapy remains low.

At the time of the evaluation, opioid therapy was available in ten sites in five cities of Estonia. Coverage is limited to Tallinn and the north east of the country (see Fig. 4). In 2010, 750 people were receiving this therapy²², which amounts to around 5-6% of all people who inject drugs (see Fig. 5)²³. This is considerably lower than in Lithuania and in other European countries (see Fig. 6). Increases in coverage seen in both Latvia and Lithuania have not yet been seen in Estonia (see Fig. 7).

However, there have been successes in introducing opioid substitution therapy into prisons and arrest houses, and in integrating provision of this therapy with TB treatment in some settings. One factor which needs further research is the extent to which amphetamine use is growing among those who inject drugs. However, it is clear that access to methadone remains sub-optimal, particularly in prisons. It is reported that buprenorphine is only available in one site. It was reported to the evaluation team that most of the programmes providing opioid substitution therapy have a waiting list. However, the National Institute for Health Development disputes this and reported that only two sites have reported waiting lists. Services provided include psychosocial support in addition to provision of medicines. The UNODC

²² The National Institute for Health Development reports that these figures are for state-budget financed services only and that the actual number is higher, because, for example, in Tallinn local city municipality also supports substitution treatment. However, no figures for numbers receiving these other services were provided to the evaluation team.

²³ The team recognizes that this calculation could underestimate coverage of opioid substitution therapy in Estonia if there are significant numbers of amphetamine users among the denominator. It would be preferable to use either the number of problem opiate users or opiate injectors as the denominator. However, this figure was not made available to the evaluation team. Even if this number were used, it is likely that coverage of opioid substitution therapy would still be much lower than in other European countries.

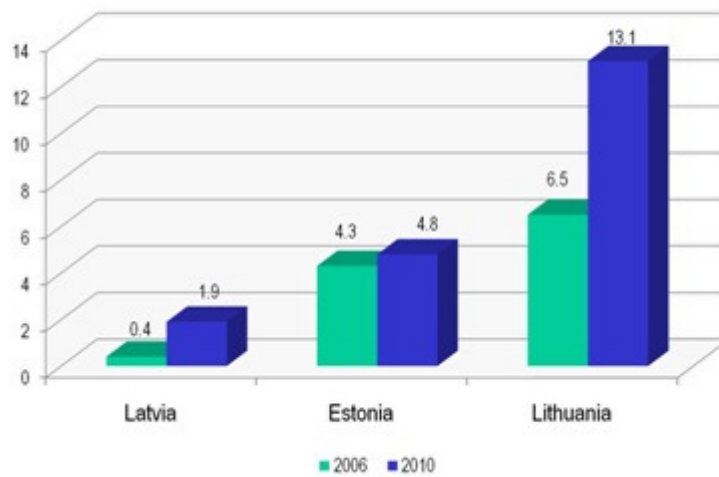
project has introduced a system of intercollegial learning for staff of these programmes, termed ‘intervision’.

Fig. 4: Geographical distribution of opioid substitution therapy sites in Estonia in 2011



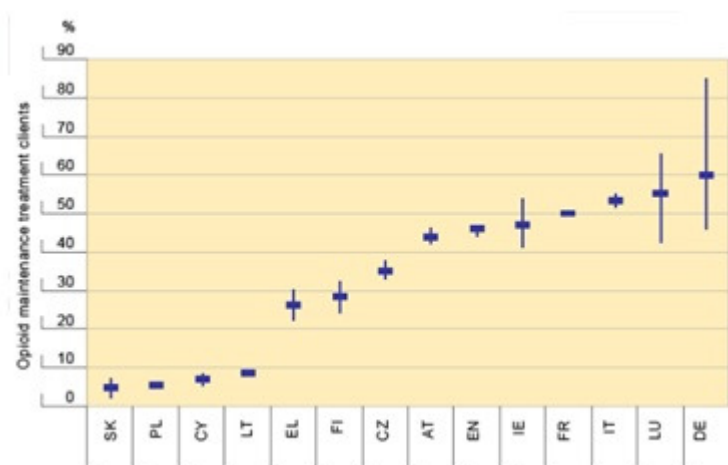
Source: National Institute for Health Development, 2011

Fig. 5: Coverage of opioid substitution therapy in Baltic States: 2006 and 2010



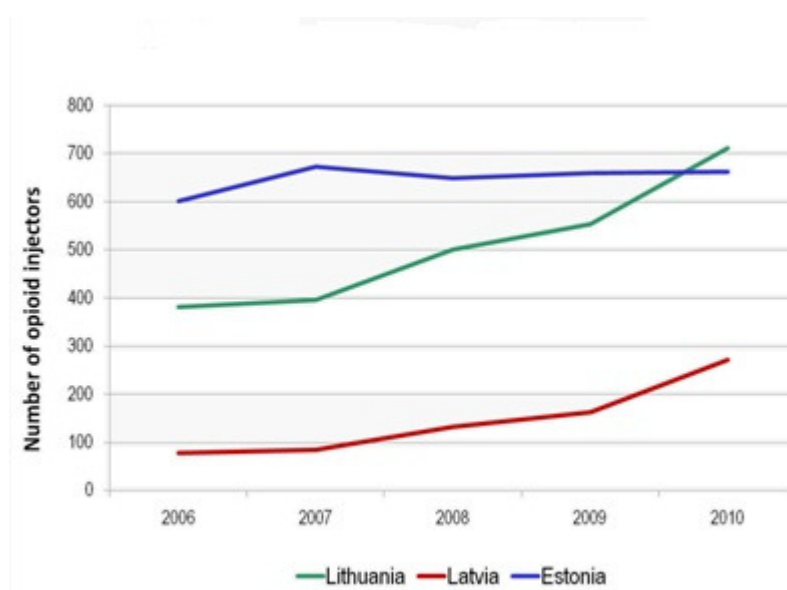
Source: National Institute for Health Development, 2011

Fig. 6: Coverage of opioid substitution therapy in selected European states: 2008



Source: EMCDDA

Fig. 7: Number of people on methadone therapy in Baltic States: 2006 to 2010



Source: National Institute for Health Development, 2011

Opioid substitution therapy still has a negative image among many drug users and health providers. In addition, staff of needle and syringe programmes do not have sufficient knowledge of the goals and benefits of this therapy. There are also inappropriate restrictions on the provision of methadone, e.g. the requirement that methadone may only be prescribed by a psychiatrist, excessive restrictions on provision of take home methadone²⁴ and recommendations frequent drug testing of

²⁴ The reason given for these restrictions is the high amount of methadone getting to the black market. However, similar restrictions are not applied to other drugs which also commonly reach the illegal market, such as benzodiazepines. The idea that provision of take home methadone should be restricted until the flow of methadone into the illegal market is controlled is misguided. Measures to restrict the flow of illegal drugs should not be applied which restrict the availability of medicines with profound health benefits, particularly when those control measures are of limited effectiveness.

programme clients. In the opinion of the evaluation team, the approach taken to drug testing appears to be based on the belief that people in opioid substitution therapy programmes should not be taking other drugs. As a result, some programmes apply sanctions to clients found to be taking other drugs and/or deny them access to other services, such as provision of sterile injecting equipment. These approaches reduce access to services and make the services less attractive and more expensive. Quality of opioid substitution therapy needs to be defined and improved.

In general, **services for people who inject drugs are less available in prisons** than in the community. Availability of condoms is more limited than it was during the time that the country received Global Fund financing. There is still no distribution of sterile injecting equipment. Services related to harm reduction, overdose prevention and sexual education are limited²⁵. There is limited support for prisoners on release. They only receive medicines for three to five days and are then expected to access treatment they need from health providers. There is very limited access to treatment for hepatitis C in prisons. At the time of the evaluation, only one person was receiving this treatment in all of Estonia's prisons.

Estonia has a web-based National Drug Treatment Database. According to this, **a total of 665 applied for drug treatment in 2010**. Drug treatment is funded from a variety of different sources including the national strategies for HIV/AIDS and Prevention of Drug Addiction and from municipalities. In addition, a person can pay for their own drug treatment. Drug treatment services are not currently included in the list of health care services financed from the Health Insurance Fund.

Currently, **detoxification services** are only available in two hospitals in Estonia – Wismari and West Tallinn²⁶. In 2009, funding was provided for detoxification of 32 clients. However, data on this is not comprehensive and it is likely that other people received detoxification services during this period.

It was reported to the evaluation team that Estonia has six²⁷ documented **rehabilitation centres** with a total capacity of less than 200 people. However, these services are poorly defined, limited, fragmented and insufficiently funded. But, according to a study carried out by the National Institute for Health Development,

²⁵ In commenting on the draft report, the Ministry of Justice explained that the Estonian prison system does not see the need for distributing sterile injecting equipment, bearing in mind that injecting behaviour within the prison system is very rare and the effectiveness of needle and syringe distribution is questionable. Also, the Ministry does not see the need for distribution of condoms, based on the idea that sexual contacts which take place between prisoners are not voluntary and based on power. According to the Ministry of Justice, different harm reduction measures have been selected and implemented within the prison system according to the principle that 'one should base solutions on one's needs'. The review team would like to re-emphasize the strong evidence for the effectiveness of distribution of sterile injecting equipment as well as condoms in reducing transmission of infectious diseases and the principle that health care services available to prisoners should be equivalent to those available in the wider community.

²⁶ In commenting on the draft report, the National Institute for Health Development provided the following information. In 2009, 32 patients were only in one treatment centre - OÜ Hospital in Kohtla-Järve. In 2010, according to the Drug Treatment Database, detoxification treatment was provided for a total of 65 people through seven medical centres, including two prisons.

²⁷ In commenting on the draft report, the National Institute for Health Development commented that the number of centres changes annually. Currently, there are seven for adults and two for adolescents, nine in total.

most of the clients in these centres are satisfied with the services offered and consider that their health and psychological condition had improved²⁸. The study recommended a critical review of the services offered and the workload of the specialists involved.

Despite an alarming increase in **drug overdose deaths**, naloxone is available only through emergency services.

Integration of different services

Estonia has **good examples of multidisciplinary approaches to the management of TB/HIV co-infection**. For example, there are sites in north east Estonia where TB, HIV and opioid substitution treatment are being provided in the same location. In general, TB/HIV collaborative activities function well and co-infected patients with active TB are well managed. HIV testing and treatment is available within the TB services. Estonia has one of the highest HIV testing rates among TB patients in the EU. In general, over the last ten years, there has been growing integration of TB services within the overall health system. While there are no NGOs currently working on TB, the current network of HIV-related NGOs could be supported to work more on TB/HIV issues.

There are also some **good examples of co-location of multiple services for people who inject drugs**. For example, the infectious diseases clinic in West Tallinn central hospital provides opioid substitution therapy and antiretroviral treatment in the same location, and this is supported by people living with HIV working as volunteers to improve treatment uptake and adherence. However, clinic staff reported that contractual restrictions on numbers of clients mean that no more than 30 people can currently benefit from this integrated approach. The National Institute for Health Development commented that it had offered to increase the number of clients but that the service provider decided not to because of limited human resources and in order to ensure the quality of services provided. This matter needs to be resolved between the National Institute for Health Development and the infectious diseases clinic in West Tallinn central hospital to allow more people to receive opioid substitution therapy.

Integration of services into low threshold centres is more limited. For example, these centres could be used much more to provide targeted HIV testing to those populations most affected by HIV. Greater integration of follow-up social and medical support for those testing positive for HIV is also needed.

Improving quality of services

The biggest advance in improving quality of care of HIV services could be achieved by developing **more client-centred services for stigmatized populations**, such as people who inject drugs. Mutual mistrust between these populations and the

²⁸ In commenting on the draft report, the National Institute for Health Development commented that the report was very critical and the sentence “most of the clients in these centres are satisfied with the services offered and consider that their health and psychological condition had improved” should be considered in the context that clients did not know what to expect from the rehabilitation services at all. Some of them were very happy to have some place to live.

medical community remains considerable. Methods to gather and use feedback from clients and involve them in decision making are still not used systematically even though these have been identified as vital elements in running effective public health programmes (Maguerez and Ogden, 2010). There has been some improvement in terms of involvement of people living with HIV, such as where infectious diseases clinic staff meet on a weekly basis with a co-located group of people living with HIV to discuss cases and services. However, this practice is not universal. In particular, it is not yet practised in drug-related services, such as opioid substitution therapy programmes. There are no methadone client boards in Estonia, although such boards exist in both Belarus and Ukraine. Improving the quality of opioid substitution therapy in Estonia is a pressing priority. Focus group discussions, client satisfaction surveys and supporting clients could open dialogue about improvement of quality of services and build trust between clients and medical staff. Additionally, some elements of opioid substitution therapy, e.g. access to buprenorphine, are more available to paying clients than to those funded by the state. Expanding choice and services could significantly enhance service quality. Improving access to services by making take-home doses²⁹ more available and providing services through pharmacies would also improve programme quality.

As noted in previous reports, there is still a need to develop **national standards** in several areas including harm reduction, case management and HIV treatment. Estonia does not have a treatment protocol for HIV which could lead to quality problems. Representatives of people living with HIV reported that sometimes drugs were prescribed on advice from pharmaceutical companies rather than based on WHO or CDC guidelines. Concerning harm reduction and case management, vital frontline work like outreach work and case management have yet to become recognized as professions. These jobs, so central to effective prevention and treatment should be supported with proper training, salaries and recognition of workers' rights.

There is **no agency in Estonia for monitoring the quality of social services** in the same way as the Health Board monitors health services.

The **Estonian Patient Association is relatively weak** and deals mostly with complaints that it receives. There are some disease-specific patient groups, such as those focused on cardiovascular disease and HIV.

CONCLUSIONS AND RECOMMENDATIONS

This section briefly considers conclusions from the evaluation and presents a small number of recommendations:

1. The current analysis of the HIV situation in Estonia is strong and appropriate. However, **there is a need for better analysis of ongoing transmission routes and a better understanding of current drug taking practices and their link to HIV transmission.**

²⁹ See footnote 24

2. Overall, Estonia's strategies on HIV and drugs are broadly appropriate. As the drug prevention strategy ends in 2012, there is an opportunity to bring these strategies closer together. There are currently plans to bring both these strategies into an overall population health strategy. If this done, **it is important that the strong focus on HIV and drugs and the intersectoral way of working in these areas are maintained and strengthened.**
3. Overall, management and coordination of Estonia's response to HIV and illegal drugs are strong. However, **there is a need to revitalize the Governmental HIV Commission and the Governmental Committee on Drug Prevention. These could perhaps be combined. There is a need for more round table discussions and working groups with organizations implementing programmes.**
4. Coverage of opioid substitution therapy remains low in Estonia. **There is need to expand opioid substitution therapy to achieve coverage levels similar to other European countries. In addition, there is a need to monitor its quality, to approve substitution therapy guidelines in line with international recommendations and to remove inappropriate regulatory barriers, such as the requirement that methadone can only be prescribed by a psychiatrist.**
5. The introduction in some places of integrated models of service provision for people who inject drugs, for example, providing antiretroviral therapy, opioid substitution therapy and TB treatment, is extremely welcome. **There is need for this integrated provision of services to be expanded.**
6. The introduction of opioid substitution therapy into prisons is an extremely positive step. However, **prisons lag behind other parts of the country in terms of providing other HIV prevention services, in particular distribution of condoms and sterile injecting equipment. This needs to be addressed.**
7. Estonia has scaled up needle and syringe programmes, particularly in Tallinn and Ida Virumaa. **Harm reduction programmes need to be expanded in geographical scale to cover the whole country and in the scope of services they provide, for example providing naloxone and HIV testing.**
8. **Significant numbers of people living with HIV are presenting late for diagnosis, clinical care and treatment. Reasons for this need to be understood and then addressed.**
9. In general management of both TB and TB/HIV co-infection is strong in Estonia. However, **there is need to promote early detection of TB among people living with HIV, ensure that all people with TB/HIV co-infection receive antiretroviral therapy regardless of CD4 count and ensure that isoniazid preventive therapy is available to people living with HIV.**

ANNEX 1: TERMS OF REFERENCE

TERMS OF REFERENCE

Mid-term evaluation of the Estonian national HIV/AIDS strategy 2006 – 2015 and national drug prevention strategy 2012

Background:

Estonia operates in a framework of the fourth national program/strategy for fighting HIV/AIDS – “National HIV and AIDS Strategy 2006-2015”. The strategy is relevant for activities in the health and other involved sectors to coordinate between them. The majority of the financial resources for implementing the strategy (and the national program before that) have been the state budget and in the past the support from the Global Fund to Fight AIDS, Tuberculosis and Malaria. In addition some support is provided by UNODC and WHO. In last years the resources from the European Social Fund (as part of government budget, but with separate rules) are allocated to public health, including HIV/AIDS. A closely related strategy is the “National Drug Prevention Strategy 2012” adopted in 2004.

Following the economical crisis in 2008, state budget allocations foreseen for implementation of the national public health strategies, including HIV and drug prevention, were significantly decreased. This in turn led to reviewing the national priorities within HIV and drug prevention, assuring budget necessary to maintain most critical services on achieved level (needle and syringe exchange, opioid substitution treatment, HIV testing and counselling, TB treatment) and temporary decrease in financing of some services (e.g. counselling for MSM) and activities.

What are the critical issues and areas implementing the current strategy?

- Strategic directions and strategies on HIV/AIDS and drug prevention;
- Coordination across sectors and accountability of health and other sectors;
- How to reach various (risk) groups;
- Assessment of service needs (a continuum from testing to treatment);
- Integration of HIV, drug use and TB services;
- Case management and other packages for integrated prevention/care;
- Sustainability of treatment and care for PLWH and people who use drugs;
- Improving quality of prevention and care;
- Sustainability of systems and funding.

Background materials for desk work and preparation:

List background data, reports available at the time of evaluation: i.e. UNODC final project report, surveillance report, finance report of previous year, human rights report, development report, ECDC mission report 2010 on HIV/STI, ECDC/WHO mission report on TB, WHO triangulation report on HIV specific questions, drug use report, etc.

Objective of the evaluation

The objective is to evaluate the last 3 years, 2008-2010 and give a perspective beyond 2015

Focus:

- 1) Integration of coordination and services under two national strategies - HIV and drug use.
- 2) Integration of HIV related services and the continuum of services needed starting from entry point (like syringe exchange or testing) to different health care services for PLWH.

The aim of the evaluation is to give practical input to Estonia for further developing the area of HIV/AIDS interventions in the future. In a larger scale the evaluation answers questions whether Estonia does the right things and whether those are done correctly to improve performance. The reference to describe interventions will be best practices in Europe (and European Union Member States where relevant). For that the evaluation needs to assess and give recommendations on two main areas: structures and systems in place, coverage and quality of services. The evaluation is requested by the Ministry of Social Affairs (MoSA) and the National Institute for Health Development (NIHD) as integral part of the collaborative agreement between the Government of the Republic of Estonia and the World Health Organization to support the scaling up the response to HIV/AIDS in Estonia.

Areas and key questions:

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

- 1.1.** Management and coordination systems (including structures and systems for drug use);
- 1.2.** Sustainability of systems and funding;
- 1.3.** Organizational development and capacity building of coordinating institutions and service providers.

Questions to be answered when investigating each of the areas (1.1-1.3):

1. What is the capacity of the systems and organizations in place?
2. Do present structures support the needs in solving the problem in Estonia?
3. What are the strong and weak parts of the developed systems?
4. Are there areas that need revision/restructuring, gaps to be filled or unnecessary practices that need to be dropped?
5. What is needed to further scale up the national response?

1.4. Integration of services

Questions to be answered when investigating area 1.4:

1. What are the linking and overlapping issues between the two strategies and how to make better use of resources by better integration of the systems and services (including the services targeted at drug users who are not injecting).
2. To what extent are HIV and AIDS services integrated to other services needed (TB, HCV, STIs, antenatal care, etc) and related to each-other?
3. What are the main gaps and positive developments in integrating different services?
4. How to integrate the existing services better considering existing possibilities (related to funding and service providers) and what are the critical activities missing?

The levels to look at under the section one:

- State level

– Level of NGOs and other service providers

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

2.1. Prevention and health care services targeted at IDUs, SWs and convicts;

2.2. Health care of PLHIV – health monitoring, ARV, relation to TB, HCV and STIs, getting PLHIV to the health care system;

2.3. Health care of people who use drugs – drug treatment, aftercare, throughcare.

2.4. Psychosocial support to PLHIV and people who use drugs and case management.

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

1. Is coverage of interventions sufficient for solving the problem, increasing the quality of life of PLHIV and people who use drugs?

2. What are the main problems in achieving the sufficient coverage?

3. Are the services accessible to the target groups?

4. What are the hindering factors related to accessing the services?

Methods

Evaluation mission will be organized with a focus on evaluating structures and systems in place and coverage and quality of services for people who use drugs, PLHIV.

Methods for evaluation:

- Desk review of documents, reports and other materials related to HIV/AIDS issues in Estonia. Materials will be provided by MoSA and NIHD before the in-country mission.
- Interviews with key informants in chosen organizations with visits to service provision sites. Key informants will be relevant government officials in different ministries and NIHD, representatives of NGOs, private companies and hospitals. Organizations will be chosen in cooperation of evaluation experts and national partners.

Expertise needed:

- organizational development
- system analyses (including financial systems)
- state level management
- national level programme planning and delivery
- capacity building in public health
- institutional support for NGOs
- NGO structures and capacity
- needed coverage and systems in HIV/AIDS prevention
- reaching and influencing target groups
- health care systems
- infectious diseases related to HIV/AIDS

Partnerships:

- World Health Organization Regional Office for Europe: HIV/AIDS, STI and Viral Hepatitis, Pharmaceuticals, Health Systems, Tuberculosis
- Independent consultant(s)
- UNODC
- Civil society: AIDS Action Europe expert

- ECDC surveillance expert
- Ministry of Social Affairs – organizing meetings (including those with other Ministries), solving technical issues, providing inputs.
- National Institute for Health Development
- Ministry of Justice – organizing meetings under the domain of the ministry.

First contact: Merilin Mäesalu, Ministry of Social Affairs.

Experts involved: Ulrich Laukamm-Josten, WHO/EURO (Team leader), Roger Drew, independent consultant, Signe Rotberga, UNODC, Shona Schonning, independent consultant (Civil Society), Brenda van den Bergh, WHO/EURO, and Risards Zaleskis, WHO/EURO.

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

Timeframe for one week mission:
18-23 September 2011.

Output

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

- Each of the evaluators involved write a 2-3 page long report on each area s/he has to cover after the mission in Estonia. When writing the report answers will be given to all questions listed in Terms of Reference and maximum 3 recommendations given for improving the situation.
- All evaluators will send their parts by October 19th to the writer who will integrate different parts to the overall report and send the draft report to NIHD by November 18th. NIHD will give its comments until December 9th.
- The deadline for the final consolidated report is December 19th, 2011.

ANNEX 2: DOCUMENTS REVIEWED

Abel-Ollo, K. (2011) *Illicit Drug Use in Estonia* PowerPoint presentation to evaluation team, 19th September

Anonymous (undated, a) *National Drug Strategy*

Anonymous (undated, b) *National Drug Prevention Strategy, 2012*

Bennett, D.E., Bertagnolio, S., Sutherland, D. and Gilks, C.F. (2008) *The World Health Organization's Global Strategy for Prevention and Assessment of HIV Drug Resistance* Antiviral Therapy, 13 Suppl 2:1-13

Drew, R., Donoghoe, M., Koppel, A., Laukamm-Josten, U., Politi, C., Rotberga, S., Sarang, A. and Stöver, H. (2008) *Evaluation of Fighting HIV/AIDS in Estonia*

ECDC (2010) *Country Mission Report: Estonia: Second Country ECDC Country Visit for STI and HIV*

ECDC and WHO (2010) *Report: Joint ECDC/WHO-EURO TB Country Visit: 2010 Estonia*

EMCDDA (2010) *New Development, Trends and In-depth Information on Selected Issues: 2010 National Report (2009 Data) to the EMCDDA by REITOX National Focal Point: Estonia - also 2008 report supplied with 2007 data*

EMIS (2011a) *The European MSM Internet Survey: Community Report 1*

EMIS (2011b) *The European MSM Internet Survey: Community Report 2*

Estonian Health Insurance Fund (2010) *Annual Report 2010*

Estonian Network of People Living with HIV (2011) *Test and Treat: Final Project Report*

EU (2004) *EU Drugs Strategy: 2005-2012*

EU (2008) *EU Action Plan on Drugs 2009-2012*

Government of Estonia (2005) *Estonian National HIV and AIDS Strategy: 2006-2015*

International Health Partnerships and Related Initiatives (2009) *Joint Assessment of National Health Strategies and Plans: Combined Joint Assessment Tool and Guidelines*

Ilijina, V. (2011) *Experiences in Combined TB/HIV Treatment among IDUs* PowerPoint presentation

IQHIV (2011) *Improving Quality in HIV Prevention in Europe* Available on <http://www.ighiv.org/> Accessed on 15th November 2011

Lai, T., Rätsep, M., Rüütel, K., Trummal, A., Kahur, K., Nielsen, S., Lauer, J., Politi, C. and Habicht, J. (2009) *Modelling Estonia's Concentrated HIV Epidemic: A Case Study*

Laisaar, K-T., Radko, A., DeHovitz, J. and Uusküla, A. (2011) *Estonia at the Threshold of the Fourth Decade of the AIDS Era in Europe* AIDS Research and Human Retroviruses, Volume 27, Number 00

Lõhmus, L., Trummal, A. (2009). HIV-i ja narkomaaniaga seotud teadmised, hoiakud ja käitumine süüdimõistetute hulgas, 2008. Tervise Arengu Instituut, Tallinn. http://www.tai.ee/failid/SM_uurimuse_raport_2008_netti.pdf

Maguerez, G. and Ogden, J. (2010) *Catalyzing Quality Improvements in HIV Prevention: Review of Current Practice and Presentation of a New Approach*. UNAIDS Discussion Document:

Ministry of Social Affairs (2008) *Rahvastiku Tervise Arengukava 2009–2020* (Estonian)

Paluste, H. (2011) *Health Care System in Estonia* PowerPoint presentation to evaluation team, 19th September

Rabkin, M. and El-Sadr, W.M. (2011) *Why Reinvent the Wheel? Leveraging the Lessons of HIV Scale-up to Confront Non-communicable Diseases*. *Global Public Health* 6:3 (247-256)

Rajasaar, H. (2011) *Database of HIV Positive Patients in Estonia* PowerPoint presentation to evaluation team, 23rd September

Redonnet, B. (2011) *HIV/AIDS Prevention and Care among Injecting Drug Users and in Prison Settings in Estonia, Latvia and Lithuania*

Rüütel, K. (2011) *HIV in Estonia* PowerPoint presentation to evaluation team, 19th September

Rüütel, K., Trummal, A., Salekešin, M. and Pervilhac, C. (2011) *HIV Epidemic in Estonia: Analysis of Strategic Information*

Schwartländer, B., Stover, J., Hallett, T., Atun, R., Avila, C., Gouws, E., Bartos, M., Ghys, P.D., Opuni, M., Barr, D., Alsallaq, R., Bollinger, L., De Freitas, M., Garnett, G., Holmes, C., Legins, K., Pillay, Y., Stanciole, A.E., McClure, C., Hirschall, G., Laga, M. and Padian, N. (2011) *Towards an Improved Investment Approach for an Effective Response to HIV/AIDS* *Lancet*, Volume 377, Issue 9782, pp2031-2041

Smart, T. (2011) *HIV and Non-Communicable Diseases* Hatip #182, Available on. <http://www.aidsmmap.com/HIV-and-non-communicable-diseases-NCDs/page/2094965/> Accessed 13 Oct 2011

Subata, E. and Rotberga, S. (2010) *Evaluation of Pharmacotherapy of Opioid Dependence in Prisons in Estonia*

Trummal, A., Lõhmus, L. and Rüütel, K. (2008) *Fighting HIV in Estonia in 2006 and 2007*

UNODC (2011) *Availability of Methadone Therapy* PowerPoint presentation

UNODC, WHO and UNAIDS (2008) *HIV and AIDS in Places of Detention: A Toolkit for Policymakers, Programme Managers, Prison Officers and Health Care Providers in Prison Settings*

Uusküla, A., Des Jarlais, D.C., Kals, M., Rüütel, K., Abel-Ollo, K., Talu, A. and Sobolev, I. (2011) *Expanded Syringe Exchange Programs and Reduced HIV Infection among New Injection Drug Users in Tallinn, Estonia* BMC Public Health, 11, 517

Viiklep, P. (2011) *Tuberculosis in Estonia* PowerPoint presentation to evaluation team, 19th September

WHO (2001) *HIV in Prisons* WHO Regional Office for Europe, Copenhagen.

WHO (2009) *Amor Youth Clinic Network in Estonia*

WHO (2010a) *HIV Drug Resistance Early Warning Indicators* June 2010 update, Available on http://www.who.int/hiv/topics/drugresistance/hiv_dr_early_warning_indicators.pdf (Accessed 4 August 2011)

WHO (2010b) *Prevention of Acute Drug-Related Mortality in Prison Population during the Immediate Post-Release Period*

WHO (2010c) *Accelerating the Implementation of Collaborative TB/HIV Activities in the WHO European Region* Report of a meeting held 16-17 July 2010, Vienna, Austria

WHO (2011a) *Collaborative Framework for the Care and Control of Tuberculosis and Diabetes* Geneva 2011 Available on http://www.who.int/tb/features_archive/diabetes_link/en/index.html Accessed 06/10/11

WHO (2011b) *Guidelines for Intensified Tuberculosis Case-Finding and Isoniazid Preventive Therapy for People Living with HIV in Resource-Constrained Settings*

WHO, UNODC and UNAIDS (2007) *Effectiveness of Interventions to Address HIV in Prisons* Evidence for Action Technical Papers

ANNEX 3: PEOPLE INTERVIEWED

Ministry of Social Affairs

- Ms Merilin Mäesalu - Chief Specialist (Public Health Department)
- Ms Eveli Bauer - Chief Specialist (Medicine department)
- Ms Katrin Karolin - Head of Public Health Department
- Ms Liis Rooväli - Head of Health Information and Analysis Department
- Ms Heli Paluste - Head of Health Care Department

Ministry of Justice

- Ms Pille Teder - Adviser (Prisons Department)
- Ms Kristel Kivimets - Harku prison (Head of Health Care department)

Ministry of Interior

- Mr Ainvar Rahe - Tallinn arresthouse
- Ms Cristel Sootla - Tallinn arresthouse
- Mr Tarmo Pruuli - Adviser (Law Enforcement and Criminal Policy Department)

National Institute for Health Development

- Dr Kristi Rüütel - Expert of HIV/AIDS (Infectious Diseases and Drug Abuse Prevention Department)
- Ms Aljona Kurbatova - Head of Infectious Diseases and Drug Abuse Prevention Department
- Ms Helvi Tarien - Expert (Infectious Diseases and Drug Abuse Prevention Department)
- Ms Annika Veimer - Director of Public Health Programs
- Dr Piret Viiklepp - Head of TB Registry

Estonian Drug Monitoring Centre

- Ms Ave Talu - Head of Centre
- Ms Katri Abel-Ollo - Researcher
- Ms Sigrid Vorobjov - Researcher (On maternity leave)

Estonian Health Insurance Fund

- Ms Sirje Vaask - Expert

Merimetsa hospital

- Dr Kai Zilmer - Head of Infectious Diseases department

LLC Corrigo:

- Dr Tiiu Sepp - Member of the board
- Ms Ljubov Uljanova - Supervising nurse at the methadone substitution centre
- Ms Ene Narusing - Social worker in the children rehabilitation centre
- Ms Maie Geimonen - Project leader in the children rehabilitation centre

Ida-Viru Central Hospital:

- Dr Kaljo Mitt - Member of the board
- Dr Ljudmilla Poklonskaja - Head of the internal medicine clinic
- Dr Jelena Schmidt - Head of the infectious diseases department
- Dr Veronika Iljina - Head of the TB department

Estonian Network for People Living with HIV in North-Eastern Estonia

- Mr Valeri Aljo'kin - Peer counsellor

- Ms Tatjana Mironova - Peer counsellor

Sillamäe Rehabilitation Centre

- Ms Olga Gluhihh - Attendant

- Mr Nikolai Litvinenko - Psychologist

LLC Elulootus

- Dr Nelli Kalikova

- Mr Indrek Kalikov

Convictus Estonia

- Ms Kristina Joost - Manager

- Ms Olga Zaimintseva - Needle exchange project coordinator

- Mr Andrei Altdorf - Consultant

